Legal Opinion on the Constitutionality of the NHI Bill

Abstract

The National Health Insurance (NHI) Bill seeks to establish universal health coverage in South Africa through a centralized, publicly-funded system. While its aims of reducing inequity and fragmentation in health care access are laudable, this opinion argues that the Bill is unconstitutional in several respects:

First, it concentrates excessive power in the national sphere and Minister of Health, undermining the concurrent provincial functions and cooperative governance principles in the Constitution. Second, the transparency and accountability provisions for the NHI Fund are inadequate, lacking robust Parliamentary oversight, public reporting and independent regulation. Third, the blanket prohibition on private medical schemes offering NHI service coverage unjustifiably restricts freedom of choice and association. Fourth, the intrusive controls on health care providers and facilities unduly infringe freedom of profession. Finally, there are insufficient funding guarantees and needs-based allocation criteria to ensure the progressive realization of the right of access to health care.

To remedy these defects, the Bill requires amendments to: empower provincial governments; strengthen NHI Fund governance; permit limited top-up insurance; revise provider regulations; and entrench an equitable funding model. If reformed thus, the Bill could provide a constitutional pathway to universal health care. But in its current form, it fails to strike the delicate balance the Constitution demands between the NHI's transformative goals and the web of individual and institutional rights it enshrines.

Introduction

The National Health Insurance Bill, 2019 (the "NHI Bill" or "Bill") seeks to provide universal access to quality health care services in South Africa in accordance with section 27 of the Constitution of the Republic of South Africa, 1996 ("Constitution"). The Bill's aims are noble and align with the global drive towards universal health coverage (UHC) - a key target under the Sustainable Development Goals. UHC

requires health systems to provide all people with access to needed health services of sufficient quality, while also ensuring that the use of these services does not expose them to financial hardship.

Achieving UHC in South Africa requires a fundamental transformation of the current two-tiered health system, in which the public sector serves the majority of the population with limited resources while the private sector caters to a minority with more substantial funding. The NHI Bill envisages addressing this inequity through the establishment of a single, publicly-owned and administered National Health Insurance Fund ("Fund"), which will purchase health care services on behalf of the population from accredited and contracted public and private providers. Users will receive these services free of charge at the point of care.

While the need for reforms to realize the right of access to health care services is clear, the precise design and mechanics of the NHI system raise several complex issues of constitutional law. The Bill has major implications for the division of powers between different spheres of government, the governance of public entities and use of public funds, the rights of health care service providers and users, and the obligations of the state to ensure access to care. An NHI system that fails to comply with the Constitution and its rights and values is likely to be vulnerable to legal challenge.

This opinion analyses key provisions of the NHI Bill and argues that they may be unconstitutional on five main grounds:

1. The concentration of powers in the national sphere, particularly the Minister of Health, to control the NHI Fund and direct the delivery of health services undermines the constitutionally-mandated concurrent functions of the provinces and their ability to make autonomous decisions. This violates the principles of cooperative governance.
2. The lack of adequate checks and balances on the NHI Fund, such as Parliamentary oversight and independent appeals mechanisms, fails to meet the standards of transparency and accountability required of an entity that will manage such significant public resources and have far-reaching impact on people's health care access.

3. Prohibiting the purchase of private health insurance and funding of non-NHI services unjustifiably limits the right of access to health care services and the freedom of users to associate with and seek care from providers of their choice. A complete ban is a disproportionate and unreasonable limitation of rights.
4. The extensive regulatory powers given to the NHI Fund over health care service providers, such as compelling adherence to treatment protocols and setting prices, go beyond what is permitted by the constitutional right to freedom of trade, occupation and profession.
5. There are insufficient provisions to guarantee the NHI Fund will have adequate resources, through dedicated funding streams and appropriate budgeting, to ensure available and quality health care services as required by the state's positive constitutional obligations regarding the right to health.

After expanding on each of these arguments, the opinion recommends solutions in the form of amendments to the Bill that would rectify the constitutional defects and enable a NHI system that is consistent with the Constitution, its values and allocation of powers, the rights of stakeholders, and South Africa's international law commitments. It concludes that pursuing UHC in a manner that respects the Constitution and the rule of law will result in a more stable, legitimate and effective reform process.

The opinion begins by setting out the constitutional rights, principles of interpretation and international law relevant to analyzing the NHI Bill. It then provides in-depth discussion of each of the five grounds of potential unconstitutionality, drawing on the constitutional provisions, court judgments and academic commentary. Thereafter, concrete proposals are made for reformulating problematic aspects of the Bill. Finally, the conclusion reiterates the importance of ensuring the NHI system is designed and implemented in a manner that complies with the Constitution.

Relevant Constitutional Rights and Principles

Right of Access to Health Care Services The Constitution entrenches the socio-economic right of access to health care services. Section 27(1)(a) provides that everyone has the right to have access to health care services, including reproductive health care. Section 27(2) obliges the state to take reasonable legislative and other

measures, within its available resources, to achieve the progressive realization of this right.

The Constitutional Court has provided guidance on the interpretation of these provisions and the obligations they impose on the state. In Government of the Republic of South Africa and Others v Grootboom and Others 2001 (1) SA 46 (CC), the Court held that section 27(2) requires the state to devise and implement a comprehensive and coordinated program to progressively realize the right of access to health care. The program must be balanced and flexible, make appropriate provision for short, medium and long-term needs, and cannot exclude a significant segment of society. Measures taken must be reasonable both in their conception and implementation. Reasonableness includes taking into account the degree and extent of the denial of the right to health care of those most desperate, and ensuring that concrete and targeted steps are taken to ameliorate their situation.

However, the Court cautioned that section 27 does not require the state to go beyond its available resources or to realize the right immediately. In Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC) ("TAC"), the Court held that courts are "ill-suited to adjudicate upon issues where court orders could have multiple social and economic consequences for the community." It will restrain from dictating specific policy measures to the state. As long as the measures adopted are reasonable, a court will not find them to be in breach of section 27 even if more desirable measures could be devised. The state has a margin of discretion to decide on the best way to fulfill constitutional rights.

At the same time, where it is clear that state policy is inconsistent with its constitutional obligations in respect of the right to health care, courts have the power to make orders directing the state to take certain steps. In TAC, the Court declared that the government's failure to make available the anti-retroviral drug Nevirapine to all HIV-positive mothers and their newborn babies in public health facilities was an unreasonable limitation of the right of access to health care. It ordered the state to remove the restrictions and roll out the drug to all clinics. The Court emphasized that the state had failed to provide any reasonable justification for restricting access to a "simple, cheap and potentially lifesaving medical intervention."

The negative dimension of section 27 was highlighted in Soobramoney v Minister of Health (KwaZulu-Natal) 1998 (1) SA 765 (CC). The applicant was a diabetic man in the final stages of chronic renal failure. He sought to compel a state hospital to provide him with ongoing dialysis treatment, which he could not afford privately. The Court held that the right to emergency medical treatment did not entitle him to indefinite, state-funded dialysis. Given the hospital's limited resources, it had adopted a reasonable policy to only provide dialysis to patients who were eligible for a kidney transplant. However, the Court affirmed that the state must manage its limited resources in order to address the health care needs of the whole population. It may not refuse emergency treatment arbitrarily or implement policies that leave patients without access to life-saving procedures available in the private sector but which they cannot afford.

The Constitutional Court has not yet considered a direct challenge to the two-tier health system or the vast disparities in financial and human resources between the public and private sectors. In Grootboom, TAC and other cases, the focus has been on specific policies or circumstances rather than the overall legislative and budgetary framework. However, some commentators argue there is scope to extend the principles in the socio-economic rights jurisprudence to assess the reasonableness of the "deep inequalities" and "rationing" in the health system as a whole.

Pieterse contends that an equitable health system requires "a more even distribution of wealth, income and access to resources." He suggests that a policy which limits access to health care according to individual wealth, when it "could reasonably have been formulated to avoid such discriminatory results", may be susceptible to constitutional challenge. In his view, where rationing decisions have an impact on individuals' survival and quality of life, there must be "particularly compelling justifications" and "wide public participation."

Similarly, Moyo criticizes the "reluctance of the courts to interrogate or critically engage with the state's budgetary and policy choices", particularly in the division of resources between the public and private sectors. He argues that the "glaring inequality in access to health care services between medical aid beneficiaries and those consigned to an overburdened public health system" is relevant to assessing the reasonableness of

current health care policy. However, he acknowledges the difficulties courts face in adjudicating complex issues with significant budgetary implications.

Nonetheless, a forceful argument can be made that the current legislative framework governing the health system fails to protect and promote the right of access to health care services in a reasonable manner. Key shortcomings include:

- The absence of an earmarked, dedicated funding stream for public health services, with health budgets subject to trade-offs and competition with other priorities in the overall fiscal framework.
- The failure to regulate private financing of health care to ensure it promotes equitable and sustainable resourcing of the overall system, rather than operating in isolation.
- Inadequate measures to ensure sufficient human resources (doctors, nurses, specialists etc.) are available in the public sector and distributed between urban and rural areas.
- Weak provisions for holding private sector providers accountable for the quality and cost-effectiveness of their services.
- The lack of an integrated approach to health service delivery between the public and private sectors.

The NHI Bill purports to address some of these issues by creating a single financing mechanism and strategic purchaser to more equitably distribute financial and service delivery resources across the health system. In assessing whether its provisions are a "reasonable" way to progressively realize the right of access to health care services, the factors and criteria developed by the Constitutional Court in its socio-economic rights jurisprudence will be highly relevant. These include the need for a comprehensive, coordinated and inclusive program; measures to cater for those most vulnerable or in desperate circumstances; short term relief for urgent needs alongside longer-term measures; transparent and participatory decision-making; and the effective and efficient use of available resources.

Division of Powers between Spheres of Government The Constitution establishes three spheres of government - national, provincial and local - which are "distinctive, interdependent and interrelated" (section 40(1)). It divides government responsibilities

and powers both "horizontally" between the three arms of government (legislature, executive and judiciary) and "vertically" between the three elected levels or spheres of government.

Schedules 4 and 5 of the Constitution set out the different "functional areas" of government responsibility. Health services is a concurrent national and provincial competence, appearing in Part A of Schedule 4. This means Parliament and the provincial legislatures can both make laws on health issues. National legislation that applies uniformly across the country prevails over provincial legislation if the matters listed in section 146(2) apply - for example, if the national legislation is necessary to maintain national security, economic unity or essential national standards.

The provinces have both legislative and executive authority over health services in terms of sections 104 and 125 of the Constitution. In Mashavha v President of the Republic of South Africa 2005 (2) SA 476 (CC), the Constitutional Court stated that these provisions confer "original" powers on the provinces rather than "delegated" ones:

"In the field of concurrent lawmaking and implementation, the Constitution accords greater strength to the national legislature and the national executive. But it does not do so in a way that usurps the original constitutional powers of the provinces. The constitutional scheme does not envisage the provinces' exclusive executive authority being eroded by national legislation in concurrent areas, save in the limited circumstances contemplated in section 44(2)."

Section 44(2) allows Parliament to intervene and pass legislation on matters that would otherwise fall within a province's exclusive jurisdiction, but only under certain conditions. These include: maintaining national security, economic unity, and essential national standards; establishing minimum standards for the rendering of services; and preventing unreasonable action by a province that is prejudicial to another province or the country as a whole.

In Ex parte President of the Republic of South Africa: In re Constitutionality of the Liquor Bill 2000 (1) SA 732 (CC) ("Liquor Bill"), the Court stressed that national legislation must be objectively necessary to fulfil one of the purposes in section 44(2).

There must be a pressing social need and a mere preference by the national government is insufficient. Similarly, the Court has warned against national legislation that would encroach on the core of provincial powers or undermine the autonomy of the provinces.

Consequently, while Parliament has the power to pass framework legislation on matters of national importance or that require uniformity, provinces must retain a meaningful role in deciding how to implement that legislation in their unique contexts.

This delicate balance between national and provincial powers is particularly relevant in the context of health care reform. On one hand, there are compelling arguments for national legislation to create an integrated, universal health system with common standards and mechanisms across all provinces. The current fragmentation and inequity between provinces in terms of health budgets, resources and outputs is a major obstacle to realizing the right of access to health care. Wealthier provinces like Gauteng and Western Cape have greater fiscal capacity to fund and manage health care delivery compared to poorer, more rural provinces.

From this perspective, shifting more responsibility to the national sphere and away from provinces could promote greater consistency and fairness in the distribution of health resources. The NHI Fund would pool financial resources nationally and allocate them based on an objective assessment of population needs rather than the vagaries of provincial budgets. National-level planning, purchasing and management of health services could prioritise underserved areas and populations and narrow unjustifiable gaps in access and quality between localities.

