

WHO OWNS SOUTH AFRICA?



CHAPTER 2

PRIVATE HEALTH

An investigation by
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Open Secrets is a non-profit organisation which exposes and builds accountability for private sector economic crimes through investigative research, advocacy, and the law.

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ACRONYMS

ANC	African National Congress
AI	artificial intelligence
AU	African Union
B-BBEE	Broad-Based Black Economic Empowerment
BHF	Board of Healthcare Funders
BUSA	Business Unity South Africa
CEO	chief executive officer
CMS	Council for Medical Schemes
DA	Democratic Alliance
DHMS	Discovery Health Medical Scheme
EBITDA	earnings before interest, taxes, depreciation, and amortisation
GEPF	Government Employees Pension Fund
GHG	General Healthcare Group
HFA	Health Funders Association
HMI	Healthcare Market Inquiry
JSE	Johannesburg Stock Exchange
NCOP	National Council of Provinces
NEHAWU	National Education, Health, and Allied Workers' Union
NHI	National Health Insurance
NHIA	National Health Insurance Act
OECD	Organisation for Economic Cooperation and Development
PFMA	Public Finance Management Act
PIC	Public Investment Corporation
POPCRU	Police and Prisons Civil Rights Union
SAPPF	South African Private Practitioners Forum
UAE	United Arab Emirates
UK	United Kingdom
WOSA	Who Owns South Africa



KEY TERMS

Council for Medical Schemes (CMS)	A statutory body established by the Medical Schemes Act 131 of 1998 to provide regulatory supervision of private health financing through medical schemes.
Healthcare Market Inquiry (HMI)	The Competition Commission investigation into competition in South Africa’s private healthcare sector, whose final report was released in 2019.
Medical aid administrator	A for-profit company that manages the day-to-day operations and administration of a medical aid scheme on behalf of the scheme’s board of trustees.
Medical aid scheme	A not-for-profit entity that provides financial cover for the medical expenses of members paying a monthly contribution to it.
National Health Insurance (NHI)	A centralised national insurance system with a fund, from which the government will provide healthcare services through healthcare providers in both the public and private sectors.
National Health Insurance Act (NHIA)	The law passed by Parliament and signed by the President to establish a National Health Insurance Fund, with the stated aim of achieving improved universal health coverage of the South African population, in line with section 27 of the Constitution.
Open scheme	A medical aid scheme that is open to the public.
Restricted scheme	A medical aid scheme that is only open to certain groups of individuals belonging to a particular industry or company.



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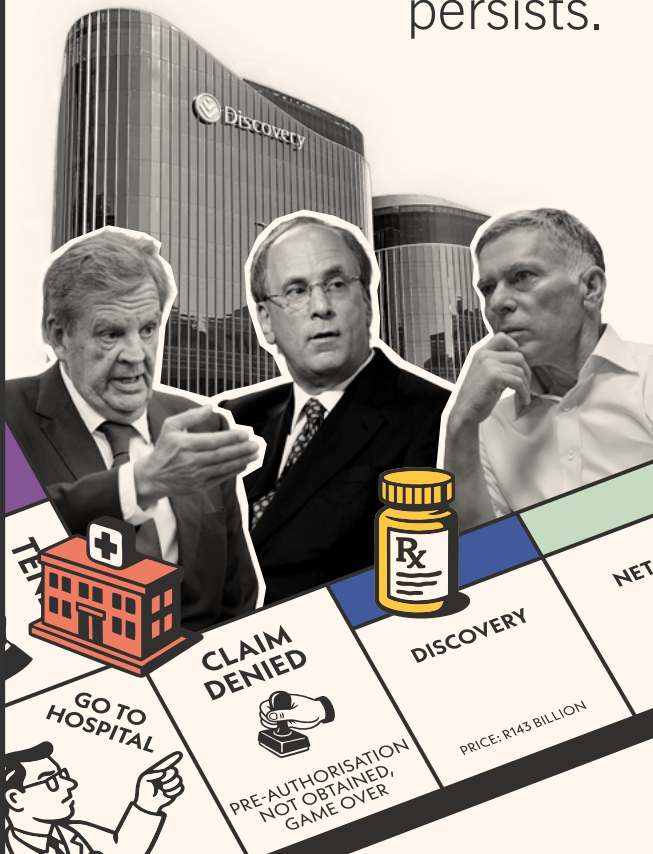
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01

WHO OWNS SOUTH AFRICA

Private healthcare in South Africa is shaped by concentrated corporate power. This report exposes who benefits, who pays, and why inequality persists.



The “Who Owns South Africa” (WOSA) series is an effort by Open Secrets to shed light on the powerful private players who control large parts of the South African economy. We argue that understanding these ownership patterns assists an informed public debate rooted in evidence-based research. If we are to work towards social justice, our argument is that we need to know who “owns” large parts of the economy.

In this instalment, we look at South Africa’s healthcare sector, which is marred by deep-rooted inequalities. At the heart of these systemic challenges lie the country’s sordid history and the current day concentration of power in the hands of a few individuals, corporations, and their shareholders. Much has been written about endemic corruption and mismanagement in the public healthcare system. We do not seek to rehash these important debates here. Instead, we turn the spotlight on the role of private players in the healthcare system and show how the concentration of private ownership and control shapes the sector.

We look closely at the history and ownership structures of private hospitals and medical aid schemes to gain insight into what the patterns are in the private healthcare system and who benefits from the systemic inequalities that underpin our society. In the first section, we examine the role of private healthcare and failing public healthcare in perpetuating inequality in access to care. We then turn to examine the ownership structures of mega hospital groups Life Healthcare, Mediclinic, and Netcare. The next section pays closer attention to some of the largest medical aid schemes and their administrators, focussing on Discovery, Bonitas, and Momentum. Finally, we turn to the debate on the dominating issue in South Africa’s health policies—the introduction of National Health Insurance (NHI)—and the relevance of private ownership to that important discussion.

02

DIAGNOSIS: HEALTHCARE INEQUALITY IS SICK

The roots of South Africa's healthcare crisis run deep. Historic injustice and corporate power continue to dictate who lives well and who is denied care.



In 1652, the Dutch East India Company temporarily set up a tent at the Cape of Good Hope to care for colonial sailors who faced illnesses such as scurvy and typhoid: this was the first hospital set up by a corporation. In 1656, a permanent hospital was established, where healthcare was provided to people by soldiers who did what they could to treat them. As demand intensified and subsequent colonial administrations grew in ambition, the foundations of a more structured healthcare system were laid, with hospitals being built in the Eastern Cape—Grahamstown, King Williamstown, Queenstown, and Port Elizabeth—by 1807.¹ By the middle of the 19th century, there was a hospital in almost every major centre in the country, staffed with formally trained doctors and nurses.² Traditional and indigenous healers were sidelined and marginalised in the process of developing state-run healthcare systems.

Much of the contemporary disfunction in the healthcare system in South Africa has its roots in the colonial apartheid era. Healthcare was fragmented, divided into 14 different health departments, which represented the division of the apartheid state at the time into the Cape Province, Natal, Orange Free State, Transvaal, and the 10 “Bantustans”. This resulted in a health system that was fractured and under-resourced, especially in poor and rural communities.³ By 1988, healthcare spending per capita in white areas was around R172, while spending in areas designated for black people was less than a third of that, at just R55.⁴

In the 1960s and 1970s, the apartheid government regulated the booming private health sector to shield white patients from corporate abuse, while excluding the majority of South Africans.⁵ By 1960, four out of five white citizens had health insurance provided by a range of pre-payment programmes, including parastatal schemes and state departments. To protect this group, the 1967 Medical Schemes Act mandated minimum benefits and fixed doctors’ fees to match what medical schemes would cover.⁶

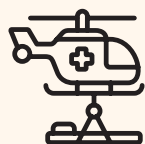
These benefits were reserved almost entirely for the white minority, while the majority of black South Africans were denied access to adequate services. Healthcare was also weaponised as a tool of apartheid repression.⁷ Some doctors and health officials colluded, whether by omission or complicity, in denying black South Africans their right to care,

as in the infamous case of the 1977 murder of anti-apartheid leader Steve Biko. Beaten into a coma by security police, he was examined repeatedly by state doctors who dismissed clear signs of brain damage as “malingering”, failing to intervene or prevent his death.⁸

In the 1980s, political resistance, fiscal pressure, and global ideological shifts toward privatisation led the National Party to loosen regulations; guaranteed payments and mandatory benefits were cut.⁹ There was a boom in private hospital construction, and public sector user fees soared. Medical scheme membership, previously restricted to whites, was opened to other racial groups. The private sector, particularly for-profit hospitals and schemes catering to a growing black middle class, expanded rapidly, but costs escalated dramatically, fragmenting an already divided health system.¹⁰ Socioeconomic status started to replace race as the primary barrier to quality healthcare.

