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Constitutional Court strikes down Certificate of Need scheme: What is it and what does it mean for the future of the NHI?

On 18 May 2026, South Africa (SA)'s Constitutional Court struck down the Certificate of Need (CoN) scheme contained in the National Health Act – the mechanism meant to control where doctors and hospitals could set up practice.[1] The judgment made headlines partly because government itself had told the Court, in its own papers, that the CoN was central to its National Health Insurance (NHI) plans. That single fact has fuelled weeks of debate over whether this judgment quietly wounds the NHI. Our view is that it does not impact the NHI as proposed, and we unpack what the judgment truly means here.

A CoN differs from ordinary professional licensing, which asks 'Is this person qualified?', in that a CoN asks 'Is this service needed here?' and also, 'would this service be better suited elsewhere?' The scheme (which had remained dormant) would have required existing clinics and hospitals to prove need or cease continued practice. Non-adherence could attract criminal liability. Similar tools operate in the USA and France, generally to manage costs and spread services more evenly.[2-4]

SA's version was designed to answer a specific problem. In 2019, the Competition Commission found a stark, structural imbalance in the health sector: private care serves a small fraction of the population, yet consumes a disproportionate share of health funding.[5] Separate work from the Human Sciences Research Council,[6] and academic studies of doctor distribution in provinces such as Limpopo, confirm a pattern of geographical inequity.[7-9] On this evidence, the case that some form of redistribution is needed is hard to dismiss.

Yet the Court did not rule on that evidence, or on the principle of needs-based licensing at all. Its judgment turned on two narrower defects: the law gave the Minister of Health almost unlimited discretion to decide which services required a certificate, and the regulations never obliged decision-makers to weigh the interests of the practitioners being restricted. Those are drafting failures, not a finding that redistribution itself is unconstitutional. The Court explicitly declined to rule on several other rights challenges raised in the case, leaving them available to use against any future scheme.

This distinction is easy to lose in the surrounding noise. Groups representing practitioners argued that doctors were being asked to absorb the cost of decades of public-sector failure, with no state support for the infrastructure, security, or capital costs of practising in underserved areas.[10] The criticism definitely touches on elements of the scheme's design. However, it is not evidence that a better-designed scheme, with proper safeguards and state support, would fail the same constitutional test.

Comparative law suggests as much. Germany's constitutional court upheld geographical restrictions on where doctors may participate in the statutory health insurance system, having weighed the rights of restricted physicians against the public interest in equitable access.[11] SA's own Constitution arguably goes further: section 27(2) does not merely permit measures to redistribute health resources, it obliges the state to take them within available resources, while section 22 makes clear that the right to trade is subject to regulation by law. Neither provision was found by the court to bar CoN-type licensing outright.

What, then, of the NHI? The Act itself makes no mention of CoNs. On a strict legal reading, then, it is correct that nothing in this judgment touches the NHI Act's validity. But the ruling does close off, for now, one key specific redistributive lever that the state said it was relying on, and it hands opponents a detailed map of what a compliant scheme must avoid. Reintroducing a CoN would require new primary legislation, years of process and a coalition government that is unified behind NHI in the first place – a political reality as significant as the legal one.

The effect of this judgment is narrower than most of the commentary surrounding it. The Court found a badly designed law, not an unconstitutional idea. The evidence for geographical inequity in SA healthcare is real and well documented; the evidence that fixing it requires exactly this scheme, in this form, is not what the Court was asked to decide.

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