On the other hand, an excessive centralization of health system functions at the national level risks undermining key constitutional principles of cooperative governance and provincialism. As the Constitutional Court has emphasized, provinces must have a substantive role in deciding how to exercise their constitutional powers in ways that best cater to their specific contexts and communities. A "one size fits all" approach imposed inflexibly from the top is inimical to the logic of provincial autonomy and experimentation.

Health needs, demographics, infrastructure and delivery models differ vastly between provinces. What works in an urban metropole like Cape Town may not be appropriate for a rural district in Limpopo. Provinces are generally better placed than the national government to assess and respond to the particular health care needs and challenges of their residents. They can tailor interventions, reallocate resources and drive implementation in ways that a distant national bureaucracy cannot.

Provincial governments also have democratic mandates from, and accountability to, the residents who elect them. The Constitution deliberately gives provinces both legislative and executive control over health issues so that the different priorities and needs of regional populations can be expressed through the provincial political system. Allowing the national government to unilaterally override these democratic choices and dictate uniform policies and budgets across all provinces is contrary to the federal character of the Constitution.

Another key rationale for decentralization of health functions is to enable responsiveness, flexibility and innovation. With multiple provincial governments responsible for health care, there are opportunities for different approaches to addressing common challenges to be developed and tested. Provinces can learn from the successes and failures of their counterparts. Where a province develops an effective model or solution, it can be adapted and scaled up by others. But if control is monopolized at the center, a single dysfunctional policy or inefficient system will be visited on all provinces with little scope for variation.

International evidence and experience supports a balanced approach that combines strategic leadership, coordination and standard-setting at the national level with a robust role for sub-national governments in the planning, management and delivery of health services. Many high-performing health systems (e.g. Canada, Australia, Sweden, Denmark) are characterized by cooperative arrangements in which the central government sets the overall regulatory and policy framework but provinces/regions have substantial operational responsibility and authority.

For the NHI reforms to succeed, a similar cooperative model premised on a genuine partnership between national and provincial governments will be essential. The national Department of Health will need to work collaboratively with its provincial

counterparts to define the parameters of the NHI, build consensus on its key pillars, and provide the necessary guidance and support for implementation. But provinces must retain the constitutional space to make decisions on the delivery of services, allocation of resources and management of facilities and personnel within their jurisdictions.

An NHI Bill that marginalizes provincial governments and over-centralizes decision-making and control in the national sphere is likely to be constitutionally problematic. The Constitutional Court has repeatedly affirmed that while the provinces' powers are not unlimited and can be regulated in the interests of the country as a whole, they cannot be entirely subverted or hollowed out. Provincial autonomy and the entitlement of provinces to exercise their constitutional powers meaningfully is a core feature of the Constitution.

The Court will be wary of a legislative scheme that effectively demotes provinces to mere implementing agents for national policies. If the powers and functions that the Constitution allocates to provinces in respect of health are shifted to national organs or entities, or made subject to unilateral national control, it could be challenged as unconstitutional. The Court will scrutinize whether provinces retain sufficient discretion and scope to make a difference in the management and delivery of health services in their territories.

At the same time, given the socio-economic rights at stake and the stark inequities in the current health system, the Court may accept a greater degree of national power than it ordinarily would. But such inroads into the provincial sphere would need to be clearly justified by reference to the criteria in section 44(2), tightly circumscribed, and accompanied by mechanisms for provincial participation and consultation. A complete bypassing or usurping of provincial health functions is unlikely to pass muster.

Cooperative Governance Beyond the specific competences of the different spheres, the Constitution envisages a system of cooperative governance in which all spheres work together in good faith and coordinate their actions in the best interests of citizens. Section 41 sets out principles of cooperative government and intergovernmental relations that bind all three spheres. These include:

- Respecting the constitutional status, institutions, powers and functions of the other spheres;
- Not assuming any power or function except those conferred by the Constitution;
- Exercising powers and performing functions in a way that does not encroach on the geographical, functional or institutional integrity of the other spheres;
- Cooperating with one another in mutual trust and good faith by assisting and supporting one another, informing and consulting one another, and coordinating actions.

Section 41(2) places a duty on Parliament to enact legislation to establish structures and institutions to promote and facilitate intergovernmental relations, as well as mechanisms to settle intergovernmental disputes. The Intergovernmental Relations Framework Act, 2005 (IRFA) was passed to give effect to this. It creates a President's Coordinating Council consisting of the President, Deputy President, Ministers, Premiers and other representatives of organized local government to discuss and coordinate high-level policy issues between the spheres.

The IRFA also obliges national and provincial executives to adhere to the principles in section 41 when developing and implementing policy and legislation in an area of concurrent responsibility like health. Before the national executive initiates legislation on a matter affecting provinces, it must consult the provinces and take their views into account. Disputes between the spheres should be resolved through consultation, negotiation and other informal means, with recourse to the courts only as a last resort.

The Constitutional Court has highlighted the importance of the cooperative governance principles in several judgments. In National Gambling Board v Premier of KwaZulu-Natal 2002 (2) SA 715 (CC), it stated that the principles are "concerned with the way in which different spheres of government should interact and interface when exercising their powers and performing their functions." All spheres must act in a manner that "does not encroach on the geographical, functional or institutional integrity of government in another sphere."

In Premier of the Western Cape v President of RSA 1999 (3) SA 657 (CC), the Court held that a national government notice altering the functions of municipalities in the Western Cape was unconstitutional because the Premier was not consulted as

required by the cooperative governance principles. The Court emphasized that the "functional and institutional integrity of the provinces must...be determined...in light of the Constitution as a whole, including the principles of cooperative government."

More recently, in Minister of Police v Premier of the Western Cape 2014 (1) SA 1 (CC), the Court declared invalid a national cabinet decision to suspend an investigation by a commission of inquiry appointed by the Premier of the Western Cape into policing failures in Khayelitsha. The Court found the decision breached the principles of cooperative governance as it had been taken without consulting the Premier or considering the views of the province. National organs of state are obliged to "respect the constitutional status, institutions, powers and functions" of provincial governments.

The NHI Bill gives rise to several potential concerns regarding cooperative governance:

- The concentration of powers in the Minister of Health and the NHI Fund leaves little room for meaningful cooperation with provinces in crucial decisions about the financing and delivery of health services. The Minister and the Fund can unilaterally determine core aspects like the health care benefits to be covered, the payment mechanisms and rates for health care providers, and the budget allocations to different levels of care.
- Provinces appear to be largely excluded from the governance structures of the NHI Fund, such as the Board and key committees like the Benefits Advisory Committee, Health Care Benefits Pricing Committee and Stakeholder Advisory Committee. These structures will make critical decisions affecting provincial health departments and facilities, but provinces have no formal representation or role in their appointment and functioning.
- The Bill concentrates responsibility for personal health care services in new District Health Management Offices accountable to the national department, seemingly bypassing existing provincial health structures. It is unclear how these offices will interface with current provincial and district health authorities and what the lines of accountability will be.
- The Fund is empowered to contract directly with accredited health care providers, which could include provincial facilities like hospitals. This implies the

Fund will have the power to dictate terms and conditions to these facilities, irrespective of provincial policies and plans.

- There is no provision for provincial health departments to be consulted on key aspects of the NHI's design and implementation, such as the registration of users, contracting of providers, health care benefits offered and funding mechanisms. Provinces are essentially relegated to passive recipients of nationally-determined policies.
- The Bill does not create any intergovernmental structures or dispute resolution mechanisms to facilitate cooperation and coordination between the national department driving the NHI and provincial health authorities. The risk of unilateral national decision-making and inadequate consultation is high.

These and other features of the NHI Bill suggest a worrying neglect of the constitutional principles of cooperative governance. While the Bill obviously deals with a matter - health services - that is a concurrent national and provincial function, it fails to create a genuine partnership between the relevant organs of state in the two spheres. Instead, it vests an alarming degree of unilateral control in the national government, with little regard for the impact on provinces and their ability to effectively perform their health functions.

As national legislation that seeks to regulate the delivery of health care across the country, there is an especially strong constitutional imperative for the Bill to adhere to section 41. Its development and implementation will require a truly cooperative approach in which the provinces are treated as partners with the autonomy and powers bestowed on them by the Constitution. The national government cannot simply impose its preferred model and ignore provincial interests under the guise of the "national interest".

Key aspects of the NHI on which the provinces must be meaningfully consulted and their views considered include:

- The overall design and institutional architecture of the new system, including the roles of different national and provincial structures;
- The composition and appointment procedures for the NHI Fund Board and major advisory committees;

- The relationship between the District Health Management Offices and current provincial and local government health departments;
- The mechanisms for user registration, revenue collection and pooling, accreditation of providers, and purchasing of services;
- The package of health care service benefits to be covered by the NHI and the system for rationing and priority-setting;
- The formulae and processes for allocation of NHI funds between districts, levels of care and public and private providers;
- The information systems, administrative capacity and infrastructure needed to implement NHI policies and the support required from national government.

To comply with the Constitution, the NHI Bill needs to be substantially amended to build in far more extensive obligations for consultation, cooperation and joint decision-making with the provinces. These should include:

- A requirement for the national Minister of Health to obtain the concurrence of provincial MECs for Health in key decisions on the design and implementation of the NHI;
- Representation for provinces on the Board of the NHI Fund and major advisory structures like the Benefits Advisory Committee and Health Care Benefits Pricing Committee;
- Mechanisms for provincial participation in decisions on the accreditation of health care providers and the contracting and payment of provincial health facilities;
- An obligation on the NHI Fund to allocate funds between provinces equitably and to consult provincial health departments on their budgetary and delivery needs;
- The establishment of an Intergovernmental Forum consisting of national and provincial health authorities to coordinate NHI policies and foster regular communication and collaboration;
- Dispute resolution procedures allowing provinces to challenge unilateral decisions by the national government that undermine their ability to ensure effective health services.

With such amendments, the NHI Bill would embody the spirit of cooperative federalism that animates the Constitution. It would position the provincial governments as essential stakeholders and partners in realizing the vision of universal health coverage, rather than as mere subordinates to be dictated to. Given the magnitude of the health challenges facing the country and the enormity of the NHI undertaking, the Constitution demands nothing less than a truly cooperative approach between all spheres of government.

Transparency and Accountability of the NHI Fund

The NHI Bill seeks to establish the NHI Fund as an autonomous public entity that will be responsible for mobilizing, pooling and strategically purchasing health care services for the entire population (clause 9). The Fund will receive vast sums of money - an estimated R256 billion in its first year of operation - from general tax revenue, payroll taxes, surcharges on income tax and other potential sources (National Treasury, 2019). It will pay contracted public and private health care providers to deliver services and act as a single purchaser for the health system. In short, the Fund will wield massive public power and make critical decisions affecting the health and lives of all people in South Africa.

Given this context, it is imperative that the Fund operates in a transparent and accountable manner and is subject to rigorous checks and balances. This is not only a moral and political imperative but also a constitutional one. Under South Africa's constitutional democracy, public power must be exercised rationally, lawfully and in accordance with the foundational values of accountability and transparency.

As the Constitutional Court held in Rail Commuters Action Group v Transnet Ltd t/a Metrorail 2005 (2) SA 359 (CC), the exercise of public power must comply with the Constitution, which is the supreme law, and the doctrine of legality, which is part of that law. The doctrine of legality requires that public power be exercised in good faith and should not be misconstrued

In AAA Investments (Pty) Ltd v Micro Finance Regulatory Council 2007 (1) SA 343 (CC), the Court explained that the doctrine of legality requires that a decision must be

rationally related to the purpose for which the power was given, otherwise it falls short of the standard demanded by the Constitution.

The principles of transparency and accountability are enshrined in several provisions of the Constitution:

- Section 1(d) proclaims that the Republic is founded on the values of "accountability, responsiveness and openness".
- Section 32 guarantees everyone the right of access to "any information held by the state" and requires national legislation to be enacted to give effect to this right. The Promotion of Access to Information Act, 2000 (PAIA) is the law passed to fulfill this obligation.
- Section 33 entrenches the right to administrative action that is "lawful, reasonable and procedurally fair" and requires national legislation to be passed to give effect to this right. The Promotion of Administrative Justice Act, 2000 (PAJA) is the relevant law.
- Section 195 stipulates that the public administration must be governed by democratic values including transparency and accountability.
- Section 57 obliges Parliament to provide mechanisms for the executive to account to it and maintain oversight of the exercise of executive authority and organs of state.
- Sections 92 and 133 provide that members of the national Cabinet and provincial Executive Councils are individually and collectively accountable to Parliament and provincial legislatures for the exercise of their powers and performance of their functions.