By the 1990s, as the African National Congress (ANC) took power, neoliberal orthodoxy and the entrenched strength of for-profit healthcare ensured that private actors would remain central in the democratic era, and inequality in access to care would continue.¹¹

INFOBOX



Section 27 of the Constitution

Section 27 of the Constitution guarantees the right to access healthcare services and creates the corresponding duty on the state to progressively realise this right for all people in South Africa.¹² Section 27(3) of the Constitution implicates the private sector by providing that no one may be refused emergency medical treatment. The corresponding duty is that healthcare providers, including private companies, must treat persons requiring emergency medical treatment.¹³ This duty is narrow in its application since emergency is defined as “a dramatic, sudden situation or event which is of a passing nature in terms of time”¹⁴ and does not include chronic or terminal illness.¹⁵

Emergency medical services are dominated by the private sector in South Africa, with Netcare 911 and ER24 EMS accounting for over 80% of all emergency services.¹⁶ This is despite most South Africans relying solely on public emergency medical services,¹⁷ especially people in rural areas.¹⁸ Public ambulance response times across South Africa remain alarmingly slow. In cities or urban areas, more than half of ambulance call-outs take over 30 minutes on average. In rural areas, the crisis is even more severe, with around 7 out of 10 patients forced to wait at least an hour before receiving urgent medical attention—a delay that can cost lives.¹⁹ In 2024 Health-E News reported that residents of KwaZangashe in the Eastern Cape often wait up to three days for an ambulance—and in some cases, no ambulance arrives at all.²⁰

A key tenant of the struggle for democracy is the right to adequate healthcare. This was reflected in the Freedom Charter adopted in 1955 and the demands made by the United Democratic Front, or UDF, in the 1980s. In a democratic South Africa, the right to access quality healthcare is enshrined in section 27 of the Constitution.²¹ However, what exists is still a deeply fractured system characterised by inequality of access to good care. Private healthcare is often perceived to have high quality services, well looked-after patients, and well-resourced facilities. This is not always the case, and this profile will show how issues of fraud, overselling, and huge inefficiencies apply to private healthcare too. Yet it too often stands in stark contrast to the reality for users of the public healthcare system—overcrowded hospitals, very long waiting times, below-standard healthcare services and declining infrastructure, and high doctor-to-patient ratios.²²

As this profile shows, partly in response to failings within the public sector, healthcare has become privatised, commercialised, and increasingly financialised,

leading to exorbitant costs while commodifying healthcare and limiting accessibility based on wealth and income.

The country's public health system is funded by the state and serves around 80% of the population.²³ In contrast, the 20% of South Africans who are members of private medical schemes pay monthly premiums to those schemes. Often ignored is an additional public subsidy provided through tax rebates intended to stimulate private medical scheme membership and lessen reliance on the state by those who can afford it. Of all spending on private healthcare, around 81% is derived from medical scheme payments on behalf of members. The majority of the rest comes from out-of-pocket payments by individuals.²⁴

Even though private health companies and medical aid schemes provide goods and services that gives effect to a constitutional right, the law governing the relationship between corporate healthcare providers and the public is largely contractual.²⁵ There are limited circumstances in which corporates must have regard for the public interest when making decisions that may affect the public, though the scope of this duty has not been sufficiently expanded on.²⁶

Nonetheless, our courts have been clear about the important role private healthcare companies play in giving effect to the constitutional right of healthcare while still running for-profit businesses. In 2021 the Constitutional Court upheld the decision by the Competition Tribunal prohibiting Mediclinic from acquiring another two hospitals in Klerksdorp and further increasing its market dominance. The court made strong statements around the need for corporations to conduct business bearing in mind the context in which they have been able to thrive in South Africa. It said:



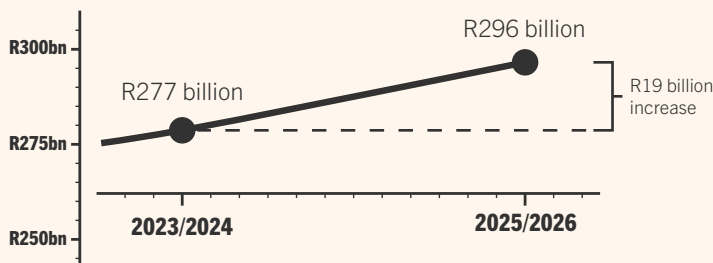
“It ought never to be acceptable for any of us, including the corporate citizens of this land, to indulge, talk less of over-indulge, in the unconscionable practice of seeking to record the highest profit margin possible by any means necessary, in wanton disregard for what that would do to the rest of humanity. Neither should the historic exclusion of some from meaningful participation, particularly in the mainstream economy, be normalised. For, this seems to be one of the most stubborn injustices of our past that require a more deliberate, intentional and systematic confrontation appropriately enabled by independent, incorruptible, efficient and effective law enforcement and justice-dispensing institutions.

Colonialism, neo-colonialism and apartheid orchestrated an institutionalised concentration of ownership and control of all things of consequence in our national economy along racial lines. Unsurprisingly, the commanding heights of the corporate sector are seemingly the exclusive terrain of our white compatriots. It is this indisputable reality and our shared commitment to ensuring that South Africa really does get to belong to all who live in it, that the constitutional imperatives, laid out in the Preamble, to improve the quality of life of all citizens and free the potential of each are realised ...”²⁷

IT IS EXPENSIVE TO BE HEALTHY

The South African state spends a relatively high percentage of the national budget on public healthcare. In 2001 African Union (AU) states pledged to dedicate 15% of their national budgets to health under the Abuja Declaration. Two decades later, only South Africa and Cabo Verde have come close. The continent's average health allocation in terms of budget was just 7.4%, and over 95% of AU countries failed to meet the commitment.²⁸

Most recently, South Africa's national health budget increased from R277 billion to R296 billion for 2025/26, constituting 11.5% of the R2.58 trillion in consolidated government expenditure for the financial year.²⁹ It is the third highest expenditure item in the budget. Despite this financial commitment, serious systemic problems remain in South Africa's public healthcare system. These include corruption, staffing shortages, medicine stock-outs, infrastructure deficits, access inequities, and poor health outcomes.



Billions more, but still not enough

Despite being the third largest budget item, public health is crippled by corruption, crumbling infrastructure, and staff shortages that money alone has not solved.

Across nearly every province, South Africa's health departments have been rocked by corruption, with dozens of cases surfacing in recent years.³⁰ The Auditor-General's 2020/21 report exposed R12 billion in material irregularities across government, with the health sector consistently ranking among the worst offenders.³¹ Provincial health departments spend as much as 30% of their budgets on procurement, and much of this is lost to fraud and corruption involving hospital administrators and private contractors.³²

Tragically, whistle-blower Babita Deokaran—a senior figure in the Gauteng Department of Health—was assassinated in 2021, underscoring the power of “mafias” benefitting from the plunder of healthcare. She was killed days after trying to stop R100 million in suspicious payments and flagging another R850 million in payments that she thought were suspicious, including those to senior figures in the provincial structures of the ANC.³³

Public hospitals are also hemorrhaging doctors and nurses. Between 2013 and 2025, nearly 125,000 doctors and nurses resigned: around 6,000 a year. Poor working conditions, low salaries, the lure of private-sector pay, and a steady exodus abroad have left hospitals understaffed and overcrowded with dangerous levels of medical staff-to-patient ratio.³⁴

The human cost extends further. Chronic medicine stock-outs plague clinics and hospitals, with essential drugs for HIV, tuberculosis, and maternal care frequently unavailable.³⁵ Infrastructure is crumbling; aging hospitals and rural clinics struggle with leaky roofs, broken equipment, and overcrowded wards. Rural patients often travel hours for basic care, while urban hospitals burst at the seams.³⁶



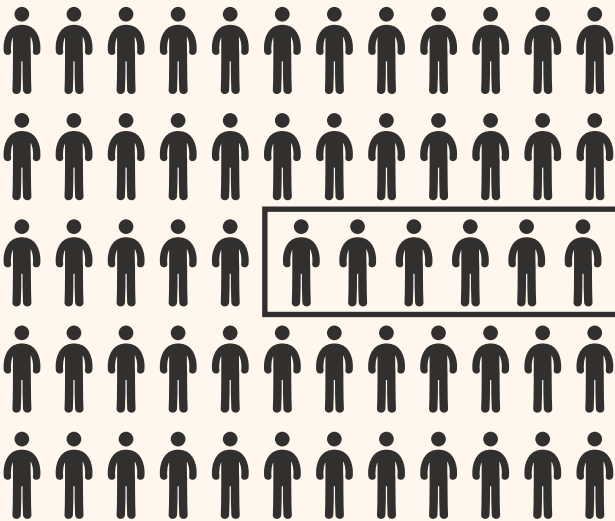
There is no doubt that it remains important for urgent action to be taken to address the myriad issues that plague the country’s public healthcare sector.

