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IN THE HIGH COURT OF SOUTH AFRICA
Gauteng Division, Pretoria

CASE NO: **2026-019811**

In the matter between:

AFRIFORUM NPC	Plaintiff / Applicant / Appellant
and	
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA ,MINISTER OF HEALTH ,MINISTER OF FINANCE ,SPEAKER OF THE NATIONAL ASSEMBLY ,CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES	Defendant / Respondent

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Combined Summons

NOTE: **This document was filed electronically by the Registrar on 2/2/2026 at 10:01:54 AM South African Standard Time (SAST). The time and date the document was filed by the party is presented on the header of each page of this document.**

ELECTRONICALLY SIGNED BY:

Registrar of Pretoria , Gauteng Division,Pretoria

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

Case No: _____

In the matter between:

AFRIFORUM NPC	**Plaintiff**
And	
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	**First Defendant**
MINISTER OF HEALTH	**Second Defendant**
MINISTER OF FINANCE	**Third Defendant**
SPEAKER OF THE NATIONAL ASSEMBLY	**Fourth Defendant**
CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES	**Fifth Defendant**

COMBINED SUMMONS

To the Sheriff or his / her deputy:

INFORM: The **PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA** (referred to as the "President" or first defendant) and Head of the National Executive, with offices at **Union Buildings, Government Avenue, Pretoria** and

care of the State Attorney, Pretoria, situated at **SALU Building, 316 Thabo Sehume Street, Pretoria**.

AND: The **MINISTER OF HEALTH** (referred to as "the Minister" or the second defendant) with offices at **Dr AB Xuma Building, 1112, Voortrekker Road, Pretoria** and care of the State Attorney, Pretoria, situated at **SALU Building, 316 Thabo Sehume Street, Pretoria.**

AND: The **MINISTER OF FINANCE** (referred to as the "Minister of Finance" or third defendant) with offices at **40 Church Street, Old Reserve Bank Building, Second Floor, Pretoria** and care of the State Attorney, Pretoria, situated at **SALU Building, 316 Thabo Sehume Street, Pretoria**.

AND: The **SPEAKER OF THE NATIONAL ASSEMBLY** who represents the interests of the National Assembly (referred to as the "National Assembly" or fourth defendant) with offices at **Parliament Building, Room S38, Parliament Street, Cape Town** and care of the State Attorney, Pretoria, situated at **SALU Building, 316 Thabo Sehume Street, Pretoria**.

AND: The **CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES** (referred to as the "National Council of Provinces" or the fifth defendant) with offices at **Parliament Building, Parliament Street, Room S11,**

Cape Town and care of the State Attorney, Pretoria, situated at **SALU Building, 316 Thabo Sehume Street, Pretoria**.

THAT: **AFRIFORUM NPC**, a non-profit company with registration number: 2005/042861/08, duly registered and incorporated in terms of the Companies Act, 71 of 2008, with registered address and principal place of business at **58 Union Avenue, Kloofsig, Centurion, 0157, Gauteng Province** (hereinafter referred to as the plaintiff), hereby institutes action against the defendants in which action the Plaintiff claims the relief on the grounds set out in the Particulars of Claim annexed hereto.

FURHTER INFORM the defendants that if they dispute the action and wish to defend the action, they shall –

(i) within **20 (*twenty*)** days of the service upon the defendants of this Combined Summons, file with the Registrar of this Honourable Court situated at Paul Kruger & Madiba St, 123 Helen Joseph St, Pretoria Central, Pretoria, 0002, High Court Gauteng Division, Pretoria, their notices of intention to defend and serve a copy thereof on the attorneys of the plaintiff, which notice shall give an address (not being a post office or *poste restante and being within 25 kilometres of the office of the Registrar*) referred to in rule 19(3) for the service upon the defendants of all notices and documents in the action.

(ii) thereafter and within **20 (*twenty*)** days after filing and serving their notices of intention to defend as aforesaid, file with the Registrar and serve upon the Plaintiff a Plea, Exception, or Notice to strike out, with or without a Counterclaim.

INFORM the defendants further that the plaintiff will accept any court process, document and/or notice as provided for in Rule 4A electronically at the following email addresses: wian@hurterspies.co.za and tharina@hurterspies.co.za.

INFORM the defendants further that if the defendants fail to file and serve the notices as aforesaid, judgment as claimed may be given against them without further notice, or if having filed and served such notices, the defendants fail to plead, except, make application to strike out or Counterclaim, judgment may be given against them.

INFORM the defendants further that if they do not intend to defend the action, they may give written notice to that effect to the plaintiff's attorneys and the Registrar of the High Court, Gauteng Division, Pretoria and the action may then, at the written request of the plaintiff's attorneys, be forthwith set down for hearing.

AND immediately thereafter serve on the defendants a copy of this combined summons and return same to the Registrar with whatsoever you have done thereupon.

SIGNED AT PRETORIA ON THIS THE 26TH DAY OF JANUARY 2026.

REGISTRAR OF THE HIGH COURT

(Gauteng Division, Pretoria)

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

HURTER SPIES INC.
Attorneys for Plaintiff
(Attorney with right of appearance
in terms of section 25(3) of the
Legal Practice Act 28 of 2014)
First Floor, Building 1
Greenpark Estate
27 George Storrar Rd
Groenkloof, Pretoria
Tel: (012) 941 9239
EMAIL: ***wian@hurterspies.co.za***
tharina@hurterspies.co.za
REF: WD SPIES/MAT5752

PARTICULARS OF CLAIM

1.

THE PARTIES:

1.1 The plaintiff is **AFRIFORUM NPC** (referred to as "*AfriForum*" or the plaintiff), a non-profit company registered under registration number 2005/042861/08 in terms of the company laws of the Republic of South Africa and also registered as a non-governmental organisation (NGO) under registration number 054-590, having its principal place of business at AfriForum Building, corner. D.F. Malan and Union Streets, Kloofsig, Centurion, Gauteng.

1.2 The first defendant is the **PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA** (referred to as "*the President*") and Head of the National Executive, with offices at Union Buildings, Government Avenue, Pretoria and care of the State Attorney, Pretoria, situated at SALU Building, 316 Thabo Sehume Street, Pretoria.

1.3 The first defendant assented to the National Health Insurance Bill ("*the Bill*") on 15 May 2024 after the National Assembly and the National Council of Provinces had passed the Bill in June 2023 and December 2023, respectively. The Bill became an Act of Parliament as from 16 May 2024, which was the date of publication in the *Government Gazette.* The Act has not taken effect in terms of section 59 thereof.

1.4 The second defendant is the **MINISTER OF HEALTH** (referred to as *"the Minister"* or the second defendant) with offices at Dr AB Xuma Building, 1112, Voortrekker Road, Pretoria and care of the State Attorney, Pretoria, situated at SALU Building, 316 Thabo Sehume Street, Pretoria. The second defendant is the responsible minister as defined in the National Health Insurance Act, No 20 of 2023.

1.5 The third defendant is the **MINISTER OF FINANCE** with offices at 40 Church Street, Old Reserve Bank Building, Second Floor, Pretoria and care of the State Attorney, Pretoria, situated at SALU Building, 316 Thabo Sehume Street, Pretoria.

1.6 The third defendant:

1.6.1 Is the responsible minister for the National Treasury, which in turn is responsible for coordinating macroeconomic policy and promoting the national fiscal policy framework;

1.6.2 Is central to economic and fiscal policy and development;

1.6.3 Has an interest in the action as appears from the contents of the particulars of the claim, in particular with reference to the financial feasibility of the National Health Insurance Scheme as envisaged by the Act.

1.7 The fourth defendant is the **SPEAKER OF THE NATIONAL ASSEMBLY**, who represents the interests of the National Assembly with offices at Parliament Building, Room S38, Parliament Street, Cape Town and care of the State Attorney, Pretoria, situated at SALU Building, 316 Thabo Sehume Street, Pretoria.

1.7.1 The National Assembly, having finally passed the Bill, has an interest in the relief sought.

1.8 The fifth defendant is the **CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES** with offices at Parliament Building, Parliament Street, Room S11, Cape Town and care of the State Attorney, Pretoria, situated at SALU Building, 316 Thabo Sehume Street, Pretoria.

1.9 The National Council of Provinces:

1.9.1 Passed the National Health Insurance Bill on 6 December 2023.

1.9.2 Has an interest in the relief sought.

2.

JURISDICTION:

This Court has the necessary jurisdiction to adjudicate upon this action.

3.

NATURE OF THE ACTION AND RELIEF SOUGHT:

3.1 The plaintiff seeks to have the National Health Insurance Act, No 20 of 2023 ("*the Act*"), declared unconstitutional based on the grounds pleaded further herein.

3.2 The plaintiff foresees material factual disputes, requiring cross-examination, to arise in the action, not only in relation to the background to and circumstances within which the Act came into existence, but more specifically in respect of several of the grounds relied upon by the plaintiff and the factual bases underpinning those grounds. This will require the presentation of both factual and expert oral evidence, in consequence of which the plaintiff has elected to seek the relief prayed for by way of action.