The Constitutional Court has repeatedly affirmed that constitutional democracy rests on the principles of openness and accountability. In Brummer v Minister for Social Development 2009 (6) SA 323 (CC), the Court stated at para 62:

"The importance of this right too, in a country which is founded on values of accountability, responsiveness and openness, cannot be gainsaid. To give effect to these founding values, the public ,must have access to information held by the state. Indeed one of the basic values and principles governing public administration is

transparency. And the Constitution demands that transparency 'must be fostered by providing the public with timely, accessible and accurate information'."."

Turning to the specific context of the NHI, the imperatives of transparency and accountability assume particular importance given the enormous impact the new system will have on people's access to health care services. The NHI Fund is not just another public entity performing routine administrative functions. It will make life and death decisions about the basket of health services to which 56 million people are entitled, which health conditions and treatments to prioritize, how to allocate limited funds between different levels of care, and which providers to contract with.

For the NHI Fund to be seen as legitimate and to enjoy public trust, it is absolutely essential that it operates openly and transparently. The public has a right to know how their money is being spent and to scrutinize whether the Fund is acting efficiently, equitably and ethically in the interests of the population. The Fund cannot be a "black box" whose internal machinations are shielded from outside examination.

The Constitution and courts are clear that the more power an entity wields, the more demanding the transparency and accountability requirements.

The NHI Bill has several shortcomings in respect of transparency and accountability:

1. **Inadequate Parliamentary oversight**

As an entity that will manage billions of rands in public funds and make critical decisions about the provisioning of health care services, the NHI Fund must be subject to robust Parliamentary oversight. This is what sections 42(3), 55(2) and 57 of the Constitution envisage in respect of the National Assembly's oversight functions. Parliament must be able to monitor the Fund's activities, receive reports on its performance, and hold its leadership to account for their exercise of power.

However, the NHI Bill contains no express provisions requiring the Fund to table its strategic plans, budgets, annual reports and financial statements in Parliament for scrutiny. Clause 51 requires the Board to submit an annual report to the Minister of Health who must then table it in the National Assembly and NCOP, but no timeframe

is stipulated for this tabling. This is unacceptable for an entity of the Fund's importance and is at odds with the Public Finance Management Act, 1999 (PFMA).

The PFMA, which regulates financial management in the public sector, requires much more stringent planning, reporting and oversight processes. Sections 52-65 require public entities to submit strategic and annual performance plans, budgets, monthly and quarterly reports, and annual reports and financial statements to their relevant executive authority (Minister), Treasury and Parliament. Annual reports and financial statements must be made public.

Parliament, through the Standing Committee on Public Accounts (SCOPA), exercises regular monitoring and oversight of the performance and expenditure of public entities. SCOPA can summon the leadership of entities to account for irregular, fruitless or wasteful expenditure and demand remedial measures. The NHI Bill should be amended to expressly incorporate these PFMA requirements and oversight mechanisms for the Fund.

Moreover, the Fund's massive public health mandate and budget arguably demand additional Parliamentary oversight. Annual or quarterly reporting is insufficient - the Fund's decision-making and operational processes should be subject to much more regular and intensive scrutiny. Parliament should consider establishing a dedicated multi-party oversight committee for the NHI Fund, with the power to summon its CEO and Board members on a monthly basis to report on the Fund's activities and respond to questions.

The heads of other entities with far-reaching impacts on socio-economic rights, like the South African Social Security Agency, are often called to account before Parliamentary committees. There is precedent in the Financial Management of Parliament and Provincial Legislatures Act, 2009 for creating a specialized oversight body - the Joint Standing Committee on the Financial Management of Parliament - to perform dedicated scrutiny.

A similar body for the NHI Fund would enhance the transparency and accountability of this important institution. The mere fact that its leadership could be regularly summoned before Parliament to explain and justify their decisions would incentivize

greater openness and adherence to constitutional requirements in the Fund's operations.

2. **Lack of representation and oversight in governance structures**

For the NHI Fund to be truly transparent and accountable, the Bill should provide for greater public and stakeholder representation and oversight in its governance structures. The Board of the Fund will be its highest decision-making body and steer the overall direction and performance of the entity. It is therefore critical that the Board is constituted in a manner that enables meaningful oversight and accountability.

However, the Bill grants sweeping powers to the Minister of Health to appoint the chairperson and members of the Board (clause 13). Besides a vague criterion that Board members must be "fit and proper", there are no minimum qualification requirements, eligibility criteria or nomination procedures. This concentrates too much discretion in the Minister to select Board members and undermines the independence of the Board.

To ensure the Board can effectively oversee the NHI Fund and hold its management accountable, some key amendments are needed:

- The appointment of the Board chairperson and members should be done through a public nomination process with clear eligibility requirements related to skills, expertise and experience (e.g. in health care, economics, law, governance etc).
- Parliament, through the Portfolio Committee on Health, should interview and shortlist candidates in a transparent manner before the Minister makes final appointments. This will enhance public confidence in the process.
- Dedicated seats should be reserved on the Board for key constituencies directly affected by the Fund, such as representatives of provincial health departments, civil society, labor and patient groups.
- A requirement that the Board must include independent members with no ties to the ruling party to prevent political interference and patronage.
- An express provision that the Minister must appoint the Board after consultation with Cabinet and the NHI Commission (see below).

The CEO of the NHI Fund, as its accounting officer, should also be appointed in a more transparent manner. Currently, clause 21 gives the Board the power to recruit and appoint the CEO in line with a vaguely defined "transparent and competitive" process. This lacks adequate checks and balances. The Bill should at minimum require:

- That the CEO appointment must be confirmed by Parliament after an interview process involving the relevant Portfolio Committee.
- That candidates must meet explicit qualifications and experience requirements.
- That the CEO recruitment process must include public advertisements and competition (not just an opaque head-hunting exercise).
- That the CEO's performance agreement must be tabled in Parliament when they are appointed (as is done for other major SOE executives).

The NHI Bill establishes several ministerial advisory committees (National Advisory Committee on Consolidation of Financing Arrangements, National Health Pricing Advisory Committee, Stakeholder Advisory Committee, Technical Committees) to advise the Minister on aspects of NHI implementation. However, these committees have no oversight powers in respect of the NHI Fund and the Minister appoints all their members (clauses 23-26).

The Bill should be amended to give these specialist committees some oversight responsibilities and create avenues for them to interact with the NHI Fund's Board and management. For example:

- The Benefits Advisory Committee could be required to review the Fund's annual health service benefits recommendations before they are finalized, and its inputs should be tabled in Parliament.
- The Health Care Benefits Pricing Committee could be tasked with annually reviewing the Fund's provider payment mechanisms and price determinations to assess their reasonableness and impact on health system costs. It should also table its findings in Parliament.
- The Stakeholder Advisory Committee should expressly include representatives from patient advocacy groups, health worker unions, private providers and provincial governments. It should have the power to request information from

the NHI Fund and make recommendations to its Board on improving the responsiveness of the NHI to public concerns.

- The Technical Committees should be selected through a public nomination process and their advice to the Minister should be published (with commercially sensitive information redacted).

In addition, the NHI Bill should establish a multi-stakeholder NHI Commission to play an independent advisory and oversight role over the NHI Fund. Commissions are valuable tools for enhancing the accountability of public entities. For example, the Financial and Fiscal Commission (FFC) is a specialist body established in terms of sections 220-222 of the Constitution to advise and make recommendations to Parliament, provincial legislatures, organized local government and other state organs on financial and fiscal matters. The FFC helps Parliament to exercise more effective oversight over the Division of Revenue process and keep a check on the executive.

A similar NHI Commission could be created with a mandate to advise Parliament on the performance of the NHI Fund and alert MPs to challenges and risks in the system. It should be empowered to investigate complaints against the Fund and assess its compliance with the NHI Act and other relevant legislation. The Commission should have wide powers to subpoena information from the Fund and summon its officials to testify. It could conduct public hearings and produce annual reports on the strengths and weaknesses in NHI financing and delivery.

Such a Commission would act as an "early warning system" for when things go wrong in the NHI. Like the FFC, it should be a constitutionally established body to safeguard its impartiality, with appointments made by Parliament in consultation with provincial governments. Its members should have demonstrable expertise in health economics, public health, medical law etc. Having an outside body providing ongoing oversight of the NHI Fund to complement Parliament's accountability functions would be a powerful way to promote transparency.

3. Insufficient public participation and sharing of information

Transparency and public accountability require meaningful public participation in the NHI Fund's decision-making and access to information on its activities and

performance. The Constitutional Court has repeatedly affirmed the importance of public participation for democratizing decision-making processes and giving people a voice in decisions that affect them.

In Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others [2005] ZACC 14, the Court stressed that: Public involvement in the law-making process is one of the essential elements of our constitutional democracy and is integral to its participatory nature.

In Land Access Movement of South Africa and Others v Chairperson of the National Council of Provinces and Others [2016] ZACC 22, it was found that the requirement to facilitate public participation in legislative processes is indeed crucial to our constitutional democracy.The very purpose of facilitating public participation in legislative processes is to ensure that the public participates in the law-making process consistently with our democracy. Public participation provides vitally important information about the interests and concerns of the public.

The National Health Act, 2003 recognizes the importance of community participation in the health system. Section 31(1)(a) requires provincial Health Councils to include community representatives and section 42 obliges health establishments to include communities in planning, provision and evaluation of services. The NHI Bill itself acknowledges that the success of NHIwill require building a responsive health care system that is people-centere. The Fund is expressly required to protect the rights and interests of users.

However, in practice, the Bill provides very limited opportunities for meaningful public participation in NHI decision-making processes. There are no structured mechanisms for citizens, civil society or affected stakeholders to engage with and provide input to the NHI Fund's strategic planning, budgeting, benefit design or contracting decisions - despite the enormous impact these decisions will have on people's lives and health.

For example, clause 11(5) requires the Benefits Advisory Committee to determine an "essential health care package" of services covered by the Fund. This is a critical decision as it will determine the range of health services available to the population under NHI. But there is no requirement for the committee to undertake any public

consultation or consider submissions before finalizing this package. The Minister merely "publishes" the package in a gazette.

Similarly, the Board of the NHI Fund must establish technical committees like the Health Care Benefits Pricing Committee to recommend the prices/tariffs to pay contracted providers (clause 26). But again, there is no obligation to solicit public input before these committees make far-reaching decisions about how to remunerate hospitals, doctors, nurses etc. The Minister appoints the committees without any public nomination or interview process.

The Bill establishes District Health Management Offices as decentralized arms of the NHI Fund responsible for purchasing primary health care services at district level (clause 36). These offices are given powers to accredit providers, manage contracts and monitor service delivery. But there are no governance structures to enable community participation in their decision-making, like the district health councils envisaged in the National Health Act.

Overall, the Bill entrenches a highly centralized, top-down model of decision-making in the NHI Fund, concentrated in the Minister and a series of ministerially-appointed advisory committees. The NHI Fund itself has no Board representatives from civil society, labour or patient advocacy groups. All the power is vested in political appointees and technical experts, with no mandatory requirements for public participation or community engagement.

This lack of participatory governance is not only at odds with the Constitution's commitment to open, accountable and responsive government, but is also short-sighted from a policy perspective. Actualizing the vision of universal health coverage will require active public support, mobilization and involvement. People are more likely to trust and embrace an NHI system if they feel a sense of ownership and believe their inputs have been considered. Transparency and inclusive participation build social solidarity.

Several amendments are therefore needed to open up the NHI Fund to greater public participation:

- Clause 51 should require the NHI Fund to publish all key planning and policy documents (annual performance plan, budget, key decisions on benefits, prices etc.) on its website for public comment before finalizing them.
- The Benefits Advisory Committee and Health Care Benefits Pricing Committee should be legally obliged to call for written submissions from the public and to hold consultative meetings with key stakeholder groups before determining benefits and prices.
- Dedicated seats for representatives of civil society, labour, patient groups and community representatives should be included on all the advisory committees, not just the Stakeholder Advisory Committee.
- The Minister's power to appoint advisory committees should be subject to a public nomination process and candidates should be shortlisted by Parliament.
- The Stakeholder Advisory Committee's role should be substantially expanded to provide a forum for ongoing engagement between the NHI Fund and affected constituencies. It should be empowered to make representations to the Fund's Board and sub-committees on issues of concern.
- The District Health Management Offices should establish local health committees with representatives of communities, civil society, labour, health worker associations and other groups to foster participation in NHI implementation at district level.
- The NHI Fund should be required to hold regular (at least quarterly) public meetings and consultative forums with citizens and stakeholders to report on its activities and obtain feedback.
- An annual "NHI Assembly" could be established where a larger group of stakeholder representatives drawn from all spheres of government, civil society, labour, business etc. meets to review progress and challenges with NHI implementation. This would enhance public involvement and government coordination.