However, often overlooked are the key factors in the private healthcare system that distort the broader healthcare system and push up costs for consumers and profits for corporations. There is increasing evidence that private healthcare services are inefficient and their pricing unnecessarily exorbitant. This is in large part explained by the concentration of ownership in both private hospitals and private medical schemes, with a small group of actors making exceptional profits.³⁷

South Africa spends a higher share of its total health expenditure—nearly 42%—on private voluntary health insurance (medical aid schemes) than any other country. This is even though less than 20% of the population are members of medical aid schemes.³⁸ This is partly because private healthcare is very expensive in South Africa. In 2016 the Organisation for Economic Cooperation and Development (OECD) found that South Africa’s private hospital prices were on par with wealthy OECD countries like the United Kingdom (UK), France, and Germany, making it unaffordable for most.³⁹

The first instalment of Open Secrets’ *Who Owns South Africa* series, “The system”, notes that wealth inequality is worsening and remains racialised: “The top 0.1% of South Africans—predominantly white—own 25% of all the country’s wealth. But the concentration is more extreme—the 0.01% (just 3,500 people) own 15% of the country’s wealth”.⁴⁰

This inequality impacts access to healthcare. According to Statistics South Africa’s General Household Survey, only 3 out of 20 South Africans—15% of all people—had access to medical aid at the end of 2023.⁴¹ While black South Africans numerically make up the largest portion of medical scheme membership (52%), uptake is highest amongst white South Africans, at around 68%. Contrast this with the stark fact that only around 10% of black South Africans are members.⁴²



Most people rely on the underfunded public health system, while medical aid cover remains concentrated among the wealthy.

Medical aid membership is starkly unequal: around 68% of white South Africans are covered, compared with only about 10% of black South Africans.

This reflects income and wealth disparities. The costs of medical schemes can range from around R450 for basic cover to as high as R12 000, with a standard of between R2 500 and R3 000. ⁴³ However, working people in South Africa make well below the living wage of R15,000, and the minimum monthly wage is a little over R4,500 a month, making private medical aid out of reach for most.⁴⁴



THE MONEY MEN TAKEOVER: TRACKING THE FINANCIALISATION OF HEALTHCARE

Understanding the consequences of the financialisation of healthcare is key. In the first profile of the *WOSA* series, we argued that financialisation—the rapidly growing power of financial actors and financial motives in directing domestic and global economic outcomes—is crucial to understanding rising inequality, high unemployment, and ever-increasing prioritisation of maximising returns to shareholders at the expense of investment or fair wages. The trends seen in South Africa are reflective of what is happening across the globe.

Financialisation has heavily impacted healthcare, and the effects are being keenly felt in the sector. In practice it has meant that healthcare has been transformed from an essential social service into an asset that can be sold to and traded by global and local financial investors.⁴⁵ The healthcare sector has become a new arena for asset managers and investors to seek returns and profits. This in turn has increased the influence of these actors on healthcare systems and outcomes and led to decision-making based on maximising shareholder returns.⁴⁶ Globally, these impacts have been felt most profoundly in middle-income countries that do not have universal public healthcare systems and already have extensive corporate healthcare services—like South Africa.⁴⁷

There are a few important consequences of the financialisation of healthcare that are evident in South Africa and come up throughout this profile. They include the following:

1

Higher costs: Private investors expect quick and high returns, which ultimately are paid for by healthcare service users, governments, or both.⁴⁸ When there is consolidation of healthcare providers—often a result of financialisation—higher prices are usually passed on to patients.⁴⁹ This is particularly the case when a small number of hospital providers are able to dictate favourable prices with insurers.⁵⁰

2

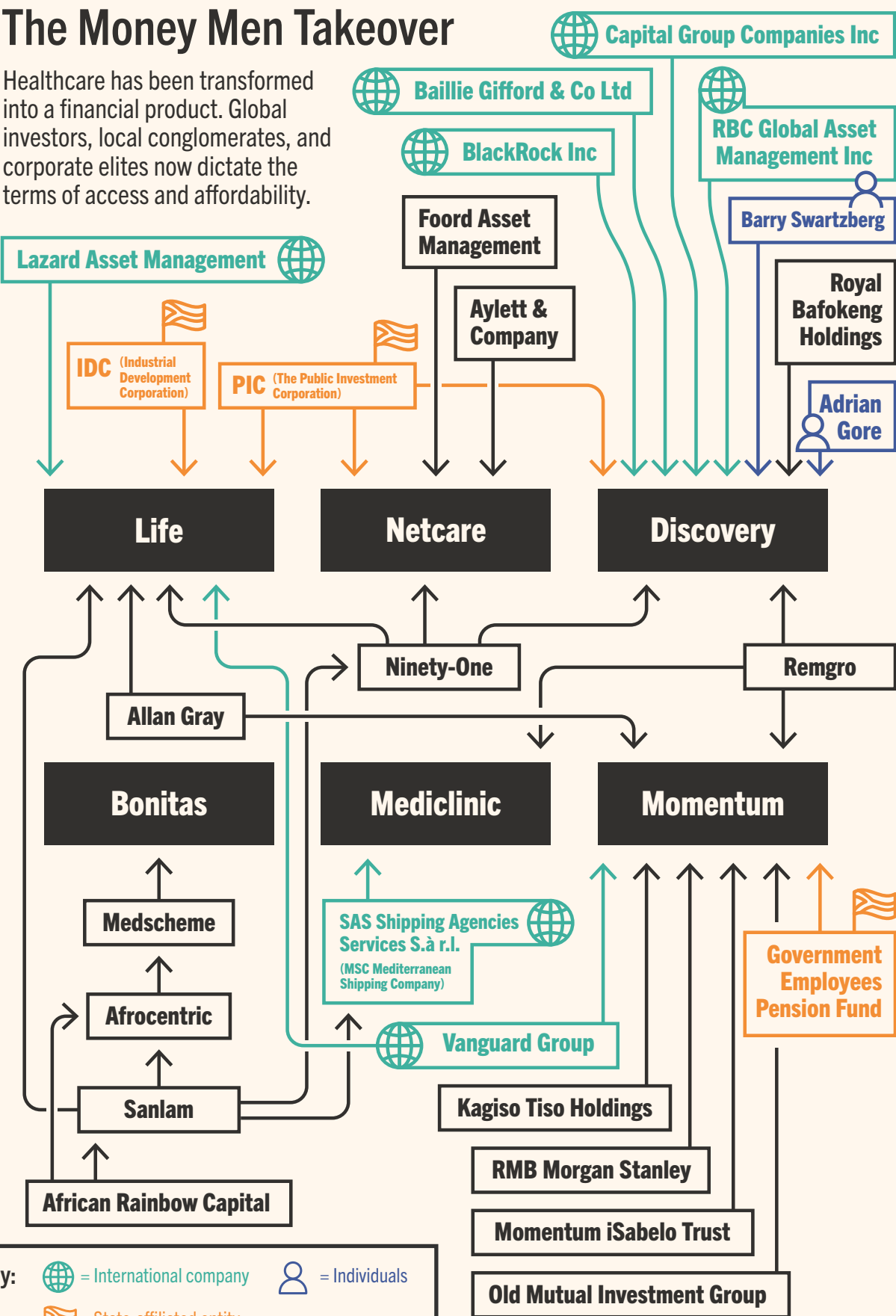
Changing the mission of health: Healthcare has usually been associated with values of care, humanitarianism, and alleviating suffering. Under privatisation and financialisation, the driving impetus has instead become the financial interests of private owners. This has meant pursuing shareholder returns at all costs, including selling unnecessary treatments, lowering the quality of care, and cutting costs by lowering the wages of the many workers central to quality healthcare.⁵¹ While specialist doctors are prized highly because they can bring in new clients, nurses, junior staff, and other workers in the healthcare system face job precarity and low wages as owners aggressively cut costs.⁵²

3

Secrecy and declining public accountability: Unlike public healthcare financing, which is open to public scrutiny, the financial and other relationships between private actors invested in the healthcare system are often hidden behind commercial contracts and corporate confidentiality regimes.⁵³ There is also a significant risk that the private financiers and owners behind healthcare can capture regulatory bodies and processes, given their resources and existing lobbying efforts that tend to favour deregulation.⁵⁴

The Money Men Takeover

Healthcare has been transformed into a financial product. Global investors, local conglomerates, and corporate elites now dictate the terms of access and affordability.