4.

PLAINTIFF'S STANDING:

4.1 The main purpose and objectives of AfriForum, as stated in its Memorandum of Incorporation, are, *inter alia,* the promotion and advocacy of civil and human rights and other constitutional rights. AfriForum's Memorandum of Incorporation is a public document lodged with the Registrar of Companies.

4.2 For purposes of furthering its objectives, AfriForum is a civil rights organisation whose *locus standi* has been recognised by the courts throughout the country in various public-related and constitutional-related litigation.

4.3 AfriForum seeks to challenge the constitutionality of the Act, alternatively, certain provisions of the Act on the grounds pleaded further herein. The plaintiff's action invokes certain constitutional rights and obligations in terms of the Constitution of the Republic of South Africa Act, No 108 of 1996 ("*the Constitution*"), including but not limited to:

4.3.1 The legality principle and the rule of law;

4.3.2 The constitutional legislative and executive competence of provinces in respect of health services;

4.3.3 The obligation of the state in terms of section 7(2) of the Constitution to respect, protect, promote and fulfil the rights in the Bill of Rights;

4.3.4 The right to human dignity in terms of section 10 of the Constitution;

4.3.5 The right to equality in terms of section 9 of the Constitution;

4.3.6 The right to life in terms of section 11 of the Constitution;

4.3.7 The right to health care services, including reproductive health in terms of section 27(1)(a) of the Constitution;

4.3.8 The obligation of the state in terms of section 27(2) of the Constitution to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the rights in section 27(1);

4.3.9 The rights of children in terms of section 28(2) of the Constitution;

4.3.10 The consideration of international law in the interpretation of the Bill of Rights;

4.3.11 The promotion of the values that underlie an open and democratic society based on human dignity, equality and freedom.

4.3.12 Common law rights, which form part of the Constitution, such as (*inter alia*) the right to informed consent to health care services.

4.4 AfriForum's standing is derived from the broader standing provisions of section 38 of the Constitution as further pleaded herein.

4.5 AfriForum currently has approximately 300 000 paid-up members country-wide, many of whom are reliant upon quality health care services, and have the right to the enjoyment of the highest attainable standard of physical and mental health as envisaged by the provisions of:

4.5.1 Article 12 of the United Nations Covenant on Economic, Social and Cultural Rights, 1966;

4.5.2 Article 16 of the African Charter on Human and People's Rights, 1981; and

4.5.3 The rights in the Bill of Rights referred to in paragraph 4.3 above.

4.6 The Act introduces provisions materially affecting or potentially affecting not only the constitutional rights of members of the plaintiff but also those of the public in general, which rights go to the heart of the future provision of health care services in South Africa, should the Act be put into operation.

4.7 The Act is controversial; has elicited broad debate from various quarters; and is of significant public interest and importance.

4.8 The constitutional challenge to the Act, alternatively, certain provisions of the Act, is based on the legality principle and fundamental rights as referred to in paragraph 4.3 above, which are threatened by its provisions, as further elaborated on herein.

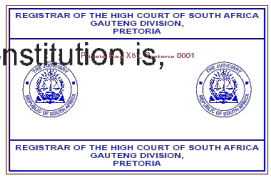
4.9 Section 38 of the Constitution provides a broad standing for anyone approaching a court for relief, alleging that a right in the Bill of Rights has been infringed or threatened, including:

4.9.1 Anyone acting in his/her own interest, as contemplated in section 38(a);

4.9.2 Anyone acting in the public interest, as contemplated in section 38(d);

4.9.3 An association acting in the interest of its members, as contemplated in section 38(e).

4.10 AfriForum's standing in terms of the aforesaid provisions of the Constitution is, respectively, founded upon it acting:



4.10.1 In its own interest, in the furtherance of its stated objectives as mentioned above;

4.10.2 In the public interest, in that the subject matter of the action involves fundamental rights, the rule of law and the legality principle in relation to legislation, thus invoking the broader public interest;

4.10.3 In the interests of its members who are affected by the National Health Insurance Scheme introduced by the Act.

5.

PURPOSE AND SALIENT PROVISIONS OF THE ACT:

5.1 In terms of section 2 of the Act, the purpose of the Act is to establish and maintain a National Health Insurance Fund ("*the Fund*") funded through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality health care services by:

5.1.1 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;

5.1.2 Ensuring the sustainability of funding for health care services within the Republic; and

5.1.3 Providing for equity and efficiency in funding by pooling of funds and strategic purchasing of health care services, medicines, health goods and health-related products from accredited and contracted health care service providers.

5.2 The purpose of the Act is also to be read in context with the Preamble of the Act that invokes provisions of international charters or agreements, such as article 12 of the United Nations Covenant on Economic, Social and Cultural Rights, 1966 and article 16 of the African Charter on Human and People's Rights, 1981.

5.3 The Preamble to the Act further refers to the following provisions of the Constitution:

5.3.1 Sections 9 and 10 of the Constitution, which respectively address the rights to equality and human dignity;

5.3.2 Section 12(2) of the Constitution, which addresses the right to bodily and psychological integrity;

5.3.3 Section 27(1)(a) of the Constitution, in terms of which everyone has the right to have access to health care services, including reproductive health care;

5.3.4 Section 27(2) of the Constitution, in terms of which the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to health care services;

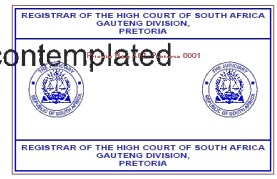
5.3.5 Section 27(3) of the Constitution, in terms of which no one may be refused emergency medical treatment; and

5.3.6 Section 28(1)(c) of the Constitution, which provides that every child has the right to basic health care services;

5.4 Section 1, the definition clause in the Act, defines:

5.4.1 "*Health care service*" as:

5.4.1.1 Health care services, including reproductive health care and emergency medical treatment contemplated in section 27 of the Constitution;



5.4.1.2 basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution;

5.4.1.3 medical treatment contemplated in section 35(2)(e) of the Constitution; and

5.4.1.4 where applicable, provincial, district and municipal health care services;

5.4.2 "*Health care service provider*" as a natural or juristic person in the public or private sector providing health care services in terms of any law;

5.4.3 "*Health establishment*" 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;

5.5 The Act:

5.5.1 Establishes the Fund, in section 9;

5.5.2 Sets out the Fund's functions to achieve the purpose of the Act, in section 10; and

5.5.3 Sets out the powers of the Fund, in section 11 of the Act.

5.6 Section 11(1) of the Act empowers the Fund to identify, develop, promote and facilitate the implementation of best practices in respect of *inter alia*:

5.6.1 In section 11(1)*(i)*(i), the purchase of health care services and procurement of medicines, health goods and health-related products on behalf of users;

5.6.2 In section 11(1)*(i)*(ii), payment of health care service providers, health workers, health establishments and suppliers;

5.6.3 In section 11(1)*(i)*(iii), facilitation of the efficient and equitable delivery of quality health care services to users;

5.6.4 In section 11(1)*(i)*(v), managing risks that the Fund is likely to encounter;

5.6.5 In section 11(1)*(i)*(vii), the design of the health care service benefits to be purchased by the Fund, in consultation with the Minister; and

5.6.6 In section 11(1)*(i)*(viii), referral networks in respect of users, in consultation with the Minister.

5.7 The role of medical schemes is addressed in section 33 of the Act, which section:

5.7.1 Provides that, 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;

5.7.2 Must also to be read with section 58 of the Act, which provides for the repeal or amendment, to the extent defined therein, of the laws specified in the Schedule to the Act, which laws include the Medical Schemes Act, No 131 of 1998 ("*the Medical Schemes Act*"), in respect of which the amendments, *inter alia*, entail:

5.7.2.1 The amendment of the definition of "*relevant health service*":

(a) to mean only health care treatment not covered by the provisions of the Act, which treatment is complementary to health care services funded by the State; and

(b) by removing therefrom, the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;

5.7.2.2 Amendment of section 2(1) thereof, to the effect that the Act will prevail over the Medical Schemes Act in the case of any conflict;

5.7.2.3 Amendment of section 24(1) thereof, to the effect that registration of a medical scheme is subject to the provisions of the Act;

5.7.2.4 Amendment of section 33(1) thereof, to the effect that any application to the Registrar of Medical Schemes for approval of any benefit option that constitutes complementary or top-up cover must not overlap with the personal health care service benefits purchased by the National Health Insurance Fund on behalf of users as provided for in the Act.

5.8 Section 48 of the Act determines that the revenue sources of the Fund consist of:

5.8.1 Money to which the Fund is entitled in terms of section 49;

5.8.2 Any interest or return on investment made by the Fund;

5.8.3 Any money paid erroneously to the Fund which, in the opinion of the Minister, cannot be refunded;

5.8.4 Any bequest or donation received by the Fund; and

5.8.5 Any other money to which the Fund may become legally entitled.

5.9 Section 49 of the Act sets out what the chief source of income of the Fund is and how it will be generated.

5.10 Section 49(1) of the Act provides that the Fund is entitled to money appropriated annually by Parliament in order to achieve the purpose of the Act.