Access to information is the other side of the transparency coin and another area of weakness in the Bill. Clause 34 requires the NHI Fund to establish a "National Health Information System" to capture, store and analyze data on patient encounters, health outcomes, financial performance etc. The explanatory memorandum highlights the

importance of this information system for effective monitoring and management of the NHI. The system has to comply with PAIA.

However, the Bill does not put in place strong enough guarantees of access to information for the public. It is silent on whether the public will be able to obtain disaggregated data on key NHI metrics like numbers of patients treated, waiting times, expenditure per facility, numbers of complaints etc. It does not stipulate that PAIA requests must be complied with rapidly or that a dedicated NHI information officer must be appointed to handle them. And it does not require proactive disclosure of performance information.

These lacunae create risks of important data on the NHI Fund's functioning being kept under wraps when it should be open to public scrutiny. The COVID-19 pandemic has highlighted the critical importance of data transparency when it comes to the public health response. Throughout the pandemic, government has faced criticism for failing to timeously and fully disclose data on issues like testing, infection rates, vaccine acquisition, hospital capacity, health worker infections etc.

The NHI system must not repeat these mistakes. As much detailed information as possible on the workings and outputs of the NHI Fund should be routinely placed in the public domain for analysis and interrogation by stakeholders. This needs to be a legal requirement in the Bill, not a discretionary choice. Where access to information from the Fund is resisted, the standard procedures and recourse options in PAIA will apply. But the presumption should be in favor of maximal proactive disclosure on the Fund's part.

To give effect to the right of access to information, the Bill should therefore be amended to include provisions that:

- Mandate the proactive disclosure of key NHI datasets, plans, policies, decision and performance information on a publicly accessible website and in user-friendly formats;
- Require the Department of Health to issue regulations specifying the types of data and documents on the NHI Fund's operations that must be made public as a matter of course;

- Stipulate that PAIA requests for access to NHI information should be prioritized and responded to within shorter timeframes than the normal 30 days, given the strong public interest involved;
- Oblige the CEO of the NHI Fund to appoint dedicated information officers to handle PAIA requests and ensure the Fund complies with its proactive disclosure duties;
- Clarify that commercial confidentiality or data privacy considerations cannot be used as blanket grounds for refusing access to information on the NHI Fund's contracting, financing or performance;
- Mandate the Fund to provide regular data updates to the oversight bodies like the Parliamentary Healthcare Committee and Health Ombud (see below).

The default position should be that all relevant information on the NHI Fund's activities is public unless there are compelling reasons for secrecy (e.g. genuine commercial sensitivity or patient confidentiality). As the Constitutional Court has affirmed, the right of access to information held by the state is central to holding government accountable and fostering a culture of transparency.

The Promotion of Access to Information Act also requires amendment to support the NHI system. Currently, it does not define "health records" or set in place procedures governing requests for such records. With the advent of NHI, PAIA will need to be aligned with the Bill to clarify:

- That all data in the NHI Fund's Health Patient Registration System and other electronic records constitute "health records";
- The specific procedures to be followed by individual patients requesting access to their own health records held by the Fund;
- The circumstances in which third parties can request access to health records, with explicit safeguards against breaches of confidentiality or commercial abuse;
- The grounds on which access to health records may be legitimately refused (e.g. if disclosure would cause real harm to a third party);
- The obligations of the Fund to maintain the security and integrity of personal health information under its control.

The importance of data protection and privacy in the digital health context makes such amendments to PAIA imperative. The NHI Fund will be responsible for highly sensitive medical and financial information on almost 60 million people. Establishing clear procedures for how that data can be accessed and used, by whom, and on what terms, is vital.

The Protection of Personal Information Act, 2013 (POPIA), which commenced on 1 July 2020, will also need to be reviewed to ensure appropriate protections for health data processed by the NHI Fund and other entities in the system (e.g. medical schemes, administrators, providers etc). The POPIA creates an Information Regulator empowered to monitor compliance with the data processing conditions in the Act, handle complaints, and issue enforcement notices.

However, in its current form, the POPIA does not deal specifically with health data as a category warranting special protections. Nor does it adequately define concepts like "de-identification", "anonymisation" or "encryption" of health data. These are complex issues at the intersection of data science, statistics and technology. Extensive consultations with relevant experts and stakeholders will be needed to ensure POPIA can effectively safeguard personal health information in the NHI context.

Amendments should aim to prescribe:

- The measures that must be taken by the NHI Fund to de-identify/anonymise personal health data before sharing with third parties for research or public health purposes;
- When express opt-in consent is needed from individuals before identifiable health information can be processed, and what constitutes valid consent;
- Limitations on the use of individual health data for commercial purposes like marketing of health products;
- The technical standards that must be met for encryption and protection of electronic personal health information;
- The circumstances that warrant extra safeguards for processing of certain categories of sensitive health data e.g. HIV status, mental health records;
- Stricter penalties (both criminal and administrative) for negligent or intentional breaches of health privacy.

Extensive public education on individuals' health privacy rights and how to exercise them will also be crucial. Patients must understand what control and say they have over their personal health information, including the right to access records, request corrections and object to misuse. They should know how to lodge complaints with the NHI Fund and Information Regulator if their data is breached or used contrary to POPIA. And the Information Regulator will need expanded capacity to monitor compliance in the complex NHI environment.

Finally, the NHI Bill itself should be amended to clarify certain powers of the NHI Fund in respect of health information. For example, clause 38(4) gives the Fund seemingly open-ended powers to collect and process health data from medical schemes, providers and "any other source" for monitoring and evaluation. This provision should be circumscribed in line with data minimization principles to only permit collection of data necessary for particular purposes.

Clause 34(2) states rather vaguely that data in the NHI Health Patient Registration System must be "accurate and accessible to the Department and the Fund". Given the sensitivity of this data, the clause should specify that access must be on a need-to-know basis for legally authorized purposes only. The Minister should be empowered to make regulations defining the categories of Fund and Departmental officials who can access identified patient data.

In summary, a substantially strengthened transparency and accountability framework is essential for the NHI Fund to fulfill its constitutional and democratic obligations. The Bill must provide for more intensive Parliamentary oversight, meaningful public participation in decision-making, proactive disclosure of performance information, and robust safeguards for personal health data. Only then will this powerful new entity enjoy the public confidence and trust needed for NHI to succeed.

4. Inadequate complaints and appeal mechanisms

A final aspect of the NHI Fund's accountability and oversight architecture relates to complaints-handling and ensuring effective redress for individuals who are denied access to services or treated unfairly by the Fund. Clause 42 of the Bill requires the

Fund to establish "an independent mechanism for complaints and appeals" but provides minimal detail on how this will work in practice.

The complaints system is a critical component of holding the NHI Fund accountable and giving users a voice when things go wrong. The Constitution requires national legislation to give effect to the rights of access to health care services (s27) and to just administrative action (s33). The National Health Act stipulates that all health establishments must implement measures to deal with complaints in a manner that is "effective, open and transparent" (s18). The PAJA also sets out the elements of procedurally fair administrative decision-making.

The NHI complaints process carries high stakes because it adjudicates individual entitlements to specific health care services and benefits. Decisions by the NHI Fund to deny or limit access to services protected in the Constitution cannot be taken lightly. They are administrative actions that must comply with the principles of lawfulness, reasonableness and procedural fairness in the PAJA.

The current wording of clause 42 falls far short of what is constitutionally required:

- It does not guarantee users the right to reasons for individual decisions denying health care services, only vague "written reasons for decisions of the Fund";
- There is no express right to a hearing or to make representations before an adverse decision is taken;
- The complaints process is not subject to legislated timeframes for resolving cases, meaning complaints could drag on for lengthy periods;
- It is unclear who will be responsible for investigating and adjudicating complaints (internal functionaries or an independent tribunal);
- There is no requirement for any reporting to Parliament or the Minister on trends in numbers and types of complaints.

These gaps create clear risks of unfair denial of health care services and lack of effective remedies for users. The complaints system could become a superficial, rubberstamping affair rather than a meaningful accountability check on NHI Fund decision-making. This would undermine the credibility of NHI in the eyes of the public and erode the social solidarity needed for it to function optimally.

Several key amendments could significantly strengthen the complaints regime:

a) Requiring all decisions limiting access to NHI services to be communicated in writing with clear reasons that are specific to the individual's circumstances;

b) Providing for an expedited internal review process where a panel of three NHI Fund officials, including a qualified clinician, must reassess the decision within a stipulated timeframe (e.g. 48 hours for urgent cases);

c) Allowing users to make written representations and introduce new evidence during this internal appeal process;

d) Establishing an independent Health Services Appeal Tribunal as a separate entity from the NHI Fund to hear appeals of internal rulings;

e) Requiring the Tribunal to be chaired by a legally qualified person and to include both clinical experts and representatives of patient advocacy groups;

f) Empowering the Tribunal to overrule the NHI Fund and order that services be provided where there are no reasonable grounds for denial;

g) Enabling class actions and public interest complaints to be brought to the Tribunal by civil society groups representing classes of disadvantaged or vulnerable users;

h) Imposing legislated timeframes for the Tribunal to resolve different categories of appeal (e.g. within 5 days for urgent cases, 3 months for complex cases);

i) Allowing a further appeal on questions of law to the High Court;

j) Requiring the Tribunal to provide quarterly reports to the Minister and Parliament on the numbers, types and outcomes of appeals;

k) Obliging the NHI Fund to implement rulings of the Tribunal and report on steps taken;

l) Providing for oversight of the complaints process by relevant bodies like the Health Ombud and SA Human Rights Commission.

These reforms would create a multi-layered, substantively fair and independent complaints system that gives users proper recourse when their rights are infringed. It would position the Health Services Appeal Tribunal as an effective watchdog over NHI Fund decision-making and a powerful ally for users, along the lines of the Competition Tribunal's role in keeping private economic power in check.

The constitutional rights at stake are too vital for a slapdash or tokenistic approach to complaints. If people's trust in NHI is to become a reality, there must be accessible, timely and effective remedies in the inevitable cases where the system fails them. The Bill requires major surgery to achieve an accountability framework compatible with the demands of administrative justice.

In addition to the individual complaints mechanism, the NHI's public accountability would be bolstered by ensuring the Office of the Health Ombud can exercise oversight of the NHI Fund. The Health Ombud was established by amendments to the National Health Act in 2013, in the wake of deaths of mental health patients in the Life Esidimeni tragedy. The Ombud's role is to investigate complaints of substandard care, maladministration or patient rights violations relating to both public and private health establishments.

Currently, the jurisdiction of the Ombud only extends to complaints regarding norms and standards set by the Office of Health Standards Compliance. The Ombud cannot investigate complaints about quality of care or maladministration by the NHI Fund itself. This creates a worrying accountability vacuum in respect of such a powerful entity. To address this, the Bill should:

- Make the NHI Fund and its staff subject to the oversight powers of the Health Ombud under the National Health Act;
- Require the NHI Fund to comply with any recommendations or directives issued by the Ombud pursuant to an investigation;
- Empower the Ombud to monitor trends in user complaints about the NHI Fund and to launch proactive investigations;
- Mandate the Ombud to report annually to Parliament on complaints relating to the NHI and to publish the findings of major investigations.

The Ombud has played a valuable role in shining a light on maladministration and poor quality care in the health system in recent years. With NHI, the Ombud's remit must expand to enable scrutiny of this new behemoth and its impact on Constitutional rights. An Ombud armed with adequate investigative and recommendation powers will incentivize better decision-making and responsiveness by Fund officials who know their conduct may be publicly called to account. It provides an extra bulwark against the abuse or careless use of public power.

The Health Ombud could essentially serve as the NHI equivalent of the Public Protector, another constitutionally-created watchdog tasked with investigating improper conduct in the public administration. Like the Public Protector, the Ombud should have wide discretion to launch investigations on their own initiative or in response to complaints. And the NHI Fund should be obliged to cooperate with and give effect to the Ombud's rulings unless they are successfully challenged in court.

Extensive public education on the role and powers of the Health Ombud vis-a-vis the NHI Fund will be essential. The Ombud's services must be widely publicized so people know they can lodge a complaint if they feel the NHI Fund has dealt with them unfairly. The stronger the public oversight of the NHI, the more responsive it will become to people's needs and concerns.