03

PRIVATE HOSPITALS

Three powerful hospital groups dominate the private sector, driving up costs and concentrating control

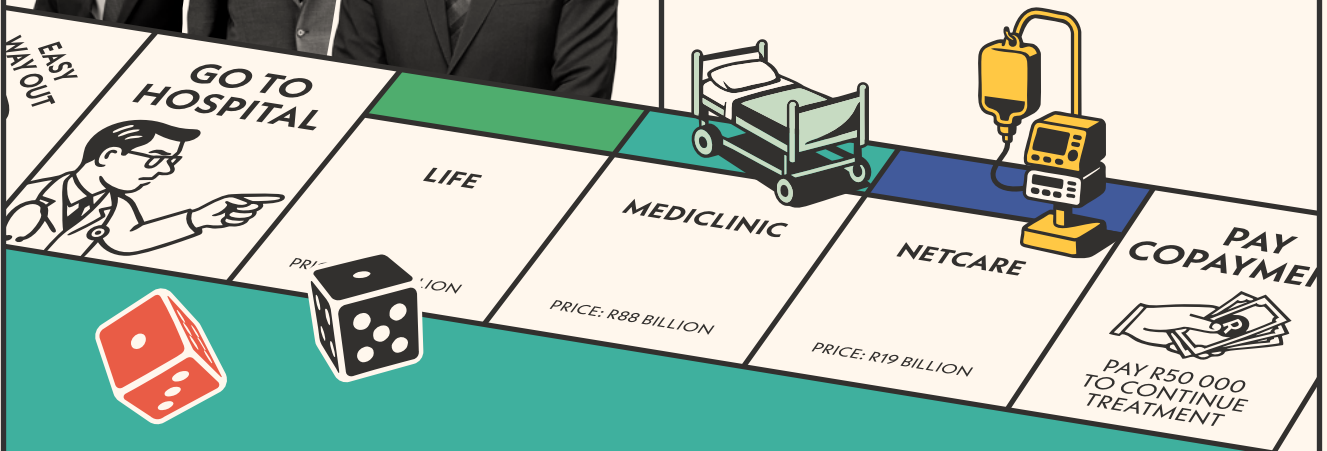
CONCENTRATED OWNERSHIP PUSHES UP PRICES

Private hospitals in South Africa have, over the last ten years, increased their prices at approximately double the rate of consumer inflation.⁵⁵ Payments to private hospitals comprise the single largest component of expenditure by medical schemes.⁵⁶

The “big three” private hospital groups—Life Healthcare, Mediclinic, and Netcare—dominate the sector. They account for around 83% of available beds, 87% of admissions, and receive the lion’s share of revenue in the sector as a result.⁵⁷

On 30 September 2019, the Competition Commission released the final findings and recommendations of its Healthcare Market Inquiry (HMI), examining competition in South Africa’s private healthcare sector. The HMI began in 2013, with a focus on Life Healthcare, Mediclinic, and Netcare, and was prompted by the Commission’s concern about high prices in the private health sector.⁵⁸

It concluded that high levels of concentration in private hospital groups and medical schemes have driven above-inflation cost increases over many years, caused not only by rising input costs but also by an absence of competition and poor oversight. Patients, it said, face a significant information gap, with little transparency on pricing, treatment outcomes, or quality of care.⁵⁹

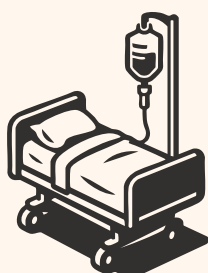


To address these failures, the inquiry recommended the creation of a new supply-side regulator for health. This body would oversee licensing, monitor competition, and publish information on quality and performance. It also proposed reforms to medical schemes, including a mandatory minimum benefits package and simpler, more comparable options. The Commission called for greater transparency across the sector.⁶⁰

Six years later, a few of the HMI's recommendations are finally being acted on, including the first steps towards a multilateral tariff negotiation forum. However, the Department of Health has said it will not establish the independent supply-side regulator that was central to the HMI's recommendations, arguing that it will be costly and that the National Health Insurance will take up some of these functions.⁶¹ In response, professor of public health at Wits University and former HMI panel member Sharon Fonn argued that "implementing the HMI's recommendations piecemeal would not foster competition or protect consumers".⁶²

The HMI concluded that South Africa's private healthcare sector was driven by profit rather than patient needs and argued that costs will continue to rise unchecked without regulatory reform.⁶³ It found:

"There has been inadequate stewardship of the private sector. Failures include the Department of Health not using existing legislated powers to provide oversight on the private healthcare market; failing to ensure regulator reviews, as required by law; and failing to hold regulators sufficiently accountable. As a consequence, the private sector is neither efficient nor competitive".⁶⁴



The inquiry also flagged cross-ownership and structural conflicts of interest in the industry. As an example, it used the relationship between Remgro, the large South African investment holding company, and AfroCentric Group, a diversified healthcare group.⁶⁵ The inquiry noted that Remgro held significant interests in the supply side of private healthcare, most visibly through its stake in Mediclinic. At the same time, Remgro had exposure to the demand side of the market (medical aid schemes) through its indirect interests in AfroCentric, which controls Medscheme, one of the largest medical scheme administrators in South Africa. Medscheme is responsible for purchasing and managing care on behalf of millions of beneficiaries, giving it influence over how funds are channelled to providers such as hospitals and specialists.⁶⁶

The inquiry flagged this as problematic because cross-ownership between entities on both sides of the market—hospitals (supply) and administrators or medical schemes (demand)—can raise conflicts of interest. For example, there is a risk that an administrator with links to a hospital group might favour contracts, pricing structures, or network arrangements that benefit its related party, rather than seeking the best value for patients.⁶⁷

Six years since the Competition Commission released its findings, little has changed in the healthcare sector. If anything, the grip of entrenched players has tightened. Ownership patterns remain stubbornly unchanged, with market power concentrated in the hands of a few corporations that continue to post eye-watering profits. Meanwhile, ordinary people in South Africa are left to shoulder the burden of relentlessly rising medical costs.

MEDICLINIC

Mediclinic was founded, in 1983, when Dr Edwin Hertzog, previously an anaesthetist, was commissioned by the Rembrandt Group (now the Remgro Group) to conduct a private hospitals feasibility study.⁶⁸ Rembrandt was the conglomerate formed by business tycoon Anton Rupert in 1948, and Hertzog's father, Dilk, had helped Rupert build the firm.⁶⁹ Hertzog served as the chairman of Mediclinic from 1992 to 2012.⁷⁰ He retired from the Board of Mediclinic in 2019.

Starting in the early 1980s, Mediclinic established a foothold in Cape Town and Johannesburg by acquiring existing hospitals. The group went public on the Johannesburg Stock Exchange (JSE) in 1986, the same year its first purpose-built facility, Panorama Hospital, opened in Cape Town. By 1989, Mediclinic had expanded to more than eight hospitals, employing over 2,600 staff to manage 1,600 beds. Mediclinic went on an acquisition spree in the 1990s, including buying Medicor, which held 11 hospitals in South Africa and Namibia. This doubled Mediclinic's operations to 20 hospitals, nearly 4,500 employees, and over 2,900 beds. The acquisition of Auckland Health Limited added another 11 hospitals.⁷¹ Today, it owns 47 hospitals in South Africa.

Mediclinic used its South African profits to pursue aggressive international expansion. In 2006 and 2007, Mediclinic acquired a controlling interest in Emirates Healthcare in the United Arab Emirates (UAE) and Switzerland's biggest hospital group, Hirslanden.⁷² Today, Mediclinic Group has subsidiaries in Switzerland, the UAE, Namibia, and South Africa.⁷³ Its global operations consist of 74 hospitals with 11,728 beds, along with several other clinics and health facilities.

Remgro remained an influential shareholder throughout Mediclinic's existence, and it still held a 45% stake in 2023. In May 2023, Remgro formed a consortium with SAS Shipping Agencies Services Sàrl—a subsidiary of MSC Mediterranean Shipping Company—and bought Mediclinic for R85 billion. The acquisition was carried out through Manta Bidco Limited, a company set up solely for the deal, and which now owns 100% of Mediclinic. In the wake of this private buyout, Mediclinic delisted from the London Stock Exchange, Johannesburg Stock Exchange, and Namibia Stock Exchange.