5.11 Section 49(2) of the Act provides that the money referred to in section 49(1) must be:

5.11.1 Appropriated from money collected and in accordance with social solidarity in respect of:

5.11.1.1 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 [section 49(2)(a)(i)];

5.11.1.2 reallocation of funding for medical scheme tax credits paid to various medical schemes towards the funding of National Health Insurance [section 49(2)(a)(ii)];

5.11.1.3 payroll tax (employer and employee) [section 49(2)(a)(iii)]; and

5.11.1.4 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 [section 49(2)(a)(iv)]; and

5.11.2 Calculated in accordance with the estimates of income and expenditure as contemplated in section 53 of the Public Finance Management Act, No 1 of 1999 ("*the PFMA*") [section 49(2)(b)].

5.12 Section 49(3) provides further that once appropriated, the revenue allocated to the Fund must be paid through a Budget Vote to the Fund as determined by agreement between the Fund and the Minister and subject to the provisions of the Constitution and the PFMA.

5.13 Section 35 of the Act amplifies the general powers of the Fund defined in section 11(1)(*i*) of the Act, in particular those pertaining to the purchasing of health care services by the Fund, by providing as follows:

5.13.1 The Fund must actively and strategically purchase health care services on behalf of users in accordance with need [section 35(1)];

5.13.2 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 [section 35 (2)];

5.13.3 Funds for primary health care services must be reimbursed directly to accredited and contracted primary health care service providers and health establishments at the subdistrict level as outlined in section 37 [section 35(3)];

5.13.4 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 [section 35(4)(a)];

5.13.5 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 [section 35(4)(b)];

5.13.6 Public ambulance services must be reimbursed through the provincial equitable allocation [section 35(4)(c)].

5.14 In addition to the provisions contained in section 35 of the Act, section 41 regulates the payment and reimbursement of health care service providers, health establishments and suppliers, *inter alia* in:

5.14.1 Section 41(1) of the Act, which provides that the Fund, in consultation with the Minister, must determine the nature of provider payment mechanisms and adopt additional mechanisms;

5.14.2 Section 41(3)(a) of the Act, which provides that 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;

5.14.3 Section 41(3)(b) of the Act, which provides that 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;

5.14.4 Section 41(3)(c) of the Act, which provides that emergency medical services must be reimbursed on a capped, case-based fee basis with adjustments made for case severity, where necessary;

5.14.5 Section 41(4) of the Act, which further empowers the Minister by providing that, without limiting the powers of the Minister to make regulations in terms of section 55, the Minister may make regulations to:

5.14.5.1 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 [section 41(4)(a)];

5.14.5.2 determine mechanisms for the payment of an individual health worker and health care provider [section 41(4)(b)]; and

5.14.5.3 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 [section 41(4)(c)].

5.15 The Fund is governed by a Board:

5.15.1 Accountable to the Minister, established in terms of section 12 of the Act;

5.15.2 Appointed by the Minister in terms of section 13 of the Act, which prescribes, *inter alia*:

5.15.2.1 the composition of the Board, in section 13(1) thereof, and

5.15.2.2 the qualifying criteria for members of the Board, in section 13(4) thereof;

5.15.3 With the functions and powers as set out in section 15 of the Act.

5.16 Section 3 of the Act provides that the Act:

5.16.1 Applies to all health establishments, excluding military health services and establishments;

5.16.2 Does not apply to members of the National Defence Force and the State Security Agency.

5.17 Section 3(5) of the Act exempts the Fund from the provisions of the Competition Act, No. 89 of 1998, to enable it to fulfil its mandate as a single purchaser and single payer as contemplated in section 2 of the Act.

5.18 Section 4 of the Act provides that the Fund, in consultation with the Minister, must purchase health care services, determined by the Benefits Advisory Committee, on behalf of:

5.18.1 South African citizens;

5.18.2 Permanent residents;

5.18.3 Refugees;

5.18.4 Inmates, as provided for in section 12 of the Correctional Services Act, No. 111 of 1998; and

5.18.5 Certain categories or individual foreigners determined by the Minister of Home Affairs, after consultation with the Minister and the Minister of Finance, by notice in the Gazette.

5.19 Section 25(1) of the Act provides for the establishment, by the Minister after consultation with the Board of the Fund, of the Benefits Advisory Committee, as referred to above and elsewhere herein.

5.20 The Benefits Advisory Committee, which fulfils a key function in terms of the Act as one of the advisory committees to the Fund, must, in terms of section 25(5) of the Act, determine and review:

5.20.1 The health care service benefits and types of services to be reimbursed at each level of care at primary health care facilities and at district, regional and tertiary hospitals [section 25(5)(a)];

5.20.2 detailed and cost-effective treatment guidelines that take into account the emergence of new technologies [section 25(5)(b)]; and

5.20.3 in consultation with the Minister and the Board, the health service benefits provided by the Fund [section 25(5)(c)].

5.21 Section 26(1) of the Act provides for the establishment, by the Minister after consultation with the Board of the Fund, of the Health Care Benefits Pricing Committee, which must, in terms of section 26(3) of the Act, recommend the prices of health service benefits to the Fund.

5.22 Section 31 of the Act addresses the role of the Minister. It amplifies the extensive powers of the Minister, derived from several provisions in the Act, in sections 31(1) and 31(2) thereof, which respectively provide that:

5.22.1 Without derogating from any responsibilities and powers conferred on him or her by the Constitution, the National Health Act, No 61 of 2003, ("National Health Act"), the Act or any other applicable law, the Minister is responsible for:

5.22.1.1 governance and stewardship of the national health system; and

5.22.1.2 governance and stewardship of the Fund in terms of the provisions of the Act; and

5.22.2 The Minister must clearly delineate in appropriate legislation the respective roles and responsibilities of the Fund and the national and provincial Departments, taking into consideration the Constitution, the Act and the National Health Act, in order to prevent duplication of services and the wasting of resources and to ensure the equitable provision and financing of health services.

5.23 Section 5 of the Act addresses the registration of users, in respect of which:

5.23.1 Section 5(1) requires a person who is eligible to receive health care services, in accordance with section 4 of the Act, to register as a user

with the Fund at an accredited health care service provider or health establishment; and

5.23.2 Sections 5(2), (3), and (4) make provision for the registration of children as users of the Fund at an accredited health care service provider or health establishment.

5.24 Section 6 of the Act lists certain rights to which a user of health care services purchased by the Fund is entitled. These rights include the right to:

5.24.1 Receive necessary quality health care services free at the point of care from an accredited health care service provider or health establishment;

5.24.2 Access health care services within a reasonable time period;

5.24.3 Be treated with a professional standard of care;

5.24.4 Make reasonable decisions about his or her health care;

5.24.5 Purchase health care services that are not covered by the Fund through a complementary voluntary medical insurance scheme registered in terms of the Medical Schemes Act, private insurance covering an international traveller with a short-term, work or student visa or out-of-pocket payments, as the case may be.

5.25 Section 7 of the Act contains, *inter alia*, the following provisions regarding users of health care services:

5.25.1 Section 7(1) provides that the Fund, in consultation with the Minister, must purchase health care services, determined by the Benefits Advisory Committee, for the benefit of users;

5.25.2 Section 7(2) provides that, subject to subsection (4):

5.25.2.1 a user must receive the health care services that he or she is entitled to under the Act from a health care service provider or health establishment at which the user had registered for the purpose of receiving those health care services [section 7(2)(a)];

5.25.2.2 should a user be unable to access the health care service provider or health establishment with whom or at which the user is registered in terms of section 5, such portability of health services as may be prescribed must be available to that user [section 7(2)(b)];

5.25.2.3 should a health care service provider or health establishment contemplated in section 7(2)(a) or (b) not be able to provide the necessary health care services, the health care service provider or health establishment in question must transfer the user concerned to another

appropriate health care service provider or health establishment that is capable of providing the necessary health care services in such manner and on such terms as may be prescribed [section 7(2)(c)];

5.25.2.4 a user, in terms of section 7(2)(d):

(i) must first access health care services at a primary health care level as the entry into the health system;

(ii) must adhere to the referral pathways prescribed for health care service providers or health establishments; and

(iii) is not entitled to health care services purchased by the Fund if he or she fails to adhere to the prescribed referral pathways;

5.25.2.5 the Fund must enter into contracts with accredited health care service providers and health establishments at the primary health care and hospital level based on the health needs of users and in accordance with referral pathways [section 7(2)(e)].

5.25.3 Section 7(2)(f) provides for the establishment of central hospitals (defined as a public hospital designated as such by the Minister as a

national resource to provide health care services to all residents, irrespective of the province in which they are located, and that must serve as a centre of excellence for conducting research and training of health workers) in respect of which the administration, management, budgeting and governance must be made a competence of the national government.