The South African Human Rights Commission (SAHRC) also has a mandated oversight role in respect of the realization of the Constitutional rights to health care services and administrative justice. Section 184(3) empowers the SAHRC to require state organs to provide information on measures taken towards fulfilling socio-economic rights, while section 184(2)(a) allows it to investigate and report on the observance of human rights.

Through its periodic reports, complaints handling, investigations and public hearings, the SAHRC shines a spotlight on key barriers to the progressive realization of the right to health care and makes recommendations for reform. In recent years it has examined issues like access to emergency medical services, mental health care, and the impact of COVID-19. The NHI Fund's critical role in enabling access to health services brings it squarely within the SAHRC's purview.

The NHI Bill should thus clarify that:

- The SAHRC has the power to require the NHI Fund to provide information on measures taken to progressively realize the right to health care services;
- The SAHRC can investigate complaints about the NHI Fund violating Constitutional rights and make recommendations;
- The NHI Fund must submit required information to the SAHRC within specified timeframes and implement its recommendations;
- Where NHI-related complaints are lodged directly with the SAHRC, it should liaise with the Health Ombud to determine appropriate referral and resolution.

Conferring an explicit oversight mandate on the SAHRC will ensure alignment between the NHI and South Africa's Constitutional and international human rights obligations. As the UHC drive intensifies globally, the role of national human rights institutions in monitoring health coverage and equity becomes more vital. The SAHRC has the legal stature and expertise to ensure NHI implementation stays true to the Bill of Rights.

In summary, the NHI Bill requires a major overhaul of its transparency and accountability provisions to pass Constitutional muster and win public confidence. The far-reaching powers of the NHI Fund over health care access for the whole population create commensurately extensive obligations of openness, responsiveness and participatory decision-making. The Fund must be subject to rigorous checks and balances, with Parliament, the media, civil society, the courts and independent watchdogs all empowered to hold it to account. Getting this oversight architecture right will lay the foundation for an NHI that earns genuine public trust and delivers on its transformative mandate.

5. Restrictions on Choice of Private Health Care Coverage

A core rationale advanced for the NHI is that it will reduce the stark inequities between the overstretched, under-resourced public health system that caters to 84% of the population and the well-resourced private system serving the 16% able to afford medical scheme cover. By creating a single, publicly-funded pool for purchasing health services from both public and private sector providers, NHI aims to improve cross-

subsidization between the young and the old, the rich and the poor as well as the healthy and the sick. Channelling all health care funding through one purchaser is intended to facilitate strategic purchasing in the public interest.

However, in a significant departure from the policy proposals in the NHI Green and White Papers, clause 33 of the Bill now states that once NHI is fully implemented, medical schemes will only be permitted to offer "complementary cover" for services not reimbursed by the NHI Fund. Explicitly prohibited is "duplicative cover", meaning cover for the comprehensive package of hospital, primary care, medicines etc. that the Fund will purchase. In effect, this means medical schemes (and by implication individuals) will no longer be allowed to pay for and access health services in parallel to the NHI system.

This prohibition on private financing for NHI services appears to be a blanket one, regardless of whether the service in question is actually available to the user at a particular time. Even if the NHI Fund has contracted with too few providers in an area leading to long waiting times, or the providers deliver poor quality services, those with private insurance will seemingly not be able to jump the queue by seeking care outside NHI.

The policy intent behind this change is clear: to maximize income and risk cross-subsidization in the NHI Fund and discourage wealthier people from opting-out of the public system, which could undermine its financial sustainability and cause a quality gulf to emerge between NHI and non-NHI services. Making NHI mandatory aims to build social solidarity and ensure the necessary funding is available to provide a high level of care for all.

While these are laudable and important goals from a health system perspective, the prohibition on private purchasing of NHI service raises difficult questions about the rights of patients and the scope of permissible state intervention in health care choices. Although socio-economic rights like health care are subject to progressive realization depending on available resources, the Constitutional Court has confirmed that the state's obligation to provide access to health care includes refraining from interfering with existing access or impairing the ability of individuals to access care (Minister of Health v New Clicks South Africa (Pty) Ltd).

The approach in clause 33 of the NHI Bill risks running afoul of the right of access to health care services in section 27(1)(a) of the Constitution by:

1. Denying those who can afford and desire it the option of accessing NHI services more quickly or from different providers by paying privately for them;
2. Compelling medical scheme members to pay for and utilize services solely through the NHI, regardless of their quality or accessibility under such centralized rationing and with no feasible opt-out mechanism;
3. Reducing existing access to health care for the 8.8 million medical scheme beneficiaries who will no longer have private cover for a wide range of essential hospital and outpatient services;
4. Potentially causing supply shortages and longer waiting times for NHI services if significant private funding is withdrawn from the health system and some private providers can no longer operate sustainably on NHI reimbursement alone.

The Explanatory Memorandum to the Bill frames this as a matter of equity - ensuring that people's ability to access quality care is not dependent on their income or wealth. It sees the continuation of duplicative cover as entrenching a "two-tier" health system divided by the ability to pay. However, the complete prohibition on private purchasing raises the concerning spectre of levelling down the availability of health care rather than levelling up.

If confronted with a deterioration in the affordability or quality of NHI services due to funding and capacity constraints, many people may feel their access to care is actually being reduced rather than enhanced by the inability to maintain private cover and choice. The denial of existing access (in the form of private insurance enabling quicker treatment) to a constitutionally-protected resource like health care requires careful justification.

It is not self-evident that allowing the option of duplicative cover would necessarily undermine the NHI if it is appropriately regulated. Medical schemes could be required to pay a levy to the NHI Fund to support its sustainability. Measures could be taken to prevent physicians from prioritizing privately-funded patients over NHI patients. And a

prohibition on using private insurance for basic NHI services like primary care could prevent opt-out from these essential services.

But some scope for choice in accessing non-essential services based on ability to pay (as already exists in sectors like education) may be a reasonable compromise between equity and liberty. Indeed, the White Paper acknowledges that under NHI "people will be free to continue membership of private voluntary health insurance schemes that cater for services or products not covered under NHI". Allowing private coverage for "top-up" services is common even in advanced universal systems like the UK, Netherlands and Denmark.

Ultimately, the desirability and likely impact of banning duplicative cover involves complex health system trade-offs. But from a constitutional law perspective, a blanket prohibition on individuals privately purchasing and accessing health care services, regardless of their circumstances, appears overbroad and disproportionate to the policy goal of income cross-subsidization. The denial of an existing entitlement to access parallel care is an extremely invasive limitation and one which a court may well find unjustifiable under the section 36 limitations clause, at least in its categorical form.

Less restrictive means of incentivizing participation in NHI while preserving some degree of individual choice could include:

- Permitting duplicative cover for a defined list of non-essential or very high-cost services, while requiring income cross-subsidization through a sliding scale of NHI contributions;
- Allowing private insurance to fund "complementary" services in underserved areas or for critical cases where NHI waiting times exceed clinically acceptable levels;
- Requiring those who purchase duplicative cover to nevertheless pay the full amount of their mandatory NHI contribution to ensure a subsidy to lower-income groups;
- Preventing simultaneous use of NHI and private insurance funding for the same episode of care to protect the NHI from unpaid patient liabilities and misuse of its resources.

A more tailored and flexible model of this kind would go some way towards balancing the legitimate goals of risk and income cross-subsidization, on one hand, and individual liberty in personal health care choices, on the other. Relegating private insurance to covering only the limited number of services not included in the NHI package comes close to violating the essence of the right to access health care in section 27(1)(a) by leaving almost no avenue for people to enhance their access or seek an alternative to the state-funded option should it prove deficient.

The courts have shown some willingness to interrogate state health care allocation and rationing decisions when they implicate the fundamental interests of vulnerable groups, as in Minister of Health v Treatment Action Campaign (TAC) which concerned access to antiretroviral drugs for pregnant, HIV-positive women. Where measures instituting a blanket prohibition on access to a constitutionally-protected resource like health care are concerned, a court will likely demand strong justification from the state. Requiring everyone to access all basic health services solely through a brand new public fund, before that fund has proven its ability to deliver timely and quality care, seems a recipe for generating such constitutional challenges.

Another relevant right potentially implicated by clause 33 is freedom of association in section 18 of the Constitution. In its positive dimension, this right has been interpreted as protecting the liberty to join and participate in voluntary associations of various kinds. Medical schemes are one such form of voluntary association, in which people elect to pool risks and resources to access private health care. Preventing people from joining medical schemes that cover the same range of services as NHI interferes with their freedom of association for the purpose of meeting their health needs.

While section 18 can be limited, the restriction on associational freedom for health purposes would need to be closely linked to an important public interest and there must be no less restrictive means to achieve that interest. For many of the reasons canvassed above in relation to section 27, an absolute prohibition on duplicative cover appears overbroad. It is not narrowly tailored to protecting the NHI's sustainability, which could be accomplished through more targeted regulation of medical schemes and enforcement of mandatory NHI contributions.

The competition law exclusion contained in clause 3(5) of the Bill adds to the freedom of association concerns. It provides that the Competition Act will not apply to "the operations of the Fund and its functionaries" as the sole public purchaser of health services. In other words, conduct by the NHI Fund that would ordinarily contravene the prohibitions on anticompetitive behavior in the Competition Act will be permissible, ostensibly to enable the fund to exercise its necessary powers as a monopsony purchaser.

However, this blanket Competition Act exemption risks immunizing the NHI Fund from competitive pressures and scrutiny even where its conduct may be harming consumer welfare and market efficiency. For example, if the Fund abused its dominant buyer power to force providers to accept extremely low reimbursement rates, reducing the quality or availability of care, this would seemingly not be reviewable by the competition authorities. Or if the Fund leveraged its position as sole purchaser to restrict the ability of providers to serve private-paying patients, again there would be minimal competition law recourse.

Some special treatment of the NHI Fund under the Competition Act is justifiable given its unique role and the need to balance competition with other public interest objectives in the health sector. But a blanket exemption is excessive and could perversely harm health care access and quality. It would be better to craft a narrower, purpose-based exemption that excludes Fund conduct which is necessary to achieve the legitimate purposes of strategic public purchasing, but which keeps the Fund subject to competition oversight in other respects (as is the case for Departments of Health as purchasers in some countries like the Netherlands).

More broadly, if the intention is to make NHI mandatory and monopolistic, this requires very strong checks and balances to substitute for the accountability inherent in having alternative options available to users. The Singaporean health system offers an example of how choice and competition can be preserved in a predominantly publicly funded system. The government provides universal public funding for basic hospital and primary care services. However, people can choose to purchase private insurance for more rapid access to elective services at private hospitals. The public funding follows the patient to their chosen provider.

Within the public system, there are also multiple tiers of hospitals and primary care clinics with different levels of amenities and co-payments, which patients can choose between. So while there is heavy subsidization and risk-pooling, an element of competition and choice is retained. This guards against complacency and creates incentives for responsiveness and quality even with extensive public financing.

The NHI Bill adopts a very different model - one in which medical schemes are essentially relegated to covering a residual list of benefits not included in the NHI package. Given how expansive that package is likely to be, the scope for any meaningful private insurance market will be minimal. Careful thought needs to be given to whether this "single payer" model is appropriate for SA's highly diverse and unequal society in which large numbers of people have become accustomed to relatively generous private cover.

There are also administrative law implications flowing from clause 33. As a public entity, the NHI Fund will be bound by the principles of just administrative action in section 33 of the Constitution as given effect to in the PAJA. This means that decisions taken by the Fund which adversely affect the rights of any person must be procedurally fair. In the context of the Fund's beneficiary population, this translates into rights to be given adequate notice of decisions to restrict access to health care benefits, to make representations before such decisions are finalized, and to be furnished with reasons.

However, none of these procedural safeguards are spelled out clearly in the Bill. Instead, the Fund is given broad powers under clauses 7 and 11 to make unilateral decisions about the health service benefits to be covered and the care pathways and referral networks to be followed by patients and providers. There is no explicit right for an individual user to be heard before the Fund limits their access to a particular medicine or treatment on cost-effectiveness grounds, for instance.

The only nod to procedural fairness is in clause 42, which requires the Fund to establish a general complaints and appeals mechanism for users and health care providers. But the Bill is silent on the need for this mechanism to comply with the PAJA in terms of timelines, the right to reasons, the impartiality of decision-making etc. Without such detail, there is a danger that the appeals process will be superficial - and cold comfort to someone denied a critical health service.

To give proper effect to administrative justice, the Bill should be amended to make clear that where the NHI Fund takes any decision that adversely affects an identifiable individual's access to health care services, that decision is administrative action under the PAJA. The Fund should have to give the affected person adequate prior notice of the proposed decision and allow them a reasonable opportunity to make representations. Where necessary, the individual should also be given an in-person hearing before the decision is finalized.