The transaction effectively consolidated control of the group into the hands of just two powerful shareholders, tightening ownership in a sector already dominated by a handful of players. Its delisting also reduced its financial reporting requirements, shielding it from public scrutiny. Despite this, the new owners released a "voluntary statement" for the year ending 31 March 2024. Remgro cited the significant contribution by Mediclinic to Remgro's bottom line as the key reason for this decision. The figures showed that Mediclinic's global operating profit surged more than 300% to R6 billion off the back of global revenues of R86.53 billion.⁷⁴



Remgro and the Ruperts

Originally incorporated as the Rembrandt Group in the 1940s by Anton Rupert, Remgro evolved from its origins in tobacco into a diversified investment holding company listed on the Johannesburg Stock Exchange. While its tobacco operations were consolidated into Rothmans and later sold to British American Tobacco, Remgro now maintains a broad portfolio across sectors including banking, healthcare, consumer products, infrastructure, industrials, media, and technology, which includes listed and unlisted companies.⁷⁵ In 2024, the company, led by Rupert's son, Johann, generated revenue of around R90.4 billion, an increase from the previous year.⁷⁶

In addition to Mediclinic, Remgro's other interests in the health sector include significant stakes in Discovery and Momentum, companies that dominate South Africa's private medical schemes market.⁷⁷ As the second largest shareholder in Discovery, Remgro not only controls a major portion of the medical aid market but also has access to influential decision-making circles in the healthcare industry.⁷⁸ This level of influence should raise concern about the extent to which Remgro's

interests shape and influence the healthcare sector in South Africa, especially as the sector struggles with issues of accessibility and affordability.

With widespread ownership across industries and substantial political ties,⁷⁹ companies like Remgro, with their intricate connections and influence, are an important part of a system that entrenches inequality and the concentration of wealth in the hands of a few.

As revealed in the first instalment of Open Secrets' *Who Owns South Africa* series, "The system", Johann Rupert is one of just eight dollar billionaires in South Africa.⁸⁰ He is the wealthiest South African, with an estimated net wealth of R275 billion and a vast portfolio of international assets and businesses. Yet 14 million people in South Africa live below the food poverty line, unable to scrape together even R27 a day to cover their basic needs.⁸¹ Remgro, and by extension Rupert, exemplify a system in which a few control immense wealth, while millions of others fight for survival.⁸²



While Mediclinic continues to rake in billions in revenue, it has announced a controversial and aggressive push towards artificial intelligence (AI) and automation to cut costs. With a view to saving nearly R3 billion by 2027, this strategy aims to cut staff numbers, leaving many employees vulnerable in the wake of automation-driven efficiency.⁸³ The company has already implemented a freeze on "nonessential new hires" and offered early retirement packages to staff after the 2023 buyout.⁸⁴ Mediclinic say that there is no specific directive to replace full-time employees with AI and that the hiring freeze and early retirement options are part of cost-saving efforts not directly tied to AI.⁸⁵

Mediclinic's senior executive team

Mediclinic Group is also a good example of the failure to transform executive leadership in corporate South Africa. Its senior executive team is headed up by a group of all white men:⁸⁶



Dr Ronnie van der Merwe
Group Chief
Executive Officer



Jurgens Myburgh
Group Chief
Financial Officer



Bertrand Levart
Group Chief
Operating Officer



Patrick Kammermann
Group Chief
Information Officer



Dr Tyson Welzel
Group Chief
Innovation Officer



Dr Daniel Liedtke
Chief Executive
Officer: Hirslanden



Braam Joubert
Chief Executive
Officer: Mediclinic
Southern Africa



Hein van Eck
Chief Executive
Officer: Mediclinic
Middle East



NETCARE AND LIFE HEALTHCARE GROUP

The other two “big three” players are Netcare and Life Healthcare Group. Netcare was founded and listed on the Johannesburg Stock Exchange in 1996. The company grew exponentially following its establishment, including through acquiring the Mediacross Healthcare Group from Fedsure in 2001, and is now South Africa’s largest private healthcare company. It employs more than 21,000 people and offers a range of medical services across the healthcare spectrum.⁸⁷

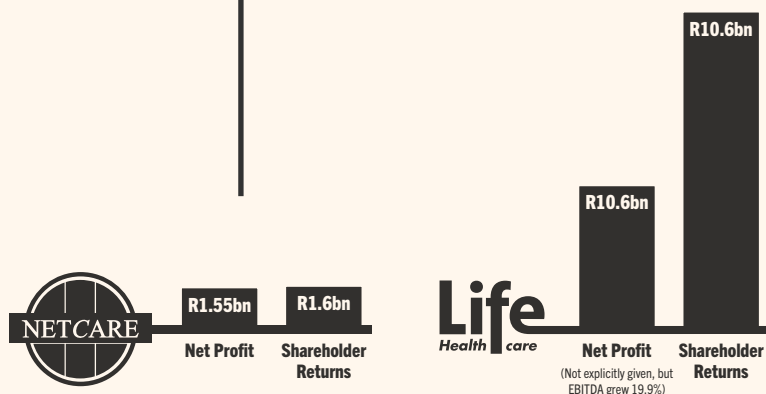
Netcare functions as an investment holding company with multiple subsidiaries offering private healthcare services.⁸⁸ It operates South Africa’s largest network of private acute care hospitals as well as emergency medical services, primary healthcare, renal dialysis, and mental health services.⁸⁹ Like Mediclinic, Netcare expanded quickly internationally, with a focus on investing in the United Kingdom. In 2006, Netcare acquired 49 hospitals of the General Healthcare Group (GHG) in the United Kingdom, which essentially gave Netcare a controlling interest in GHG.⁹⁰ Today, Netcare operates 10,834 beds and across 156 healthcare facilities, which include acute care hospitals, mental health facilities, and Netcare 911 sites.⁹¹

Dr Richard Friedland has been at the helm of Netcare Limited as group chief executive officer (CEO) since 2005, after joining the company in 1997. He was also instrumental in establishing Netcare UK. Under his leadership, Netcare has expanded aggressively, amassing market power and profitability, and in turn shaped costs, competition, and access in South Africa’s private healthcare sector.⁹²

Life Healthcare Group was established, in 1983, as African Oxygen Limited (Afrox Healthcare) before becoming the Life Healthcare Group in 2005. Today, Life Healthcare operates 6,500 beds in 64 healthcare facilities in southern Africa.⁹³ The group offers a wide range of hospital and complementary services.⁹⁴

Both Netcare and Life Healthcare Group have delivered significant returns to their shareholders in recent years. For the year ending 30 September 2024, Netcare reported revenue of R25.2 billion, with normalised earnings before interest, taxes, depreciation, and amortisation (EBITDA) growing 10.1% and net profit rising 15.8% to R1.55 billion. Crucially, the group also returned R1.6 billion to shareholders through dividends and share buybacks, including a 7.7% increase in dividends to 70 cents per share.⁹⁵

Life Healthcare Group posted revenue of R25.5 billion for the year ending 30 September 2024, a 12.7% jump from the previous year, while its normalised EBITDA surged by 19.9%. Life Healthcare returned R10.6 billion to shareholders, including a final dividend of 31 cents and a special dividend of 70 cents per share.⁹⁶



Billions for Shareholders, Not for Patients

In 2024, Netcare and Life Healthcare each generated over R25 billion in revenue. Netcare paid out R1.6 billion to investors, while Life Healthcare returned an extraordinary R10.6 billion to its shareholders.

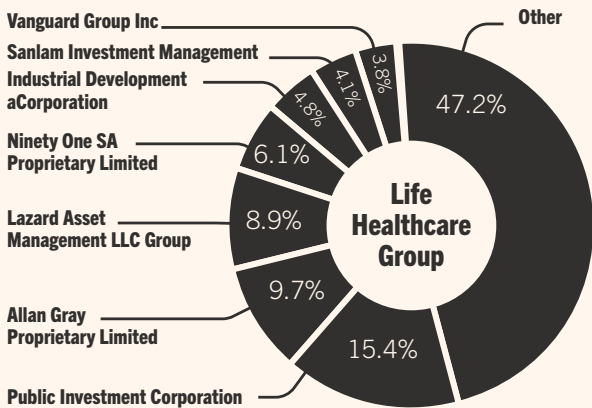
This paints a picture of one of the key features of South Africa’s financial and economic system: a focus on increasing return to shareholders through buybacks and dividends. The overriding goal of shareholder value maximisation, together with financialisation of our economy, has supported the extraction of resources from corporations for dividends and share repurchases, shifting these away from wages and reinvestment.⁹⁷ These dividends are enabled by high prices passed onto patients, and they are not reinvested into healthcare facilities.