5.25.4 Section 7(3) provides that, for the purpose of section 7(2)(b), "*portability of health care services*", in respect of a user, means the ability of a user to access health care services by an accredited health care service provider or at an accredited health establishment other than by the health care services provider or at the health establishment with which or at which that user is registered in terms of section 5.

5.25.5 Section 7(4) of the Act provides that treatment must not be funded if a health care service provider demonstrates that:

5.25.5.1 No medical necessity exists for the health care service in question [section 7(4)(a)];

5.25.5.2 No cost-effective intervention exists for the health care service as determined by a health technology assessment [section 7(4)(b)]; or

5.25.5.3 The health care product or treatment is not included in the Formulary, except in circumstances where a complementary list has been approved by the Minister [section 7(4)(c)].

5.26 "*Formulary*" is defined in the Act to mean the Formulary and its composition referred to in section 38(4) of the Act.

5.27 Section 38(4) of the Act provides that the Health Products Procurement unit must support the Benefits Advisory Committee in the development and maintenance of the Formulary, 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 as approved by the Minister in consultation with the National Health Council and the Fund.

5.28 Section 38(6) of the Act provides that an accredited health care service provider and health establishment must procure according to the Formulary, and suppliers listed in the Formulary must deliver directly to the accredited and contracted health service provider and health establishment.

5.29 Section 39 of the Act provides for the accreditation of health care service providers and health establishments.

5.30 One of the powers of the Chief Executive Officer of the Fund in terms of section 20(3)(*d*) of the Act is to establish a unit for accreditation. No further particulars are provided in the Act as to the qualifications or criteria for persons eligible for appointment to the accreditation unit.

5.31 Section 8 of the Act contains provisions in relation to cost coverage.

5.31.1 Section 8(1) provides that a user of the Fund is entitled to receive the health care services purchased on his or her behalf by the Fund from an accredited health care service provider or health establishment, free at the point of care.

5.31.2 Section 8(2) provides further that a person or user, as the case may be, must pay for health care services rendered directly or through a voluntary medical insurance scheme registered under the Medical Schemes Act or through a private insurance covering an international traveller with a short term, work or student visa or out of pocket payment, if that person or user:

5.31.2.1 is not entitled to health care services purchased by the Fund in terms of the Act [section 8(2)(a)];

5.31.2.2 seeks services that are not deemed medically necessary by the Benefits Advisory Committee [section 8(2)(b)];

5.31.2.3 seeks services that are not covered by the Fund as prescribed [section 8(2)(c)]; or

5.31.2.4 seeks services that are not included in the comprehensive health care services as advised by the Benefits Advisory Committee [section 8(2)(d)].

5.32 Section 38 of the Act provides for the establishment and functions of a Health Products Procurement Unit, which is established by the Board of the Fund after consultation with the Minister and which unit sets the parameters for the public procurement of health-related products.

5.33 Section 38(2) of the Act provides that the Health Products Procurement unit located within the Fund is responsible for the centralised facilitation and coordination of functions related to the public procurement of health-related products, including but not limited to medicines, medical devices and equipment.

5.34 Section 38(3) of the Act requires ("*must*") the Health Products Procurement unit to:

5.34.1 determine the selection of health-related products to be procured [section 38(3)(a)];

5.34.2 develop a national health products list [section 38(3)(b)];

5.34.3 coordinate the supply chain management process and price negotiations for health-related products contained in the list mentioned in section 38(3)(a) [section 38(3)(c)];

5.34.4 facilitate the cost-effective, equitable and appropriate public procurement of health-related products on behalf of users [section 38(3)(d)];

5.34.5 support the processes of ordering and distribution of health-related products nationally, and at the district level with the assistance of the District Health Management Office [section 38(3)(e)];

5.34.6 support the District Health Management Office in concluding and managing contracts with suppliers and vendors [section 38(3)(f)];

5.34.7 establish mechanisms to monitor and evaluate the risks inherent in the public procurement process [section 38(3)(g)];

5.34.8 facilitate the procurement of high-cost devices and equipment [section 38(3)(h)]; and

5.34.9 advise the Board on any matter pertinent to the procurement of health-related products [section 38(3)(a)].

5.35 Section 38(7) of the Act provides that the provisions of section 38 are subject to public procurement laws and policies of the Republic that give effect to the

provisions of section 217 of the Constitution, including the Preferential Procurement Policy Framework Act, No 5 of 2000, and the Broad-Based Black Economic Empowerment Act, No 53 of 2003.

5.36 Chapter 9 of the Act makes provision for complaints to the Fund; investigation of complaints; and appeals to an appeal tribunal. In terms of section 44(1) of the Act, the appeal tribunal is appointed by the Minister after consultation with the Cabinet.

5.37 Section 55 of the Act confers extensive powers upon the Minister to make regulations. These include regulations regarding –

5.37.1 All practices and procedures to be followed by a health care service provider, health establishment or supplier in relation to the Fund [section 55(1)(v)];

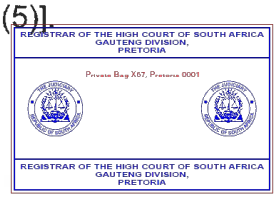
5.37.2 The scope and nature of prescribed health care services and programmes and the manner in, and extent to which, they must be funded [section 55(1)(w)].

5.38 Section 57 of the Act addresses transitional arrangements, which *inter alia* provide for:

5.38.1 The gradual phasing in of National Health Insurance in two phases, with Phase 1 from 2023 to 2026 [section 57(2)(a)];

5.38.2 Objectives that must be achieved in Phase 1, which entail *inter alia*, legislative reforms regarding virtually all health-related legislation [section 57(4)(h)];

5.38.3 Objectives that must be achieved in Phase 2 for a period of three years from 2026 to 2028, which include the establishment and operationalisation of the Fund as a purchaser of health care services through a system of mandatory prepayment [section 57(5)].



6.

GROUNDS FOR THE UNCONSTITUTIONALITY OF THE ACT:

The essential factual and legal grounds for the constitutionality challenge to the legislative scheme of National Health Insurance introduced by the Act, and the Act and its salient provisions, and the grounds for the relief sought by the plaintiff, are pleaded further below.

7.

DIMINUTION OF THE CONSTITUTIONAL POWERS OF PROVINCES:

7.1 In terms of Part A of Schedule 4 of the Constitution, the functional area of legislative competence in respect of health services is assigned to provincial governments concurrently with the national government.

7.2 Ambulance services are the exclusive domain of provincial legislative competence in terms of Part A of Schedule 5 to the Constitution.

7.3 The aforementioned schedules are to be read with section 104 of the Constitution, which provides for legislative competence of provinces and section 125, which provides for the executive authority of provinces.

7.4 Section 146 of the Constitution makes provision for conflict between national and provincial legislation falling within the functional area listed in Schedule 4.

7.5 It is within the Constitutional purpose and design that certain governmental competencies and authorities, such as health services and basic education, are decentralised and devolved upon and delivered through provincial governments.

7.6 Health care services, as in the case of basic education, are public functions which require accountability, responsiveness, equity and efficiency to local users, which are best achieved through decentralised health services and are consistent with the principles of subsidiarity, which entail that decisions are to be made as close as possible to the users where they will have their effect.

7.7 It is the intention of the Constitution that health care services are organised and delivered locally, with certain interventions determined at the national level confined to norms and standards, frameworks or national policies.

7.8 To achieve this constitutional design, a substantial portion of nationally raised taxes is allocated to provincial governments and distributed using the Provincial Equitable Share ("*PES*") formula.

7.9 The Act, by centralising the funding of health care services and the purchasing of health care services, medicines, health goods, health products and health-related products, undermines the Constitutional powers of provinces to budget, finance, plan, and run health care services.

7.10 The centralisation of the PES to the Fund in terms of section 49(2)(a)(i) of the Act constitutes an intrusion by national government into the legitimate tax revenue of provinces allocated to the performance of their constitutionally mandated functions, in respect of health care and ambulance services, given that these health care services are constitutionally and legitimately the domain of provincial governments, inclusive of financing (raising and allocating funds), planning, organising and service delivery required for the execution of those services by provincial hospitals, clinics and transport services.

7.11 The creation or designation of certain public hospitals as central hospitals in terms of section 7(2)(f) of the Act constitutes further legislative encroachment by the national government upon health care services rendered by provincial governments.

7.12 In the premises, and to the extent that the Act adversely affects the constitutional functional areas of health care services and ambulance services rendered by provinces, the Act is unconstitutional.

8.

ADVERSE EFFECT ON THE PRIVATE SECTOR, PATIENTS AND CLINICAL INDEPENDENCE OF PRACTITIONERS:

Freedom of Choice of Patients:

8.1 The Act, by virtue of sections 7(2), 8 and 11(1)(*i*)(viii) requires that all users obtain health care services exclusively through accredited providers within the National Health Insurance ("*NHI*") network and, ordinarily, by following a prescribed sequence of access and referral pathways.

8.2 Section 33 of the Act further stipulates that, once NHI has been fully implemented, medical schemes may only provide complementary cover. This places the future existence of Medical Schemes and private health care at risk and creates financial uncertainty, thus undermining investment and adversely affecting the economy.