Decisions to deny or limit access should be communicated in writing with detailed reasons specific to the individual case. And there must be accessible, timely and impartial mechanisms for internal appeal and review of such decisions, over and above the generic complaints procedure envisaged in clause 42. Only then will the NHI Fund's far-reaching rationing powers be subject to appropriate administrative law safeguards against unfair, arbitrary or unreasonable decision-making.

These administrative justice protections are especially vital given how "high-stakes" access to health care is as compared to other public benefits. Decisions wrongly depriving someone of a critical medicine or treatment can cause them serious harm or even loss of life. The Constitution and PAJA recognize this through the variable intensity of procedural fairness protections depending on the impact of the administrative action. Refusing someone an essential health care entitlement would entail extremely rigorous procedural safeguards.

Finally, there is a more fundamental rights-based objection to the prohibition on duplicative cover - one premised on the value of individual autonomy in a free society. Section 12(2)(b) of the Constitution protects the right "to security in and control over their body", while section 12(2)(c) enshrines the right "not to be subjected to medical or scientific experiments without their informed consent". These provisions recognize the importance of personal bodily integrity and decisional autonomy in relation to health care matters.

A categorical ban on accessing health services with private financing, and compelling reliance on the state for all essential health needs, represents a significant incursion into individual autonomy. It deprives people of control over key decisions about their own health and bodily wellbeing and forces dependence on a single state-run scheme.

For those who have built up a personal financial provision for future health expenses, it negates their ability to deploy those resources to meet their own needs as they see fit.

Such a restriction may be justifiable for certain non-essential, highly cost-ineffective or experimental treatments where ability to pay should not determine access. But extending it across virtually all health care takes the rationing logic to an extreme that is hard to square with the Constitution's strong protections for personal liberty. The state certainly has a critical role in ensuring equitable access to care, but taking such a rigid either/or approach and allowing almost no space for individual choices risks overreach.

A constitutional democracy founded on the values of individual freedom and autonomy should afford people at least some degree of input into personal health care decisions that will profoundly affect their lives. The state's role is to ensure that no one is left behind for lack of resources, not to completely eliminate the ability to independently enhance one's own access to a fundamental social good like health care.

In summary, clause 33's prohibition on duplicative health coverage and other aspects of the NHI Bill significantly restrict individual choice and autonomy in relation to a constitutionally protected right of access to health care services. For the state to constrain access to such an essential resource to this degree requires extremely compelling justification and necessitates robust checks, balances and due process.

While the underlying policy rationale of income and risk cross-subsidization is important, a complete ban on "opting-up" one's own health care access through private financing appears overbroad and risks doing more harm than good. It arguably violates the right to freedom of association for health purposes and severely diminishes the scope for holding the NHI Fund accountable through competitive pressures and individual choice.

The state can achieve its legitimate goals of equity and redistribution through more targeted regulation of medical schemes without completely excluding top-up private financing. This could include mandatory minimum benefits for medical schemes, income-based contribution subsidies for NHI membership, and preventing

simultaneous use of NHI and private cover. Such measures would preserve an element of progressivity in health financing while still respecting individual liberty.

Whatever the final model, meaningful statutory rights to administrative justice and due process in NHI Fund coverage decisions are essential. Users must have accessible avenues to challenge adverse determinations on their health care entitlements, especially where critical services are being rationed. The Bill requires significant strengthening to constitutionalize the NHI Fund's exercise of public power over a social good as fundamental as health care.

6. Limitations on the Rights of Health Care Providers

Another concerning aspect of the NHI Bill relates to its extensive powers of control over health care providers like health professionals (doctors, nurses, pharmacists etc.), hospitals and clinics. Several provisions have the potential to infringe the constitutional rights of providers to freedom of profession, freedom of association, and administrative justice. While regulation of the health care sector is necessary to achieve equity and cost-effectiveness, the Bill arguably goes beyond what is strictly required and risks counter-productively undermining the engagement of providers in the system. Key concerns include:

a) **Uncertainty around the contracting of health care providers**

Clause 38 of the Bill empowers the NHI Fund to accredit and contract with certified public and private sector health care providers that meet certain quality, performance and operational criteria. These criteria are not specified in the primary legislation but left to be determined through Ministerial regulations. Furthermore, the Bill states that the Fund "must transfer funds directly to accredited and contracted central, provincial, regional, specialized and district hospitals" and "Funds must be transferred to Contracting Units for Primary Health Care" at the sub-district level.

The wording of these provisions suggests that the NHI Fund will have a large degree of discretion over which health establishments to contract with and that funding flows will be channeled primarily through hospitals and new sub-district structures (Contracting Units) rather than individual or group medical practices. Clause 37(2)(e)

also indicates that these Contracting Units "must manage contracts entered into with accredited providers in the relevant sub-district."

This centralization of funding and contracting powers carries risks of undermining health providers' freedom to choose where and how they practice. General practitioners and other professionals in private solo or small group practices may find themselves forced to contract through the larger Contracting Units, which would decide on their participation in NHI and their level of reimbursement. The Fund/Units could choose not to contract with providers who don't meet the as-yet-unspecified accreditation criteria or could use monopsony power to drive down prices.

Such an arrangement may fall foul of section 22 of the Constitution which protects the right to freedom of trade, occupation and profession. Health professionals have the right to practice their profession in a way that supports their financial and operational viability. Compelling contracting via particular channels and dictating all reimbursement rates interferes with providers' professional autonomy.

If large numbers of private practices can't obtain NHI contracts on sustainable terms, they may be forced to close down, reducing access to services. Even if they can remain in business serving non-NHI patients under the limited duplicative cover permitted, their freedom to operate will still have been significantly constrained.

The Constitutional Court has held that laws regulating access to a profession will only be permissible if they are rationally linked to a legitimate government purpose and do not restrict the freedom more than is necessary to achieve that purpose (see Affordable Medicines Trust v Minister of Health). The NHI Bill's heavy-handed approach to centralizing provider contracting and reimbursement appears disproportionate to the aim of strategic public purchasing.

There are less-restrictive means available that would preserve greater freedom for practitioners to engage with NHI on their own terms. These could include:

- Specifying that practitioners may choose to contract either individually, via Contracting Units, or through new independent practitioner associations created for NHI purposes;

- Detailing the precise grounds on which provider accreditation may be refused and creating an independent appeal mechanism to review such decisions;
- Requiring the NHI Fund and any Contracting Units to negotiate reimbursement rates with representatives of provider groups, rather than dictating them unilaterally;
- Setting a cap on the percentage of a practice's services that must be delivered through NHI contracts to participate, rather than an "all or nothing" approach;
- Creating an alternative dispute resolution mechanism to mediate conflicts between contracted providers and the Fund/Units.

Some of these measures are employed in other countries with mandatory national health insurance like Canada. There, it is provincial medical associations that negotiate fee schedules with the provincial ministries of health on behalf of all doctors. Groups of providers can make representations to the ministry if they feel the schedules are unreasonable. And there is no blanket requirement for providers to work solely in the public system - those who wish to maintain a separate private practice are free to do so.

The NHI Bill's silence on these key operational issues of contracting and reimbursement creates immense uncertainty for health care providers. It is not clear that adequate consultation has occurred with professional groups to understand how the contracting model can be designed in a way that respects their constitutional rights. The mere promise of further Regulations is cold comfort. Far more engagement and specificity is needed.

b) Compelling adherence to treatment protocols and formularies

Clause 38(2) states that one of the conditions for a health care provider to be accredited and reimbursed by the NHI Fund is "adherence to treatment protocols and guidelines, including prescribing medicines and procuring health products from the Formulary". Clause 7(4) goes even further - it bars the Fund from paying for any treatment where "no cost-effective intervention exists for the health care service according to health technology assessment, or the health care product or treatment is not included in the Formulary".

In other words, to be paid by NHI, health professionals must abide by the clinical protocols, standard treatment guidelines and approved lists of medicines and devices determined by the Benefits Advisory and Health Technology Assessment Committees. Providers seemingly have no leeway to deviate from these "one-size-fits-all" requirements, even where they believe an alternative intervention may be more suitable for a particular patient.

Such rigidity risks infringing on health professionals' clinical autonomy and freedom to practice in accordance with their training, experience and professional judgment. It fails to recognize that different patients may respond differently to the same treatment, depending on factors like age, co-morbidities, tolerance etc. Forcing adherence to fixed protocols for every case is a blunt approach.

It also creates ethical dilemmas where the approved treatment in the protocol/formulary may be sub-optimal for the patient's specific needs. The doctor could find themselves torn between doing what they believe is clinically best and maintaining their NHI accreditation and income. This places an unfair burden on professionals.

There are other mechanisms to promote cost-effective prescribing that still respect practitioner autonomy, such as practice reviews, benchmarking data and financial incentives. An outright prohibition on reimbursing any care that deviates from centrally-determined guidelines (irrespective of individual circumstances) is draconian and short-sighted.

In some cases, it may even endanger patients' health if they are denied funding for items not on the formulary that could help them. The Soobramoney and TAC judgments make clear that unreasonable limitations on access to treatments infringe the constitutional right to health care. Similar arguments could be made where NHI protocols create arbitrary obstacles for patients.

The impact on practitioner rights is particularly severe given that NHI looks set to become the overwhelmingly dominant purchaser in the health system. When a single entity controls access to the majority of health care funding, any restrictions it imposes

amount to an extreme limitation on freedom of profession. Providers may have no real choice but to comply.

Again there are less restrictive alternatives. Treatment guidelines and formularies could be indicative rather than compulsory. Mechanisms could be created for doctors to motivate for departures where appropriate for particular patients. And there should be an independent appeal or review process where the treating provider believes the protocols/formulary are not in the patient's best interests.

c) Lack of representation in NHI governance structures

Another concern from a health provider-rights perspective is their absence or under-representation in the key governance structures of the NHI Fund. As already emphasized, the Fund will wield enormous power over the conditions and sustainability of health practice in SA. It is therefore essential that providers have a meaningful voice and avenue for input in its major decisions.

However, the Board of the NHI Fund is appointed entirely by the Minister of Health, with no seats reserved for representatives of health professionals or establishment groups (clause 13). The Benefits Advisory Committee, which will determine the package of services covered by NHI, has only two members appointed on account of their expertise in medicine (out of 10-15 members). The remainder are ministerial appointees (clause 25).

The Health Care Benefits Pricing Committee, which recommends the prices/tariffs to be paid to providers, has two members representing public and private providers, out of 23-24 members (clause 26). And the Stakeholder Advisory Committee, intended as a multi-stakeholder forum, has only one representative of associations of health professionals, out of 8-12 members (clause 27).

This means that the governance structures entrusted with the most critical NHI design decisions - what to cover, how much to pay, which providers to contract - are heavily dominated by political appointees and "technical experts" like economists and public health specialists. The voice of frontline health professionals, who understand the practical realities of delivering services, is marginalized.

Such an exclusionary approach is not only unwise from an operational perspective, but may also violate the right to procedurally fair administrative action in section 33 of the Constitution. This right entitles those adversely affected by administrative decisions to be given an opportunity to make representations and have their views considered before the decision is finalized. Where decisions have a deep impact on a defined group (like health practitioners), there is a strong argument they should be directly represented in the decision-making structures.

The NHI Fund, as a public entity, is clearly bound by the PAJA. Its decisions about what to cover, whom to contract and how much to pay are administrative actions that profoundly affect health providers' rights and legitimate expectations. At minimum, those decisions should be preceded by meaningful consultation with representatives of key provider constituencies. Ideally, providers should have dedicated seats on governance bodies like the Benefits and Pricing Committees.

The Competition Commission's Health Market Inquiry found a lack of effective participation by practitioners in many of the decisions affecting them (like benefits and tariffs) to be a problem even in the current medical scheme environment. Under NHI, where schemes are reduced to a complementary role only, the risks of marginalizing providers are even greater. The Fund will have a de facto monopoly over the livelihood of most health professionals.

To respect their rights and promote sustainability, significant amendments are needed in the NHI Bill to strengthen provider representation and voice:

- Key advisory committees should have 50% of their membership drawn from health professional associations, with the number of representatives proportional to the providers they speak for (e.g. more GPs and nurses given their numerical dominance);
- The NHI Fund should be statutorily required to consult with health professions representatives before making major decisions on benefit packages, reimbursement mechanisms, pricing etc.;
- The Stakeholder Advisory Committee (or a new representative forum) should be given greater powers to engage with and make recommendations to NHI structures on issues affecting providers;

- Existing professional bodies like the Health Professions Council of SA and the SA Medical Association should have formal opportunities to provide technical input on implementation;
- Dedicated dispute resolution mechanisms should be created for providers to challenge contracting, accreditation or payment decisions by the Fund/Units.