South African private healthcare has increasingly been transformed into a set of assets for local and global financial firms to invest in, and this business has in turn been good for investors. Tens of billions of rands have been paid out in dividends and share buybacks, benefiting shareholders.

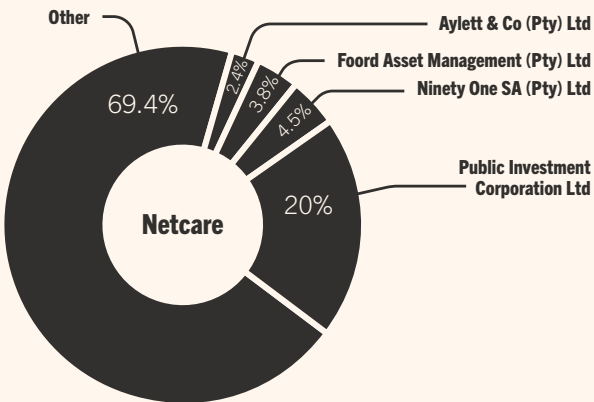
INFOBOX

Life and Netcare’s top shareholders

Life Healthcare Group is a publicly listed company on the Johannesburg Stock Exchange (JSE). The largest shareholders and primary beneficiaries of the dividend payments are as follows:



Netcare is also a publicly traded company on the JSE and is also dominated by a few major shareholders, including the following:^{98 99}



The Public Investment Corporation (PIC) holds the largest stake in both Netcare, at 20.04%, and Life Healthcare, at 15.4%. This is an important reminder that there is also significant public ownership in South Africa’s largest companies, through the PIC. The PIC invests money for the Government Employees Pension Fund (GEPF); it holds over R3 trillion in assets and owns around 10% of all shares on the JSE.¹⁰⁰ As a result, government employees are also beneficiaries of the financial success of private healthcare companies.

The PIC has had its own significant scandals and governance issues in recent years, and we will return to it in more detail in a later chapter on private pensions and asset managers in South Africa. Other prominent shareholders, including Ninety One,

Allan Gray, and Sanlam, will also be the focus of more detailed analysis in forthcoming profiles in the WOSA series.

Looking at the other major shareholders, it is notable that several of the large institutional shareholders operate outside of South Africa. This means that a substantial portion of dividends paid by private hospital groups also leave the country to benefit wealthy investors based elsewhere.

In the case of Netcare, Foord Asset Management is a boutique wealth management firm with roots in South Africa and a footprint stretching from Singapore to London.¹⁰¹ The firm was launched, in 1981, by Zimbabwe-born Dave Foord and his colleague Liston Meintjes, opening its first office in Cape Town's Greenmarket Square.¹⁰² The company has since gone global, adding offices in Guernsey (1997), Singapore (2012), and Luxembourg (2013).¹⁰³ These three countries are in the top 10 of the Tax Justice Network's Financial Secrecy Index, considered countries "most complicit in helping individuals to hide their finances from the rule of law".¹⁰⁴ More than four decades on, founder Dave Foord remains at the helm as portfolio manager and global chief investment officer.¹⁰⁵

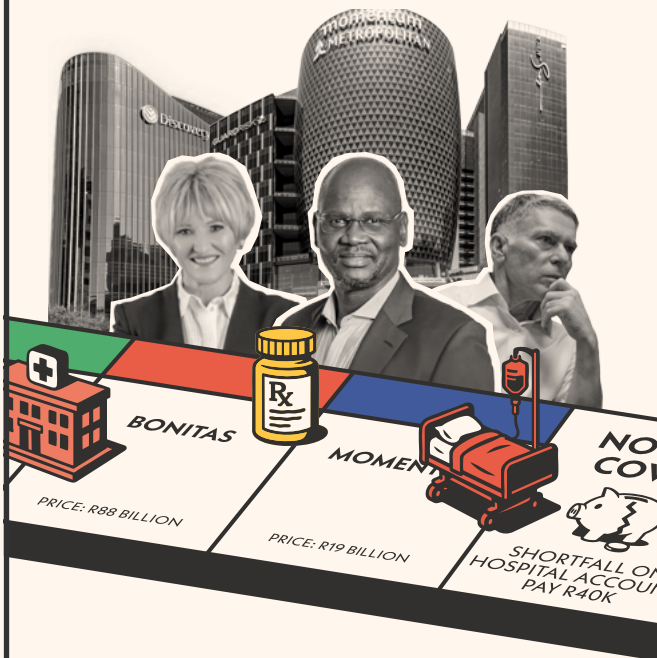
In the case of Life Healthcare, Lazard Asset Management and the Vanguard Group are major shareholders. Both are American firms. Lazard Asset Management manages investment portfolios and provides investment advice to institutional and individual investors around the world, and it is a part of Lazard Group, which was established in 1848.¹⁰⁶ Lazard Group is headquartered in New York in the United States, but it also has operations in Asia, Australia, Europe, the Middle East, and North and South America.¹⁰⁷

The Vanguard Group is also an American investment management firm, founded in 1975. Unlike traditional firms, Vanguard is owned by its own funds, and those funds are in turn owned by their shareholders. In January 2025, the company had around \$10 trillion in global assets under management and operated 17 global offices across Asia, Australia, Europe, and the United States.¹⁰⁸ This is a stark reminder of the growth and sheer scale of financial actors that increasingly own significant portions of South Africa's economy; the Vanguard Group manages assets equal to 68 times South Africa's current national budget.



WHO OWNS THE MEDICAL AIDS?

Medical aid schemes are nominally non-profit, yet their administration and ownership link them directly to South Africa's corporate elite.



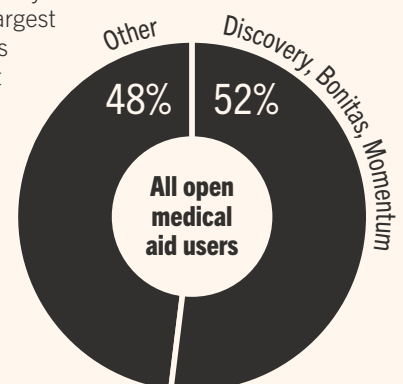
There is a similar concentration of big players in the world of private medical aid schemes, which has gotten more pronounced in democratic South Africa. In 2000, there were 144 schemes, but these have nearly halved to 71 in 2025 due to significant consolidation in the sector. Of these, 55 are restricted schemes, while only 16 are open to the public. **There are over 9 million people covered by medical aid in South Africa, with around 4.8 million (52%) covered by open schemes.¹⁰⁹ Discovery, Bonitas, and Momentum, the three largest medical aid schemes discussed in this chapter, cover over 4 million of these.** These household names are owned by some of the country's largest corporations and powerful private actors.

Crucially, the concentration of ownership in the private hospital market has significant impacts on the costs of private medical schemes. Since the banning of centralised bargaining, in 2003, by the Competition Commission, the big hospital groups (Life Healthcare, Mediclinic, and Netcare) negotiate prices with medical aid schemes or their administrators on an individual basis.¹¹⁰ This process sets the national prices for all the hospitals within the group, i.e. Mediclinic or Life Healthcare. The nature of the concentration ownership in private hospitals means that medical aid schemes are often compelled to accept the terms of the hospitals, which often means higher prices and price increases.¹¹¹

INFOBOX

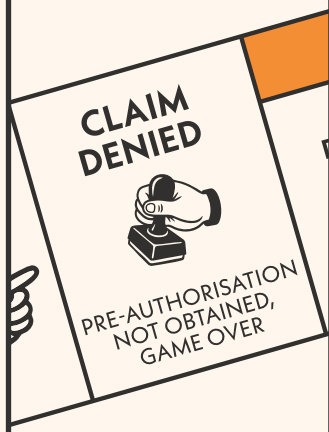
Types of medical aid schemes

Open medical aid schemes are schemes that are open to the public. These include Discovery, Bonitas, and Momentum, amongst others. Restricted or closed medical schemes are only open to certain groups of individuals belonging to a particular industry or company. The largest in South Africa is the Government Employee Medical Scheme, which is administered by Medscheme.



Medical schemes are registered with the Council for Medical Schemes (CMS), an independent statutory body created by Parliament to regulate medical schemes that acts in accordance with the Medical Schemes Act.¹¹² The schemes are technically non-profit organisations and derive their income from investment returns and member contributions, and surplus funds that are not used to fund members' claims are placed in the scheme's reserves.¹¹³ However, there is an important distinction between medical schemes and the companies that administer them, which are profit-seeking entities seeking to maximise returns to shareholders. Medical schemes can either outsource their administration to larger financial services companies, like Bonitas does with Medscheme, or be administered internally, such as Discovery Health.