8.3 The combined effect of the aforesaid provisions of the Act will:

8.3.1 Eliminate the present available range of coverage options;

8.3.2 Substantially narrow the range of health care providers that patients may access without incurring prohibitive out-of-pocket expenditure; and

8.3.3 Limit the choice of access by patients to both public and private health care service providers and health establishments.

8.4 The abovementioned represents a material reduction in freedom of choice, both in relation to medical cover arrangements and in relation to the selection of providers.

8.5 In constitutional terms, these limitations and infringements on freedom adversely affect section 7(1) of the Constitution, which provides that the Bill of Rights is a cornerstone of democracy in South Africa and enshrines the rights of all people in the country and affirms the democratic values of human dignity, equality and freedom.

8.6 The abovementioned further adversely affects and infringes upon and/or threatens other fundamental rights in the Constitution, such as:

8.6.1 The right to life [section 11];

8.6.2 The right to human dignity [section 10];

8.6.3 The right of access to health care services, including reproductive health care [section 27];

8.6.4 The right to freedom of trade, occupation and profession [section 22]; and

8.6.5 The rights of children [section 28(2)].

8.7 In addition, the abovementioned limitations and infringements do not constitute reasonable legislative and other measures to achieve the progressive realisation of the right of access to health care services as required by section 27(2) of the Constitution, despite the fact that the preamble to the Act proclaims to do so.

8.8 Further, the abovementioned limitations and infringements adversely affect the right afforded to persons by section 9 of the Constitution not to be unfairly discriminated against, whether directly or indirectly. The unfair discrimination applies to all persons who have thus far enjoyed the freedom of choice to be members of medical schemes and a range of benefits that medical schemes offer, in terms of current legislation, and to enable such members to have access to quality health care services in the private sector.

8.9 The Act also adversely affects the freedom of choice of access to public health establishments.

8.10 The limitations on freedoms and infringements of rights as referred to above must also be seen in the context of years of poor quality of health care services, poor health service management and poor outcomes in the public

sector and, in particular, in eight of the nine provinces, the Western Cape excluded.

8.11 The State, in its obligation to achieve the progressive realisation of the right to health care services by reasonable legislative and other means, has the concomitant negative obligation not to adversely affect existing rights. The Act adversely affects existing rights.

8.12 In the premises and in view of what is pleaded above in paragraphs 8.1 to 8.11, and to the extent that the Act infringes upon or threatens the freedoms and rights as pleaded above, the Act is unconstitutional.

Informed consent:

8.13 The rights and freedoms in terms of the common law, to the extent that they are consistent with the Bill of Rights, are endorsed in terms of section 39(3) of the Constitution.

8.14 The doctrine of informed consent in terms of the common law, is further given effect to in terms of sections 6, 7 and 8 of the National Health Act and entails the benefit of choice of a range of diagnostic procedures and treatment options generally available to a user, and to be informed of the benefits, risks, costs and consequences generally associated with each option.

8.15 The doctrine of informed consent entails a patient-oriented and patient-centred approach instead of the long-outdated paternalistic approach of medical treatment of patients.

8.16 The doctrine of informed consent forms the basis of a contractual relationship between the patient (user) of health care services provided by a health care provider and a health establishment.

8.17 The Act, in terms of section 3(3), prevails over the National Health Act, to the extent that any conflict arises.

8.18 Section 5, read with section 4 of the Act and further read with section 33 of the Act that limits the coverage of medical schemes to health care services, is coercive in that it obliges users to register with the Fund.

8.19 Once a user is so registered, he or she is dependent upon the exercise of control by the Fund over health care services and medicines, equipment and health-related products in terms of sections 6(a), 7(4), 8, and the Formulary as determined in terms of section 38(4) of the Act.

8.20 This effectively limits patient choice to that which the Fund is prepared to finance and procure.

8.21 As a result, treatments, diagnostics or medicines not on the prescribed formulary or protocol will generally be unavailable unless paid for privately by users. While the formal requirement for consent remains, its substantive

content is weakened by the restricted range of options available under NHI coverage.

8.22 In the premises and in view of what is pleaded above in paragraphs 8.13 to 8.21, and to the extent that the Act infringes upon patients' freedom and the benefit of choice, the Act is unconstitutional.

Clinical Independence of health practitioners:

8.23 In terms of section 39 of the Act and in particular section 39(2) read with section 39(8), health care service providers accredited by the Fund and, in order to comply with accreditation requirements and not risk the withdrawal of accreditation, must adhere to, *inter alia*, the following:

8.23.1 Treatment protocols and guidelines, including prescribing medicines and procuring health products from the Formulary;

8.23.2 Health care referral pathways;

8.23.3 National pricing regimen for services delivered;

8.23.4 Delivery of services of a quality acceptable to the Fund, which effectively makes the Fund the determinant of the standard of services.

8.24 Departure from these requirements risks non-payment and possible de-accreditation.

8.25 This regime introduces a significant constraint on the clinical discretion of health care professionals, potentially placing them in conflict with their ethical duties under the Health Professions Council of South Africa's ("*HPCSA*") codes and making them subject to professional oversight and control by the Fund instead of the HPCSA as their regulatory body.

8.26 Whereas evidence-based protocols are an accepted feature of many health systems, the absence of an independent mechanism to protect professional discretion in rendering health care and reproductive health care services heightens the risk of administrative and state control overriding clinical judgment.

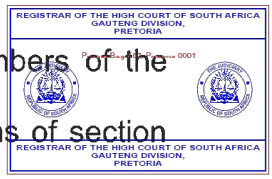
8.27 Executive and state control are further accentuated by every level of the functioning of the Fund and its structures, as appears from various provisions of the Act, including but not limited to the following:

8.27.1 Executive control over the appointment of the Board of the Fund and its Chairperson, its Chief Executive Officer and the accountability of the Board to the Minister, all of which appear from sections 12, 13,14,15 and 19 of the Act.

8.27.2 The power of the Fund to "*identify, develop, promote and facilitate the implementation of best practices in respect of … the design of*

the health care service benefits to be purchased by the Fund, in consultation with the Minister …" [Section 11(1)(*i*) (vii)].

8.27.3 The power of the Fund to "*identify, develop, promote and facilitate the implementation of best practices in respect of … referral networks in respect of users, in consultation with the Minister …*" [Section 11(1)(*i*) (viii)].



8.27.4 The establishment of and appointment of the members of the Benefits Advisory Committee by the Minister in terms of section 25 of the Act.

8.27.5 The establishment of the Health care Benefits Pricing Committee by the Minister and the appointment of its chairperson by the Minister in terms of section 26 of the Act.

8.27.6 The appointment of the Stakeholder Advisory Committee by the Minister in terms of section 26 of the Act.

8.27.7 The approval by the Minister of the Formulary in terms of section 38(4) of the Act.

8.27.8 The determination of complaint procedures by the Fund in consultation with the Minister in terms of section 42 of the Act.

8.27.9 The establishment of the Investigating Unit by the Chief Executive Officer (the latter being appointed by the Minister) and the reporting by the Investigating Unit to the Chief Executive Officer in terms of section 42(2) of the Act.

8.27.10 Decision-making powers of the Fund in respect of complaints in terms of section 42(3) of the Act.

8.27.11 The appointment of the appeal tribunal in terms of section 44 of the Act.

8.27.12 The overall role and control exercised by the Minister and the National Department of Health in terms of sections 31 and 32 of the Act.

8.28 The potential erosion and infringement of independent professional clinical judgment is not in the interest of either the health professions or patients, nor in the promotion and protection of quality standards of health care and reproductive health care services implicit in section 27(1)(a) of the Constitution.

8.29 In the premises and in view of what is pleaded above in paragraphs 8.23 to 8.28, and to the extent that the Act infringes upon independent clinical judgment and decision making of health care professionals, the Act is unconstitutional.

Effect on private pharmacies and over-the-counter medicines:

8.30 Pharmacists are, in terms of the National Health Act, read with the definition of health care service provider in terms of the Act, also providers of health care services.

8.31 The establishment of the Health Products Procurement Unit located within the Fund in terms of section 38 of the Act centralises the procurement and distribution of medicines, medical devices, equipment and health-related products to accredited health care service providers.

8.32 The centralised model implies that NHI-covered medicines will be dispensed only through Fund-accredited channels.

8.33 The likely result is a diminution of the role of private pharmacies and retail outlets in supplying basic medicines, with adverse implications for accessibility, competition, and patient convenience. While a private cash market for over-the-counter products will persist, lower-income users will be confined to Fund distribution channels, potentially exacerbating inequities in availability and convenience.

8.34 The potential erosion and infringement of the trade and practice of private pharmacists and pharmacies is not in the interest of the health professions and patients, and the promotion and protection of quality standards of health care and reproductive health care services implicit in section 27(1)(a) of the Constitution.

8.35 The potential erosion and infringement of the free trade, practice of the profession, private pharmacists and private pharmacies in terms of the Act amounts to an infringement and limitation of existing rights in terms of section 22 of the Constitution.