These measures would go some way to equalizing the balance of power between the NHI Fund as the monopoly purchaser of services and health care providers who depend on it for their livelihood. They would help realize the vision of NHI as a partnership between government and providers in delivering universal coverage, rather than an imposition from above.

d) Potential for political interference and arbitrary decision-making

A final concern relating to provider rights stems from the lack of insulation of the NHI Fund and its various sub-structures from political interference. As already noted, the core governance and advisory committees are appointed largely by the Minister of Health. The Board members serve at the Minister's pleasure and can be removed/replaced at any time (clause 13).

Even more strikingly, the adjudication of complaints and appeals against the Fund is also ultimately under Ministerial control. Clause 43 envisions the establishment of an "Appeal Tribunal" but its members are appointed by the Minister, with only vague criteria of "technical expertise". The chair must be legally qualified but there are no other safeguards of its independence or due process (e.g. public nominations, set terms of office, statutory duties of procedural fairness).

This leaves providers who are aggrieved by NHI Fund decisions - whether on accreditation, contracting, appropriate care, reimbursement etc - at the mercy of a Ministerially-appointed Appeal Tribunal. They have no assurance the Tribunal will be impartial and not swayed by political considerations in deciding cases. The lack of any further appeal on the merits to an independent and specialised administrative tribunal or health ombudsman (and only a very narrow scope for judicial review) heightens the sense of provider vulnerability.

The absence of an explicit "rule of law" framework surrounding NHI decision-making also creates unease. Many of the most important rules and criteria will be delegated to regulations, with limited oversight or constraint. The Minister of Health will have extensive unilateral powers to decide details of beneficiary registration, health care benefits, provider payment mechanisms, referral networks, procurement processes and more, via regulation (see clauses 15(2)(g)-(k)).

While some degree of regulatory rule-making is inevitable in a health system restructure of this size, the Bill places few parameters around how such powers should be exercised. For example, there is no statutory requirement that NHI regulations must be rationally connected to the purpose of the empowering provision, that they should be proportional and minimize any adverse impact on health professions, that they should adopt the least-restrictive means to achieve their objectives, or that they must be procedurally fair and include adequate consultation with affected groups.

In the absence of such "rule of law" direction, there is a danger of arbitrary or inconsistent rule-making that fails to adequately consider the rights, interests and legitimate expectations of health care providers. Important aspects of the NHI that will fundamentally shape how they can operate - like accreditation criteria, treatment protocols, referral rules etc - may be imposed in a top-down manner without sufficient checks, balances or oversight. This violates the ethos of participatory and responsive law-making that should animate a transformative project like NHI.

To address these deficits, the NHI Bill should be amended to:

- Require that the Minister of Health may only appoint members of the Appeal Tribunal after an open public nomination process and that candidates must be shortlisted based on objective criteria related to their expertise, experience and impartiality;
- Set statutory terms of office for Tribunal members to insulate them from political pressures and arbitrary removal;
- Explicitly require the Tribunal to comply with the requirements of procedural fairness when deciding cases, including allowing parties to be heard, providing reasons for decisions, and ensuring no conflicts of interest;

- Impose statutory duties on the Minister to follow due process when making NHI regulations, including publishing draft regulations for public comment, considering all submissions received in good faith, ensuring regulations are rationally related to their purpose and do not impose disproportionate burdens on health providers and other stakeholders;
- Create an additional, merits-based right of appeal to an independent administrative appeals body or existing tribunals like the Health Professions Council, where providers are still aggrieved after exhausting the internal NHI appeals mechanism;
- Explore the creation of a specialist Health Ombud or expanded powers for the existing Health Ombud to deal with complaints of maladministration, unethical conduct or violations of the health rights of providers and the public under NHI.

These reforms would enhance the rule of law framework for NHI governance and mitigate the risks of unfair, arbitrary or politically-tainted decision-making. They would give health care providers a greater stake in the system and assure them of impartial avenues to pursue any grievances.

The NHI Fund looks set to become the most consequential public entity for the health rights of both patients and professionals. It is therefore critical that its wide-ranging statutory powers are accompanied by an equally robust accountability and oversight framework. The Fund's conduct should be open to scrutiny by independent judicial and administrative bodies, with accessible remedies for those adversely affected by its decisions.

Overall, as NHI reshapes the entire health market, extensive engagement with and accommodation of the interests of health care providers is non-negotiable. Their rights to practice their professions and earn a decent livelihood cannot simply be sacrificed at the altar of the "public good" or "transformation". The state must seek to achieve its valid NHI objectives in a way that respects the constitutional entitlements of all citizens, including health professionals. A more balanced, consultative and rights-sensitive approach is essential if NHI is to realize its lofty ambitions.

7. Risks of Inadequate Funding and Resourcing for NHI Implementation

The final concern about the NHI Bill's constitutionality relates to whether it contains sufficient guarantees that the NHI Fund will be adequately resourced to ensure access to the health care services promised. The Constitution obliges the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of the right of access to health care services (section 27).

The NHI Bill proclaims that an essential principle of the new system is ensuring health care services "are provided in a manner that is affordable and sustainable for the country" (clause 6(1)(c)). The Bill also requires the NHI Fund to take all reasonable steps to "ensure the sustainability of funding for health care services within the Republic" (clause 10(b)). But beyond these broad statements, it is light on specifics regarding the funding sources for NHI, the projected costs of the reforms, and how the government will ensure the necessary resource flows materialize.

Clause 49(1) simply states that the NHI Fund "is entitled to money appropriated annually by Parliament, in order to achieve the purpose of the Act." Clause 49(2) envisages a variety of potential funding sources, including shifting funds from the provincial equitable share and conditional grants, phasing out medical scheme tax credits, payroll taxes, surcharges on personal income tax, and the reallocation of funding for medical schemes. But there are no firm revenue commitments or targets.

Instead, clause 49(3) kicks the can down the road by providing that the money to be appropriated to the NHI Fund annually will be "calculated in accordance with the estimates of income and expenditure as contemplated in section 53 of the Public Finance Management Act (PFMA)". In other words, NHI funding will be dealt with through the ordinary, annual parliamentary budget process. There is no prescribed mechanism to determine the health resource allocation relative to other priorities.

Moreover, clause 49(4) states that in the first phase of NHI implementation, the chief revenue sources for the Fund will be general tax revenue and medical scheme tax credits. New taxes like payroll or personal income tax surcharges will only be "introduced through a money Bill by the Minister of Finance and earmarked for use by the Fund" at some indeterminate future point. So in the critical early years, NHI will have to rely mainly on existing funding streams.

This "holding pattern" approach to NHI financing raises several concerns:

a) Given the parlous state of the South African fiscus, the economic impact of COVID-19 and low projected growth, it's unlikely there will be substantial additional resources available for health in the short-to-medium term. Health budgets were already under strain pre-pandemic and have come under further pressure from the need to fund the COVID response. In this environment, it's hard to envisage a significant ramping-up of NHI allocations without squeezing other essential programmes.

b) The primary reliance on general tax revenue to initially fund NHI creates risks of under-resourcing and uncertainty. Unlike a dedicated payroll tax or income tax surcharge for NHI, funding from general revenue will be subject to annual appropriations and could fluctuate significantly based on economic conditions and other budget priorities. It will be difficult for the NHI Fund to engage in long-term planning, purchasing and contracting without a secure and predictable revenue source.

c) The lack of an upfront, multi-year projection of the costs of the NHI reforms and how these will be financed over time is problematic. The Bill's socio-economic impact assessment estimates a funding shortfall of R70 billion by 2026, based on a status quo provincial equitable share and merely removing medical tax credits. But there is no concrete strategy to close this gap or specify what new taxes will be used. Expecting a funding requirement of this magnitude to somehow be absorbed through general tax revenue is unrealistic.

d) There is little clarity on how functions and funds will be shifted from other parts of the health system to support NHI. For example, the Bill provides that "funds currently in the provincial equitable share for personal health care services will be shifted to the Fund" (clause 49(1)(a)). But it doesn't explain how this will occur or what oversight will be in place to ensure provinces don't divert these resources to other purposes in the interregnum. Similarly, there is no roadmap for how funding for medical schemes will be "reallocated" to the NHI Fund (clause 49(2)(a)(iv)).

e) Unlike other transformative socio-economic reforms like land restitution or basic education funding, the Bill does not establish any statutory body to advise on and

monitor the resourcing of NHI. It doesn't mandate the Finance and Fiscal Commission or any other expert entity to make recommendations to Parliament on the annual resource requirements and allocation processes for NHI. This creates a vacuum of independent oversight and technical input on the largest public health spend in SA's history.

These gaps and ambiguities in the NHI Bill's resourcing provisions are not just unfortunate from a planning perspective. They arguably fall short of what is required by the Constitution to fulfill the positive obligations of the state vis-a-vis socio-economic rights. In Glenister v President of the RSA, the Constitutional Court held that where legislation aims to give effect to a socio-economic right, it must make "adequate provision for legal and financial mechanisms to achieve its purpose."

In other words, it's not enough for the state to simply pass a law related to a socio-economic right. That law must concretely provide for the necessary resources and implementation measures to make the right a practical reality over time. A mere symbolic or aspirational legislative scheme, without clear deliverables or funding streams, will likely be unconstitutional. It's instructive that the NHI Bill's transitional provisions talk of progressive implementation over a 25-year time horizon (clause 57(2))!

To comply with its section 27 duty to progressively realize the right of access to health care services within available resources, the state must do more than pay lip-service to the "sustainability and affordability" of NHI in the Bill. It must present a credible financing plan with tangible revenue sources and phased expenditure projections. These should be expressly included in the legislation to create a binding framework for Parliament and the Executive.

Comparative examples offer guidance here. When Thailand introduced its Universal Coverage Scheme in 2002, the implementing law created a dedicated Annual Budget Allocation to ensure adequate funding. A specific formula was used to calculate the government's allocation, including estimates of the population to be covered, their anticipated utilization and the costs of the service package. This gave the scheme a stable fiscal footing.

Similarly, the UK's National Health Service Act of 1946 empowered the Minister of Health to set a fixed annual budget for the NHS in consultation with an expert advisory committee. It was agreed upfront that funding would be split between different levels of government, with local authorities covering community and preventative care while Whitehall covered hospital services. This provided a clear division of resourcing responsibilities.

The SA NHI Bill, by contrast, is much vaguer on the funding arrangements. It neither introduces any dedicated NHI taxes, nor prescribes any concrete funding commitments from existing revenue streams. Health care providers and the public are left wondering whether NHI will actually have the resources to deliver all that it promises. The risk is that grand promises of "universal coverage" amount to unfunded mandates.

To strengthen the Bill's compliance with the state's constitutional duties, several amendments could help:

a) Insert a clause requiring the Minister of Finance, in consultation with the Minister of Health, to table a comprehensive financing framework for NHI in Parliament within 1 year of the Act taking effect. This should set out the estimated costs of rolling out NHI over 5, 10 and 20 years, the planned sources of funds, and the mechanisms for ensuring the necessary money is earmarked for NHI annually. The fiscal framework should be updated every three years to reflect new estimates and priorities.

b) Mandate that the annual Budget presented to Parliament by the Finance Minister must expressly indicate the amount allocated to the NHI Fund and the sources of that revenue (e.g. X from general tax, Y from payroll tax, Z from provincial equitable share). This will ensure transparency and enable effective oversight of the NHI resource envelope.

c) Require the establishment, within 2 years, of at least one new dedicated tax or revenue stream for the NHI Fund (e.g. payroll tax or personal income tax surcharge). Given the unreliability of funding NHI purely from general revenue, a secure source of funding is essential. The Minister of Finance would be empowered to introduce this

tax after consultation with the NHI Fund and health sector stakeholders. But some statutory deadlines are needed so this critical issue is not endlessly delayed.

d) Stipulate that in any given year, the funds appropriated to the NHI Fund must be sufficient to cover: (i) The full costs of the health service benefits package to be purchased by the Fund that year; (ii) The projected number of NHI beneficiaries entitled to receive services; (iii) The reasonable fees payable to accredited and contracted health care providers;

(iv) The Fund's administrative and operational costs, as approved by the Minister.