Medical schemes are also regularly criticised for unfairly denying members access to health services. According to the CMS, private medical scheme members paid R40 billion for benefits not covered by medical aid in 2023/24.¹¹⁴ This is indicative of how medical schemes often look for reasons to deny claims, often doing so unfairly and despite legally mandated prescribed minimum benefits.¹¹⁵ The CMS upheld around 50% of the complaints lodged by scheme members who were initially denied coverage.¹¹⁶



INFOBOX

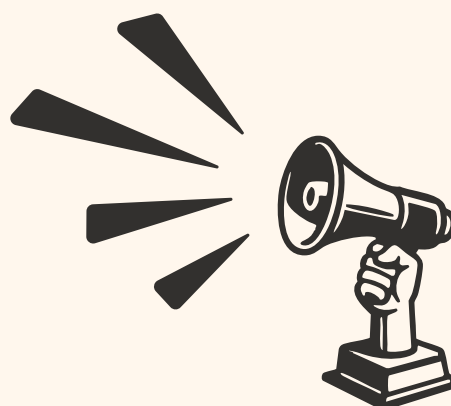
Allegations of racism and collusion

Medical schemes and their administrators have been the subject of much scrutiny in recent years. In 2019, members of Solutionist Thinkers Group, a non-profit organisation that represents black and Indian medical practitioners, and the National Health Care Professionals Association alleged that they were being unfairly treated by medical schemes based on race.¹¹⁷ The Council for Medical Schemes (CMS) subsequently appointed a panel to investigate the allegations of racial discrimination against, and procedural fairness in the treatment of, black healthcare providers.¹¹⁸

The investigation also looked into possible fraud, waste, and abuse defences that were used by the schemes and administrators.¹¹⁹ Evidence against Discovery, Medscheme (Bonitas' administrator), and the Government Employees Medical Scheme showed that they were more likely to find black healthcare providers guilty of fraud, waste, and abuse.¹²⁰ The final report found that the schemes were guilty of racial discrimination against black healthcare professionals.¹²¹ While this was not a legal finding, it was significant in terms of showing a pattern of systemic racial discrimination at the country's largest medical aid schemes.

Just three years after allegations of racism in its medical aid business, Discovery found itself in another scandal. It and other major financial firms like Momentum, Sanlam, and Old Mutual were accused of colluding to fix prices

for decades.¹²² On 25 August 2022, the Competition Commission announced that it would be conducting a search-and-seizure operation at eight South African insurance companies over allegations of price-fixing and collusion.¹²³ According to the commission, the allegation of collusion is related to practices to fix the trading conditions regarding fees for investment products such as life insurance, retirement annuities, funeral cover, and other risk-related products.¹²⁴ Discovery, Momentum, and the other companies stated that they did not believe they were guilty of price-fixing and that they were cooperating with the commission.¹²⁵



DISCOVERY

The largest open medical aid scheme in South Africa is Discovery Health Medical Scheme (DHMS), which is administered by Discovery Limited’s health division. Discovery Limited (referred to as Discovery SA) was founded and set up as a small specialist risk insurance company, in 1992, by Adrian Gore and Barry Swartzberg, and RMB Holdings. This was the same year that RMB Holdings acquired Momentum Life—which we visit later in this chapter.¹²⁶ Having listed on the Johannesburg Stock Exchange in 1999, Discovery has since become one of the country’s largest companies and most well-known brands, with a market capitalisation of R143 billion.¹²⁷ Discovery SA reported over R11.6 billion in profit at the end of its financial year in June 2024.¹²⁸

While DHMS is the largest open medical aid scheme in the country, accounting for a market share of 57.9%, it is just one of the schemes that Discovery Health administers.¹²⁹ Discovery Health, which brought in a profit of R3.9 billion in 2024, also manages 18 restricted medical schemes. Its administration of these schemes accounts for over 40% of total medical aid cover in South Africa.¹³⁰

Discovery launched a wide range of services related to medical and life insurance in the late 1990s and early 2000s. It launched Discovery Health, its medical insurance scheme and managed care provider, in 1993. It launched Vitality, its wellness programme, in 1997, and in 2000, it launched its insurance arm, Discovery Life.¹³¹ In 2004 it pivoted towards financial services and launched Discovery Card, and later in 2007, Discovery Invest. In 2019, it launched Discovery Bank, the world’s first “behavioural bank”.¹³² In 2021 Discovery introduced Vitality Health International, expanding its health insurance and wellness initiatives across the globe.

As it launched new products, it also began rapidly expanding into different global markets. Starting with a foray into the UK, Discovery now has operations or joint ventures in more than 40 countries on six continents, including significant investment in the United States. Discovery is yet another company that has used domestic success to invest heavily outside of the country.

Discovery’s Global Expansion¹³³

From its first overseas venture in 2004, Discovery has steadily expanded its footprint through joint ventures and partnerships across Europe, Asia, the Americas, and Africa. This timeline shows how a South African company built and international empire.

Discovery and Prudential plc launched PruProtect, which offers various services related to personal and business protection.



Discovery expanded PruHealth and acquired Standard Life Healthcare in the UK.

2007

2004

Discovery started its joint venture with UK firm, Prudential plc and established PruHealth, a life and health insurance plan designed for critical illnesses.

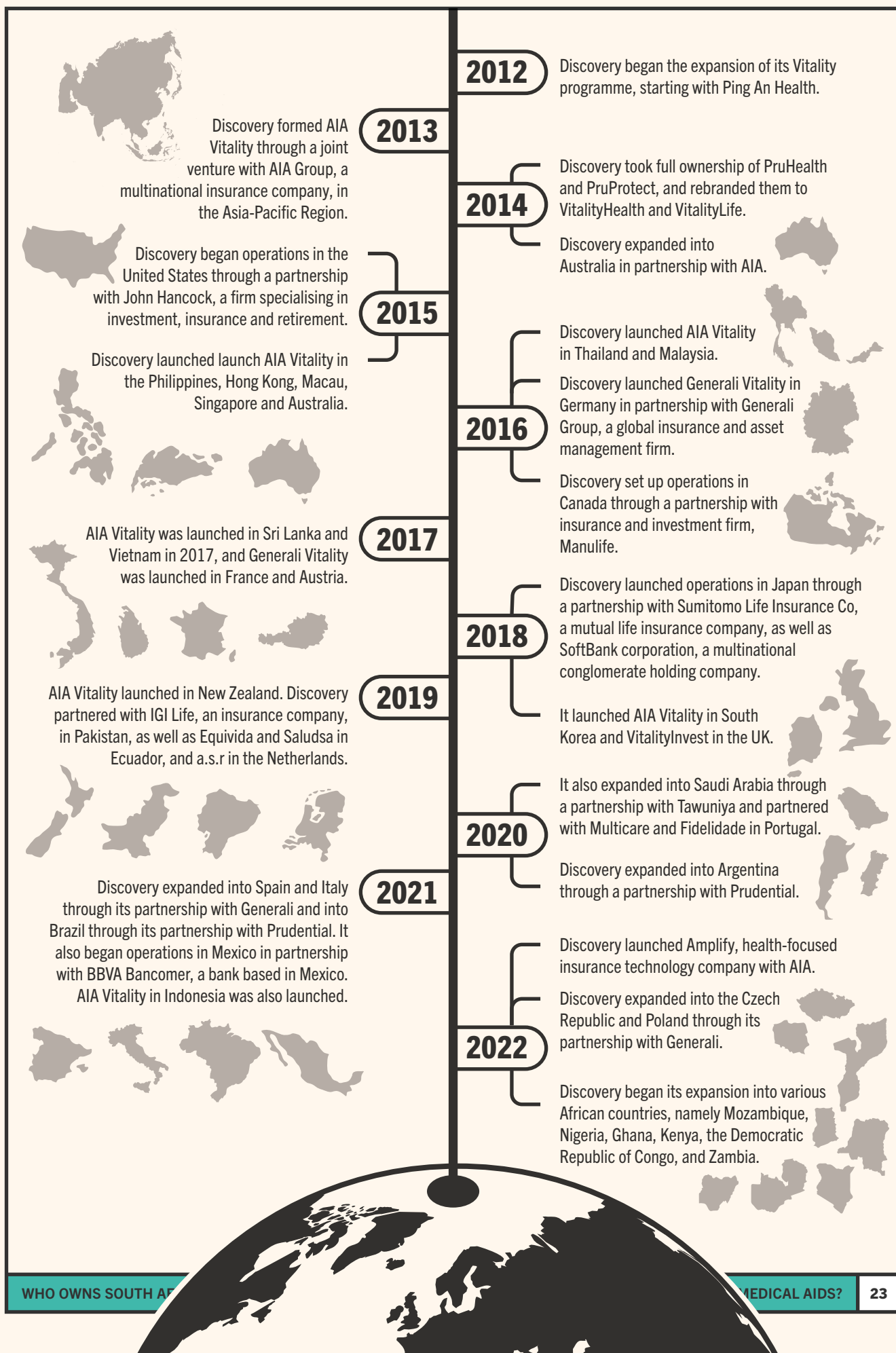
2009

Discovery set up operations in China and acquired 25% of health insurance company, Ping An Health.