8.36 In the premises and in view of what is pleaded above in paragraphs 8.30 to 8.35, the Act is unconstitutional.

9.

ADVERSE EFFECT ON INTERNATIONAL HUMAN RIGHTS OBLIGATIONS ON HEALTH:

9.1 The preamble to the Act refers to Article 12 of the International Covenant on Economic, Social and Cultural Rights,1966 ("*ICESCR*"), and Article 16 of the African Charter on Human and Peoples' Rights, 1981, both of which recognise the right of everyone to the highest attainable standard of physical and mental health.

9.2 The ICESCR was adopted by the General Assembly of the United Nations on 16 December 1966.

9.3 South Africa is a party to the ICESCR, having signed it in 1994 and ratified it on 12 January 2015.

9.4 Article 12 of the ICESCR provides as follows:

*"**Article 12***

1. *The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*

2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:*

   (a) *The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*

   (b) *The improvement of all aspects of environmental and industrial hygiene;*

   (c) *The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*

   (d) *The creation of conditions which would assure to all medical service and medical attention in the event of sickness."*

9.5 The salient provisions including Article 16 of the African Charter on Human and Peoples' Rights ("*ACHPR*"), adopted in Nairobi on 27 June 1981, provide as follows:

*"**Chapter I. Human and Peoples' Rights Article***

Article 1

The Member States of the Organisation of African Unity parties to the present Charter shall recognise the rights, duties and freedoms enshrined in this

Charter and shall undertake to adopt legislative or other measures to give effect to them.

Article 2

Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind, such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.

Article 3

1. *Every individual shall be equal before the law.*

2. *Every individual shall be entitled to equal protection of the law.*

Article 16

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.

2. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."

9.6 South Africa is a party to the African Charter on Human and Peoples' Rights, having acceded to it on 9 July 1996.

9.7 As the Act invokes international law, human rights instruments, and, in particular, the aforesaid provisions on health, the interpretation of the Act is subject to the interpretation provisions of the Bill of Rights in terms of section

39(1)(b) of the Constitution, and any interpretation must consider international law.

9.8 Section 233 of the Constitution stipulates that when interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law.

9.9 The Republic is bound by the aforementioned international human rights charters by virtue of:

9.9.1 The provisions of section 231 of the Constitution;

9.9.2 The fact that article 12 of the ICESCR and article 16 of the ACHPR have been incorporated into the Act.

9.10 Section 39(1)(a) of the Constitution also provides that when interpreting the Bill of Rights, a court must promote the values that underlie an open and democratic society based on human dignity, equality and freedom.

9.11 The preamble to the Act only refers to the right to equality and human dignity, ignoring another fundamental value of our Constitution, such as individual freedom associated with an open democratic society.

9.12 The United Nations Economic and Social Council, through its Committee on Economic, Social and Cultural Rights, in its General Comment number 14 of

2000 (Geneva: April – May 2000) on the interpretation of article 12 of the International Covenant on Economic, Social and Cultural Rights states, *inter alia*, the following:

> *"1. Health is the fundamental right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity….;*
>
> *2. The human right to health is recognised in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: 'Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.'[1] The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States Parties recognise 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'."*

9.13 General Comment 14 further emphasises that other rights and freedoms also form integral components of the right to health, such as the realisation of other human rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, privacy, and freedom of association.

9.14 Having regard to the aforesaid comment it follows that if a person has a right to a standard of living adequate for the health of himself and his family, including clothing, education, housing and medical care, the State should not, in seeking to comply with its obligation in terms of section 27(2) of the

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1 Emphasis inserted.

Constitution to take reasonable legislative and other measures to achieve the progressive realisation of the access to health care services for all persons, deprive other categories of persons of the right and freedom to have access to quality health care services in accordance with their standard of living and adequate for their own health and that of their families through their own private ability and means.

9.15 The State's endeavour through the Act to take reasonable legislative and other measures to achieve the progressive realisation of the access to health care services is unreasonable and irrational and infringe fundamental human rights in terms of international law and the Constitution to the extent that the measures would result, or is likely to result in the deprivation of the rights of persons to enjoy existing quality health care services in accordance with their standard of living and adequate for their own health and that of their families through their own private ability and means.

9.16 Therefore, the State has an obligation not to pass any legislation which is likely to adversely affect, deprive or place at risk accessibility to private quality health care through existing private medical schemes or other private sources.

9.17 The deprivation of access arises when the State, through legislative or administrative conduct, deprives people of the existing access they enjoy to socio-economic rights, which is unconstitutional.

9.18 The measures intended to be legislated in terms of the Bill are likely to adversely and unconstitutionally affect also the socio-economic rights of those persons and citizens in the Republic who wish, in accordance with their standard of living and means, to have free and unfettered access to private health care services.

9.19 Whilst the Act purports to give expression to the international law commitments, its design is non-compliant.

9.20 The adoption of a single-purchaser model in a context of persistent governance incapacity, poor quality of delivery of health services in the public sector and fiscal constraint and questionable affordability of the National Health Insurance Scheme in terms of the Act, renders it improbable that the system can deliver the intended improvement in access to quality health care services for all, and does not amount to a reasonable measure in terms of section 27(2) of the Constitution.

9.21 Furthermore, by restricting the role of medical schemes to complementary cover and limiting avenues for patients to exercise choice in accessing care, the Act risks diminishing existing entitlements for a significant proportion of the population. This constitutes a retrogressive measure in conflict with both the ICESCR and the ACHPR.

9.22 As a result, whilst the Act purports to align itself with international human rights instruments and law, in substance it is non-compliant with such international treaty obligations and international law and the Bill of Rights in the Constitution,

as it risks and threatens existing rights and lacks rationality as a measure for progressive realisation of the right of access to health care services and reproductive health care and infringes the legality principle.

9.23 In the premises and in view of what is pleaded above in paragraphs 9.1 to 9.22, the Act is unconstitutional.

10.

LACK OF RATIONALITY OF THE NATIONAL HEALTH INSURANCE FRAMEWORK:

10.1 The constitutional legality principle requires legislation to comply with the rationality standard.

10.2 For the reasons pleaded below, the Act fails to comply with:

10.2.1 the rationality standard; infringes the legality principle; and is unconstitutional; as well as

10.2.2 Section 27(2) of the Constitution as a reasonable legislative measure by the State within its available resources to achieve the progressive realisation of the right in section 27(1)(a) of the Constitution.

10.3 The National Health Insurance Scheme ("*NHI*") was introduced by the Act in the form of a monopolistic single-purchaser and single-payer model or framework for health care services in the Republic.

10.4 Two key areas are relevant in the consideration of the rationality of the NHI framework, namely:

10.4.1 The feasibility, appropriateness and risks associated with the institutional framework; and

10.4.2 The feasibility and appropriateness of the financial framework.

Lack of proper feasibility assessment of the institutional framework:

10.5 No proper systematic diagnostic assessment has been made to make a clear connection between the weaknesses of the existing health system and the policy underlying the Act's legislative framework to reform the public and private health sectors.

10.6 As such, the rationale for the NHI framework has not been properly demonstrated.

10.7 The Act's projected reforms have not been the subject of feasibility studies that should normally accompany a set of proposals that aim to substantially disrupt pre-existing public and private sector health coverage regimes.

10.8 In particular, the following analyses have not been performed:

10.8.1 A technical review that clearly identifies the coverage failures in the current Universal Health Coverage ("*UHC*") framework in South Africa and their underlying causes.

10.8.2 An institutional feasibility study, which collates the evidence from international best practice and local empirical research to demonstrate how the public interest will be served, to demonstrate that the Act's provisions represent the least disruptive route to the achievement of improved UHC.

10.8.3 A study that carefully considers the international and domestic evidence relating to the decentralisation of health functions; the systems of financial transfer required to preserve equity; and the accountability regimes that ensure that services are planned, financed and managed in a manner that is responsive to the served population, including an analysis of the institutional causes of corruption in the public health system and the State as a whole.

10.8.4 A financial feasibility study, which can demonstrate whether it is fiscally feasible to raise taxes to the levels required for a monopoly purchaser to guarantee social protection for the entire population without diminishing any person's current legitimate rights to health cover. As the objectives of the Act are directly tied to the raising of an additional tax, it would have been reasonably expected that the

central design assumption would have been fully tested, given that South Africa is technically assessed to be at tax capacity.

10.8.5 A valid legal assessment of the constitutionality of:

10.8.5.1 the re-direction of the PES (Provincial Equitable Share) to national government;

10.8.5.2 the emasculation of the constitutional powers allocated to provinces in terms of Part A of Schedules 4 of the Constitution through national legislation, coupled with the redirection of funds through national structures; and

10.8.5.3 the apparent prohibition of parallel coverage through medical schemes.

10.9 In addition to the aforementioned, the following rationality issues arise from the NHI framework:

10.9.1 The NHI framework seeks to undermine the Constitutional powers of provinces to finance, plan and run health care services without amending the Constitution through the removal of national funding for provinces for health care via the Provincial Equitable Share (PES).