This will ensure the NHI Fund has the necessary resources to meet its coverage commitments. Of course, these amounts must be rationally determined based on the Fund's negotiated agreements with providers and facilities. But the appropriations must align with and enable the implementation of these agreements.

e) Empower the Finance and Fiscal Commission (FFC) to play an annual advisory role on the funding needs of NHI and the appropriate division of revenue between the Fund, provinces, local government etc. The FFC has a constitutional mandate to advise on intergovernmental fiscal matters. The NHI Bill should expressly require the FFC to submit recommendations to Parliament on what quantum of funds should go to the NHI Fund and other health system components each year. Parliament must consider these recommendations when deciding on the Division of Revenue Bill and health budget allocations.

f) Establish a multi-stakeholder NHI Financing Forum, including representatives from Treasury, the Department of Health, provinces, local government, health care providers, medical schemes etc. This forum would meet twice a year to assess NHI resource needs, review utilization trends and cost pressures, and make advisory recommendations to the Ministers of Finance and Health on NHI budget and revenue requirements. While its inputs wouldn't be binding, they would foster collaborative planning and early warning of funding gaps.

g) Require the NHI Fund to prepare and submit a 5-year financial sustainability plan to Parliament as part of its strategic planning processes. This would compel the Fund to examine issues like revenue adequacy, risk trends, enhanced value-for-money in contracting, efficiency measures etc. The plan should be updated annually based on performance and reviewed by the Parliamentary health committee. Where fiscal risks emerge, Parliament can take steps to address these pre-emptively.

h) Mandate that the annual reports of the NHI Fund must include disclosure on financial performance relative to budgets and any concerns about future revenue. The Fund should be obliged to report to Parliament timeously on factors that may compromise its financial position or the delivery of the defined health service package and population coverage. It cannot quietly accumulate deficits without oversight.

i) Provide special powers for the Minister of Health to approach Parliament for an adjusted NHI budget allocation in-year if service delivery is critically compromised. This would enable emergency top-up funding from the national contingency reserve if health needs spike unexpectedly. But it would be circumscribed to genuine crises only. The more proactively the core NHI allocation is set from the outset, the less this oil-can should be needed.

Taken together, these reforms would go a long way towards creating the predictable, sufficient and transparent NHI funding flows essential for the constitutional progressive realization of the right to health care. They would set in place the "legal and financial mechanisms" to give practical effect to the NHI vision that the Court demanded in Glenister. Resourcing universal health coverage cannot be done on a wing and a prayer - it requires clear, upfront fiscal commitments and earmarking of the necessary revenues.

Another legal imperative for NHI funding is that it complies with the Bill of Rights' equality provisions. Section 9 prohibits unfair discrimination on grounds like race, gender, age and disability. In the context of health care services, this implies that NHI allocations and resources must be distributed between different population groups and geographical areas in an equitable manner. There can be no arbitrary under-servicing of vulnerable groups or poorer provinces.

The Constitutional Court has repeatedly affirmed that where state resources are deployed to fulfil socio-economic rights, there must be a rational connection between the allocative decisions and the constitutional and statutory obligations. In Gauteng Provincial Legislature In re: Gauteng School Education Bill, the Court stated:

"In dealing with public resources . . . Parliament and the provincial legislatures have a constitutional duty to distribute resources equitably and to provide effectively for the basic needs of the poor, the vulnerable and the disadvantaged."

Similarly, in City Council of Pretoria v Walker, Justice Langa held:

"The purpose of [affirmative action] is to ensure that . . . benefits are fairly distributed and shared. Where the distribution of public resources is skewed in favour of a certain group or geographical area, this must be justified in terms of the constitution and the bill of rights."

In other words, the state has a duty to allocate resources in a way that redresses historical inequalities in access to services. It cannot perpetuate patterns of privilege and deprivation. Any differential treatment in health care funding by the state must be shown to be fair and non-discriminatory.

Currently, the public health system is characterized by deep inequity between provinces, districts and facilities. Some regions have much higher per capita spending, staff ratios, and access to services than others. Wealthier urban provinces benefit from better resourced tertiary hospitals and medical schools. Meanwhile, poorer provinces, especially those incorporating former homelands, endure chronic human resource and infrastructure backlogs.

The NHI Bill rightly seeks to address these inequities through a national pooling and purchasing mechanism. But to give effect to the equality rights in section 9, there must be concrete guarantees that NHI funds will flow disproportionately towards underserved populations and areas. The section 27 right of access to health care services must be realized equitably.

However, the current Bill is largely silent on how NHI resources will be equitably distributed. Clause 10(i) requires the Fund to "take measures to ensure that the

funding of health care services is appropriate and consistent with the concepts of primary, secondary, tertiary and quaternary levels of health care services." But there is no explanation of what an "appropriate" allocation to different levels of care looks like.

Clause 35 charges the Fund with "ensuring the equitable and fair distribution and use of health care services" but again provides no detail on how this will be achieved. Apart from passing references to "equity" in the preamble and principles section, the Bill contains no express provisions for how NHI funds will be allocated between beneficiary groups, geographical areas or types of services to redress historical inequalities.

A number of amendments could help to more explicitly embed a non-discrimination and equality lens in NHI resource allocation:

a) The list of beneficiary registration requirements in clause 5 should state that no person may be unfairly discriminated against on grounds of race, age, disability etc. in the registration process. Proof of identity, residence, income etc. can be required but these must be applied fairly and flexibly across the population.

b) The section on the composition and appointment of the NHI Fund Board (clause 13) should specify that the Board must be broadly representative of the South African population in terms of gender, race, disability etc. and must promote equitable access to NHI services in its decision-making.

c) The Fund's responsibilities in clause 10 should include adopting a formal resource allocation framework, in consultation with the Minister and stakeholders, which sets out the criteria and weightings that will be used to equitably allocate funds between different geographic areas, levels of care and population groups based on need. Factors like disease burden, population size, deprivation, rural-urban differences etc. should be objectively incorporated in the framework.

d) The contracting and payment mechanisms the Fund adopts for accredited providers (clauses 39-41) should be tailored to incentivize greater service delivery in underserved areas. This could include top-up payments for rural providers, capitation

models that adjust for risk profile, and rewarding performance on equity metrics. The Fund should be required to report annually on how its contracting is reducing service disparities between districts.

e) An explicit power could be assigned to the Minister to make regulations prescribing the "minimum required range of personal health care services" that must be equitably accessible to the population in each district, with due regard to differences in disease burden (clause 7(2)(b)(i)). This would set a floor for an equitable basic package across all areas.

f) The annual reporting requirements (clause 51) should include that the Fund must disclose key equity performance data, like what share of resources were spent in each district and province, trends in utilization of services by different groups, and measures of fairness in the distribution of benefits. The Minister and Parliament can use this to monitor progress and hold the Fund accountable.

g) A specific mandate could be added for the Office of Health Standards Compliance to monitor the impact of NHI implementation on the equitable quality and distribution of health care services. The OHSC should report to Parliament if it finds the NHI is worsening inequities in quality of care.

h) The Competition Commission market inquiry findings on the negative effects of the current highly concentrated private hospital and medical scheme markets on accessibility and affordability of services should be referenced. The NHI Fund's contracting should counteract these abuses of market dominance by stimulating competition and innovation.

i) The powers of the Minister to identify and designate under-served geographical areas for licensing and contracting purposes (clause 55(1)(b)) should expressly refer to the need to achieve an equitable distribution of health care services and address historical inequities.

j) The health care needs of vulnerable groups like women, children, the elderly, people with HIV, sex workers, LGBT+ populations etc. should be explicitly considered in the NHI benefits design, formulary, provider contracting and M&E processes.

Representatives of these groups should participate in the relevant decision-making structures of the Fund.

These are not exhaustive proposals but aim to illustrate how a stronger equity and non-discrimination focus could be mainstreamed in the institutional arrangements and implementation of NHI. As the state's primary vehicle for achieving universal health coverage, it's essential that NHI embodies a pro-active, multi-pronged approach to advancing equality in access to services.

Interestingly, the right to equality arguments around NHI resourcing could cut both ways. On one hand, the imperative to allocate funds based on need and redress historical disadvantage points to prioritizing poorer districts and provinces. There is precedent for such a redistribution in the "equitable share" formula used to divide nationally-collected revenue between provinces currently, which has components for poverty, economic output and population.

However, wealthier groups and areas might also seek to challenge any NHI funding model that results in net outflows from them to other regions as unfairly discriminatory. They could argue that they have contributed disproportionately to the tax base historically and should not now be relatively deprived of health care allocations. The NHI Bill's prohibition on purchasing additional private cover might be attacked as an invidious cross-subsidization, especially if the quality of publicly-funded services in affluent areas declines.

These competing equality-based arguments will require careful navigation as NHI is rolled out. The Constitutional Court has emphasized that affirmative measures to achieve substantive socio-economic equality must be tailored to context and cannot impose undue harm on relatively advantaged groups. In Minister of Finance v Van Heerden, the Court stated:

"Whether a measure will achieve its purpose of advancing the position of a disadvantaged group depends to a considerable extent on the facts of each case and the nature of the measure...It must be accepted that such differentiation does not constitute unfair discrimination. However...if the measure at issue does not further the purpose of advancing those previously disadvantaged, it loses its validity."

This suggests that while NHI funding allocations can privilege worse-off groups and regions to redress inequity, this must be rationally connected to actually improving their access to quality care and health outcomes over time. There must be a reasonable prospect that a targeted allocation will make health care delivery more equal in reality, based on objective indicators and data. The cross-subsidization inherent in NHI cannot be punitive or place a grossly disproportionate burden on any population segment.

The NHI Fund will have to develop sophisticated needs-based resource allocation models, incorporating key epidemiological and social determinants of health, to navigate this. These must be transparently grounded in the equality and progressive realization duties of the Constitution. The goal should be steady, demonstrable progress towards an equitable universal health service, not divisive cost-shifting for its own sake. Proper oversight and consultation in developing the allocation mechanisms will help to secure legitimacy.

In summary, the NHI Bill requires significant bolstering of its resourcing and funding provisions to pass constitutional muster and give effect to the imperatives of progressive realization and non-discrimination in relation to health care services. The establishment of an ambitious new universal service cannot be premised on vague aspirations of future funding. There must be clear, upfront earmarking of adequate revenue sources, needs-based allocations, and hard mechanisms to ensure money flows to where it's most needed.

8. Conclusion

In conclusion, while the aims of the NHI Bill are laudable, the analysis in this opinion suggests that aspects of the proposed legislation are constitutionally flawed. To pass muster, the following key amendments should be considered:

a) The excessive centralization of powers in the Minister of Health and national sphere must give way to more cooperative governance arrangements with provincial and local

governments, the devolution of key functions to sub-national levels, and a less top-down approach to implementation.

b) The transparency and accountability provisions need a major overhaul, with greater Parliamentary oversight, public reporting, proactive information disclosure and independent regulation built into the NHI Fund architecture.

c) The prohibition on duplicative private health insurance should be relaxed to allow greater freedom of choice, with a more mixed funding model that still achieves cross-subsidization and risk-pooling goals.

d) The provisions regulating health care providers like professionals and facilities must be amended to prevent an undue incursion on freedom of profession and impose narrowly-tailored rather than blanket controls on private practice.

e) Significantly more detail is needed on the funding streams, revenue sources, needs-based allocation formulae and oversight mechanisms for NHI to ensure adequate resourcing and equitable distribution of benefits over time.

If these issues are addressed, the NHI Bill could become a constitutional and durable platform for finally realizing the promise of universal health coverage in South Africa. But in its current form, it falls short.

There is no doubt that fixing the deep inequities and fragmentation of the health system is an urgent national priority. Section 27 of the Constitution demands that everyone - regardless of race, class or geography - is able to access the essential health services they need to survive and thrive. The status quo is simply unacceptable.

However, the end does not justify the means. A transformational project with such far-reaching implications as NHI must still comply with the Constitution and the web of individual and collective rights it enshrines. It cannot be a vehicle for centralizing and concentrating power, undermining accountability, constraining choice and competition, or failing to ensure adequate checks and balances. The rule of law and separation of powers matter.

Getting NHI right is also essential for its long-term success and sustainability. A system imposed from above, without sufficient participation and accommodation of stakeholder interests, that fails to empower frontline providers and citizens, is unlikely to take root and deliver on its promises. Reforms that compromise quality, choice and responsiveness in the name of equity are likely to breed resentment and non-compliance.

The road to universal health care is a long and winding one. It will require all spheres of government, health sector actors, civil society, Parliament and the courts to work together in a spirit of cooperative constitutionalism. The NHI Fund, once established, must be a beacon of good governance - open, accountable and responsive to the needs of all who depend on it.

If the NHI Bill can be amended to embody these principles, it will mark the start of an exciting new era in which the right to health finally becomes a lived reality for all in South Africa. But if the constitutional pitfalls are not addressed, even the best-laid plan for UHC may be derailed. The stakes are high. The time for informed public and political debate on how to make NHI work within our supreme law is now.

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