10.9.2 The centralisation of the PES (Provincial Equitable Share) is effectively an intrusion by the national government into the legitimate tax revenue of provinces to carry out their constitutionally mandated functions, which include health care services and ambulance services.

10.9.3 The centralisation of purchasing, either via the Fund or the District Health Management Office (DHMOs), cannot reasonably improve efficiencies, local responsiveness and accountability.

10.9.4 Successful models internationally involve local autonomous structures that are accountable for performance to communities through local governance frameworks, and moves that shift health systems toward decentralisation that are technically sound, and also reflect the shift away from authoritarian forms of concentrated power and are consistent with the principle of subsidiarity.

10.9.5 There is no evidence to suggest that the performance failures in the public health system have resulted from the absence of a purchaser-provider split operated by a monopoly purchaser. The failures are attributable to governance weaknesses in eight out of nine provinces, which the NHI fails to resolve.

10.9.6 While performance has been poor in eight of the nine provinces, the reason for the performance failures relates to correctable features of the governance framework, which include similar

failures of national government, various public entities, and several municipalities.

10.9.7 The NHI framework proposes to maintain a system of political appointments and such appointments are placed within an organisational context where power is highly concentrated nationally in the hands of political office-bearers. This essentially combines patronage incentives with concentrated power. Such institutional models are invariably predatory and not in the public interest of health care.

10.9.8 The degree of concentrated power in the hands of political appointees is unprecedented in South Africa and represents a threat to the viability of the entire health system, if it were feasible to implement.

10.9.9 The NHI framework envisages disrupting the social protection framework offered through medical schemes prior to the establishment of a viable public scheme.

10.9.10 There is no single technical review of the financial viability of the NHI framework when fully implemented, that has suggested it to be feasible.

10.10 The preamble to the Act situates the reform within the constitutional imperative to improve the quality of life of all citizens through expanded access to health care.

10.11 In principle, measures that increase the availability of affordable and effective health care services can contribute directly to improvements in population health, which in turn represent a critical determinant of quality of life. However, the test is not rhetorical but empirical: whether the institutional and financial arrangements embodied in the Act are reasonably capable of achieving the stated objective.

10.12 The public health system is characterised by persistent governance failures, fiscal mismanagement, and weak organisational capability.

10.13 These weaknesses are reflected in the comparative under-performance of South Africa's maternal mortality ratios relative to other peer countries, poor audit outcomes across provincial health departments, and the absence of an effective quality assurance framework.

10.14 The Act does not address these root causes of dysfunctionality. Instead, it superimposes a highly centralised purchaser model on a system whose primary constraints lie not in fragmented financing but in the incapacity of public institutions to deliver services effectively and accountably.

10.15 In this context, the expectation that the Act will improve the quality of life is not substantiated by evidence. On the contrary, the diversion of scarce fiscal

and administrative capacity into constructing a new institutional framework is likely to exacerbate existing dysfunctions.

10.16 The rationality standard requires a demonstrable rational connection between means and ends. The Act's reliance on centralisation as a cure for service failure does not meet this threshold. Instead, it treats the symptoms of unequal access without remedying the underlying "*disease*" of institutional incapacity.

10.17 The Act cannot, therefore, reasonably be expected to achieve the improvement in quality of life it proclaims, and risks regressing current entitlements by undermining existing avenues of access without securing a viable alternative.

10.18 In addition, the Act, when implemented, is likely to have an adverse effect on the retention of skilled health professionals and, by extension, on the wider socio-economic environment and risk their migration to other countries.

10.19 The risk is twofold:

10.19.1 First, by restricting the role of medical schemes to complementary cover and concentrating purchasing authority within the Fund, the Act narrows the scope of practice opportunities outside of the state-controlled system. Practitioners whose clinical independence is constrained by NHI Fund protocols are likely to elect to migrate to jurisdictions where professional discretion is better safeguarded.

10.19.2 Second, the broader uncertainty regarding the affordability and sustainability of the NHI model may accelerate the emigration of highly skilled professionals, thereby compounding the very capacity deficits the Act purports to resolve.

10.20 From a socio-economic perspective, such outcomes would have multiplier effects. The loss of skilled professionals erodes the human capital base essential for both health system performance and economic growth. At the same time, fiscal resources diverted into an administratively complex and financially untested model reduce the scope for alternative pro-growth remedies.

10.21 When measured against the standard of rationality and the reasonability of the measures in terms of section 27(2) of the Constitution, the Act risks aggravating a practitioner exodus and diminishing the country's economic base, while overlooking more feasible growth-oriented alternatives.

10.22 The Act, therefore, fails to demonstrate that it constitutes the least restrictive and most effective means of achieving the constitutional objective of progressively realising the right of access to health care services.

Financial Feasibility:

10.23 Over a period of nearly 15 years (since 2010), the NHI process leading up to the Act has been unable to generate a financial feasibility assessment of the NHI framework. The Davis Tax Commission (DTC) raised the following

concerns after the publication of the White Paper in 2017, which have to date not been addressed:

10.23.1 "*The large degree of uncertainty and lack of common understanding of how the NHI will be implemented and operate is of concern, given the magnitude of the proposed reform.*" (Davis Tax Commission, 2017, p. 42);

10.23.2 "*Given the considerable size of projected funding shortfalls, substantial increases in VAT or Personal Income Tax and/or the introduction of a new social security tax would be required to fund the NHI.*" (Davis Tax Commission, 2017, p. 44);

10.23.3 "*The magnitudes of the proposed NHI fiscal requirement are so large that they might require trade-offs with other laudable NDP programmes such as expansion of access to post-school education or social security reform.*" (Davis Tax Commission, 2017, p. 44);

10.23.4 "*Given the current costing parameters outlined in the White Paper, the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth.*" (Davis Tax Commission, 2017, p. 44);

10.24 There is no official or research-based financial analysis that has ever produced different results from the above.

10.25 A constraint arises particularly where general taxes are raised from existing tax bases, which are predominantly from medical scheme members (directly or indirectly), to return to them a lower benefit (there are no scenarios where the benefit can be better) in a system they have not chosen.

10.26 Over a period of nearly 15 years (since 2010, being the government's first estimate of NHI), a considerable number of financial assessments could have been performed to validate whether the institutional reform matches the financial implications, but they have not been done.

10.27 Government is facing significant fiscal constraints over the medium- to long-term, and any increased revenues, to the extent that they materialise, are more likely to be prioritised for higher priority programmes (*inter alia*, debt reduction, social assistance and infrastructure) than for the NHI Fund. The existing public health budget allocation is more than what is appropriate relative to other pressing social considerations in South Africa.

10.28 South Africa has effectively reached its tax capacity. In this context, policies that stimulate growth, thereby expanding revenue and reducing dependency on the public health system, represent a more rational pathway.

10.29 Such measures include strengthening provincial governance arrangements consistent with subsidiarity, implementing risk equalisation in the medical schemes sector to expand coverage, and reinforcing accountability frameworks to improve the efficiency of public expenditure.

10.30 There are also no official feasibility or affordability assessments conducted by the government since the introduction of the 2019 NHI Bill, and prior to the adoption of the Bill by Parliament in 2024, which substantiates the financial assumptions of the Act; nor is there any evidence of comprehensive, independently verifiable government studies released after 2019 that address the fiscal and macroeconomic sustainability of the NHI in its enacted form.

10.31 The 2017 White Paper (Minister of Health, 2017) contained indicative revenue options, including payroll taxes, surcharges on taxable income, and VAT increases, but these have not been revisited in light of the subsequent deterioration in fiscal space in the context of low economic growth since then.

10.32 South Africa has reached the limits of its tax capacity: revenue-to-GDP ratios are high relative to peer countries; economic growth is stagnant; and the debt burden has escalated. In this context, any additional earmarked NHI financing would either displace existing social spending or further destabilise the fiscal framework.

10.33 The absence of updated government feasibility reports since 2019 is, therefore, material and indicative that the Act was adopted without the benefit of a current affordability assessment capable of demonstrating that its objectives are achievable when implemented within available resources.

10.34 The Act's reliance on an expansive new fund (the NHI Fund), coupled with the elimination of duplicative medical scheme cover, creates obligations of a scale that cannot be financed sustainably under present economic conditions.

Without an updated technical basis, the Act's financial framework remains speculative.

10.35 Accordingly, the claim that the Act represents a rational, feasible and reasonable measure in terms of section 27(2) of the Constitution is undermined by the State's failure to produce recent feasibility or affordability studies.

10.36 In the absence of such analysis, the Act cannot demonstrate that it constitutes a rational or reasonable legislative measure to achieve progressive realisation of the right of access to health care services.

10.37 In addition to the abovementioned, the undermentioned considerations demonstrate the irrationality of the NHI scheme and the Act and non-compliance with section 27(2) of the Constitution:

10.37.1 Over the past 15 years, South Africa has experienced an increase in the level of government debt to a current level of about 75% of GDP. 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. South Africa experiences persistently low economic growth, with annual population growth exceeding annual economic growth.

10.37.2 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 of even 2% per annum is beyond the ability of the economy. The country's short-term and long-term growth potential is estimated at 1.5% per annum.

10.37.3 Based on estimated 2028 values for NHI fully phased in, an annual funding gap (based on the government's estimates of 2010 and the 2015 and 2017 White Papers) exists of some R483,1 billion (based on 2024 calculations). 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 about 8.9%, which is fiscally unsustainable.

10.37.4 To fund the 2028 gap would require a 31% surcharge on personal income tax, a 2,5% point increase in VAT and a payroll tax on income above R 212 544.00 per annum, which is not feasible.

10.37.5 When a 15-year phase-in period of the NHI is considered to 2039, the funding gap is calculated as R1198,4 billion or some 233% of estimated government health expenditure in that year (based on 2024 calculations).

10.37.6 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.

10.37.7 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 NHI. 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 (based on 2024 economic projections).

10.37.8 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 not affordable currently or in South Africa's longer-term economic future.

10.38 In the premises and in view of what is pleaded above in paragraphs 10.1 to 10.37.8, the Act does not meet the constitutional rationality standard and is irrational and/or fails to comply with section 27(2) of the Constitution as a reasonable legislative measure by the state, within its available resources, to achieve the progressive realisation of the rights in section 27(1)(a) of the Constitution.

10.39 As a result, the Act is unconstitutional and stands to be declared as such.

11.

VAGUENESS OF PROVISIONS OF THE ACT:

11.1 Various provisions in the Act, as demonstrated below, are characterised by vagueness and indeterminacy.

11.2 It is part of the constitutional rationality standard and legality principle that legislation must be sufficiently clear to guide those subject to it and to prevent the arbitrary exercise of public power. The law must indicate with reasonable certainty to those who are bound by it what is required of them so that they may regulate their conduct accordingly.

11.3 Provisions of the Act that are vague and lack reasonable clarity, are the following:

11.3.1 Section 33 (Role of Medical Schemes, Complementary Cover, and Implementation Trigger). Section 33 provides that medical schemes "*may only offer complementary cover*" once the NHI Fund is "*fully implemented.*" The provision is vague in at least three respects:

11.3.1.1 "*Complementary cover*" is undefined. The Act does not specify whether this term refers only to services expressly excluded from the NHI Fund's benefit package, or whether it could include services notionally included but not effectively delivered by the NHI Fund (for instance, where

delays or rationing occur). This ambiguity creates uncertainty for schemes, providers, and members, and permits arbitrary administrative or executive interpretation and determination.

11.3.1.2 Lack of clarity with "*full implementation*": The Act offers no statutory criteria for determining when "*full implementation*" has been achieved, leaving the decision to executive discretion. The timing of when schemes must cease offering current benefits is therefore indeterminate.

11.3.1.3 The Act implicitly ties "*full implementation*" to the introduction of a new prepayment tax, but does not define the form, scope, or legislative process for such a tax. As South Africa has reached its tax capacity, the introduction of a new earmarked levy is highly improbable. By making the fate of medical schemes contingent on an undefined and potentially unattainable tax, section 33 institutionalises vagueness and fiscal uncertainty into the core of the Act.

11.4 Further vagueness appears from the indirect mandatory nature of the Fund. The Act does not require universal membership of the Fund, nor does it obligate all providers, public or private, to contract with it. Instead, the Fund becomes mandatory indirectly by eliminating coverage alternatives. Section 33 restricts medical schemes to complementary cover; provincial health departments are reduced to service delivery agents of the Fund; and existing

financing streams are progressively withdrawn in favour of allocation through the Fund.

11.5 The effect of the aforementioned is that users are forced into the Fund not by a direct legal requirement, but by the removal of all viable alternatives. Yet the Act does not make this mechanism clear and transparent. Rather, it leaves key elements (the withdrawal of provincial budgets, the enforcement of Fund contracting on public facilities, and the permissible scope of private provision) open to uncertain interpretation. This structural opacity weakens accountability and invites disputes over the intended reach of the NHI Scheme and the Fund.

11.6 Furthermore, the Schedule to the Act amends various statutes. Of concern is the deletion of references to "*reproductive health services*" in the Medical Schemes Act, without explanation or corresponding provision elsewhere in the NHI framework. It is unclear whether this deletion is intended to transfer reproductive health coverage exclusively to the Fund; to restrict its scope; or whether it is an inadvertent drafting anomaly. Given the constitutional sensitivity of reproductive health, implicating rights to dignity, equality, and bodily autonomy, this omission creates material uncertainty.

11.7 Other provisions that are vague and lead to uncertainty are:

11.7.1 Section 8 (Entitlement to Benefits): While listing exclusions, the Act provides no statutory definition of "*medically necessary*" or the procedures by which coverage determinations will be made. Patients

and providers are left without predictable rules governing entitlements.

11.7.2 Section 39 (Accreditation of Providers): Accreditation requires compliance with "*prescribed performance criteria*," but these are left entirely to subordinate regulation. In the absence of statutory benchmarks, accreditation can be applied arbitrarily at the sole discretion of the Minister. In addition, section 20(3)(d) of the Act empowers the Chief Executive Officer of the Fund to establish, inter alia, a unit for accreditation, whilst no qualification criteria are set out for persons to be eligible for serving on the accreditation unit.

11.7.3 Section 38 (Health Products Procurement Unit): The Unit's functions are broadly defined, without statutory safeguards against conflicts of interest or clarity on how "*strategic purchasing*" will be operationalised. Given South Africa's history of procurement-related corruption, this vagueness is material and cannot be remedied through inclusion in subordinate regulations.

11.7.4 Section 7(2)(f) (Central Hospitals): The Act allows central hospitals to be designated either as "*national government components*" or "*organs of state*," with no criteria for choosing between them. The governance model for central hospitals is, therefore, left unsettled. Given the widespread corruption occurring through provincial hospitals, the absence of a clear governance framework for central hospitals is not rational or reasonable.

11.7.5 Section 57 (Transitional Arrangements): The Act sets out phased implementation to 2028, but does not specify conditions or indicators for the conclusion of each phase. This creates indeterminacy in the sequencing of rights and obligations, particularly regarding when the NHI Fund may be deemed "*fully implemented*." Importantly, the feasibility of the timelines appears questionable, given that the final phase presumes the implementation of the prepayment tax.

11.7.6 Furthermore, sections 57(2)(a) and 57(2)(b) of the Act stipulate time periods for phasing in, namely in respect of phase 1, a period of four years from 2023 to 2026 and phase 2, for a period of three years from 2026 to 2028, which is clearly not achievable and which renders the phasing in of the Act, uncertain.

11.7.7 Section 49(2)(a)(ii) – reallocation of funding for medical scheme tax credits paid to various medical schemes towards the funding of National Health Insurance: The reference to medical scheme tax credits is vague, as medical scheme tax credits are paid to members.

11.8 The aforesaid vague provisions compromise the Act's ability to function as a rational and predictable framework for the progressive realisation of the right to health care. The Act confers excessive discretion on the executive without providing clear standards for its exercise. This is irrational considering South Africa's systemic weakness in public health care services marked by the failure of capability and oversight.

11.9 In summary, the vagueness of key provisions, especially the undefined concepts of "*complementary cover*" and "*full implementation*," the opaque reliance on a prepayment tax, the indirect mandatory nature of the Fund through removal of coverage options, and the unexplained deletion of reproductive health references in the Medical Schemes Act, amplify this weakness. Instead of building reasonable certainty, the Act is exposed to indeterminacy and opens the space for arbitrary interpretation, undermining both constitutional rationality and public confidence in the health care reform.

11.10 In the premises and in view of what is pleaded above in paragraphs 11.1 to 11.9, the Act does not meet the constitutional rationality standard and is irrational and/or fails to comply with section 27(2) of the Constitution.

11.11 As a result, the Act is unconstitutional and stands to be declared as such.

12.

RELIEF CLAIMED:

In the premises, and on one or more or all of the grounds pleaded herein, the plaintiff claims the following:

12.1 That the National Health Insurance Act, No 20 of 2023 ("*the Act*) is declared to be inconsistent with the Constitution of the Republic of South Africa Act, No 108 of 1996, and invalid.

12.2 Parliament is directed to, within 24 months of date of the order, amend the Act to remedy the defects in the Act or to repeal the Act in its entirety.

12.3 That the order of invalidity of the Act in prayer 12.1 is, in terms of section 15(1)(a) of the Superior Courts Act, 10 of 2013, referred to the Constitutional Court for confirmation.

12.4 That the Registrar of this Court is directed to lodge, within 15 days of the order of this Court, a copy of the order with the Registrar of the Constitutional Court.

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PRETORIA

12.5 That such defendant or defendants who oppose the relief sought are ordered, jointly and severally, to pay the plaintiff's costs, including the costs of two counsel on scale C.

12.6 Further and/or alternative relief.

DATED at PRETORIA on this, the 21st day of JANUARY 2026

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