2010



Discovery



Discovery's shareholders

The top 10 largest shareholders in Discovery are as follows:

- Public Investment Corporation (ZA): 11.55%
- Remgro Limited (ZA): 7.44%
- Gore A (ZA): 7.01%
- Capital Group Companies Inc: 5.21%
- RBC Global Asset Management Inc: 3.80%
- Swartzberg B (ZA): 3.74%
- Ninety One SA (Pty) Ltd: 3.71%
- Royal Bafokeng Holdings (Pty) Ltd: 3.44%
- Baillie Gifford and Co Ltd (SC): 3.26%
- BlackRock Inc: 3.17%

OWNERSHIP AND INFLUENCE

The three largest shareholders in Discovery, as of October 2024, were the Public Investment Corporation, Remgro Limited (co-owner of Mediclinic), and Adrian Gore, with holdings of 11.55%, 7.44%, and 7.01% respectively.¹³⁴

There is an enormous financial benefit to being one of these shareholders. For example, Remgro holds over 51 million shares, which means that at the end of the 2024 financial year, with interim dividend of 87 cents and final ordinary dividend of 152 cents per share,¹³⁵ it received over R122 million just from its financial holdings in Discovery. It has already been noted that Remgro holds extensive interests in both private hospital groups and medical schemes, something raised as a concern by the Competition Commission.

Other prominent investors include large international wealth management firms, namely Capital Group Companies, RBC, Baillie Gifford and Co, and BlackRock.

These firms collectively hold over 106 million shares, which means that they received over R253 million in dividends in 2024. BlackRock is a US-headquartered asset management firm with global operations, including in South Africa. Though it was only founded in 1988, it has grown into the largest asset manager in the world, with a staggering \$12.5 trillion under management.¹³⁶ This gives it immense power to shape markets, economies, and even governments.¹³⁷

A major individual shareholder is CEO Adrian Gore. While he is not on the list of eight South African dollar billionaires, Gore is one of the most prominent and influential South African businessmen. He not only earned R30.7 million—including a R9 million performance bonus—during the 2024 financial year but also received dividend payouts of around R114 million that year.¹³⁸



Gore's prominence in the business world gives him significant political influence. In 2021, he was appointed the vice president of Business Unity South Africa (BUSA), a group that represents South African business interests, has close connections to various processes with the government, and represents business at the National Economic Development and Labour Council.¹³⁹ BUSA is also the secretariat of Business 20, which is being hosted in South Africa in 2025 bringing together global business interests from the Group of 20 countries. BUSA has also been very vocal about its opposition to the National Health Insurance Act since its proposal as a Bill, as has Discovery.¹⁴⁰

Gore's extensive business interests in South Africa and elsewhere, along with his ties to organised business groups in South Africa, translate into political influence. He was included in the South African president's delegation that travelled to the United States for meetings with US President Donald Trump in May 2025. This was to repair souring economic and political relations in the face of a disinformation campaign



around South Africa's land expropriation bill and "white genocide".¹⁴¹ While Gore was not part of the public meeting with Trump, he provided strategic support to the delegation, indicating his proximity to political power.

This influence—particularly with the Presidency—is further exemplified by Gore's position as the co-convenor of Operation Vulindlela, a joint initiative of the government, and the business sector. Implemented through different phases, with three focus areas of logistics, energy, and crime and corruption, the initiative's stated aims are to foster economic growth and job creation.¹⁴² Gore spoke at the launch of the second phase of Operation Vulindlela, which saw 140 CEOs pledge an additional R150 million for practical and financial support, claiming that the initiative had been an "unqualified success".¹⁴³ Gore's growing influence in interactions between the government and business reveals not only how he has positioned himself as a "go-to" guy for South African business in working with government but also how influential corporate power has become in South Africa.

BONITAS AND MEDSCHEME

Bonitas is the second largest open medical scheme in the country, covering over a million people—giving it a 15% market share.¹⁴⁴ It was established as a medical scheme for black civil servants in 1982, but became an open medical scheme in 1995.¹⁴⁵ It has benefitted from amalgamations with other schemes, starting in 2005. Bonitas has absorbed the members of several medical schemes over time, furthering concentration in the sector.

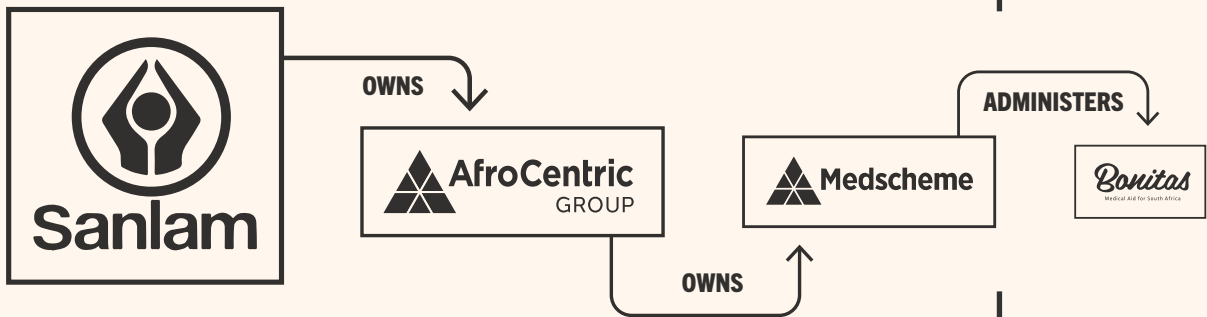
In 2005 it merged with Protector Health, and in 2006 it merged with mining company BHP Billiton's health unit.¹⁴⁶ Pro Sano Medical Scheme merged with Bonitas Medical Fund in January 2013.¹⁴⁷ In October 2016 it amalgamated with Liberty Medical Scheme.¹⁴⁸ In June 2017 the Council for Medical Schemes requested Bonitas to take on the members of the Community Medical Aid Scheme after it was placed under curatorship. Bonitas took on these members in August 2017.¹⁴⁹ In November 2021 the Competition Tribunal of South Africa approved the amalgamation of Bonitas and Nedgroup Medical Aid Scheme, the medical scheme for Nedbank and Old Mutual employees.¹⁵⁰

OWNERSHIP

Bonitas is administered by Medscheme Holdings (Pty) Ltd (Medscheme), a health risk management services provider and a medical scheme administrator. Medscheme is responsible for two open medical schemes and 16 restricted medical schemes, including the Government Employee Medical Scheme and the South African Police Service Medical Scheme.¹⁵¹ This means that it administers not only the country's second largest open medical scheme but also its two largest restricted medical schemes, giving it market share of around 30%. It has operations in South Africa, Eswatini, Mauritius, Namibia, and Zimbabwe and has subsidiaries in Botswana and Kenya.

Medscheme is a wholly owned subsidiary of AfroCentric Investment Corporation Limited, a black-owned investment holding company that was founded in 2008 and listed on the Johannesburg Stock Exchange in the same year.¹⁵² AfroCentric is chaired by influential businesswoman Dr Anna Mokgokong, and the deputy chair is Joe Madungandaba. In 1995, the two co-founded Community Investment Holdings,

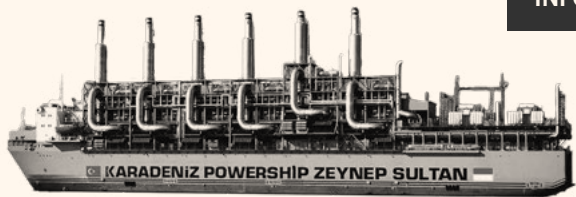
which has a significant stake in AfroCentric. Sanlam acquired a stake of 60% in AfroCentric in May 2023—giving it indirect control of all of AfroCentric’s operating assets.¹⁵³ This follows an initial acquisition that Sanlam had made in ACT Healthcare Assets, a wholly owned subsidiary of AfroCentric, for a 28.7% stake in 2015.¹⁵⁴ At the end of its financial year in June 2023, AfroCentric’s other major shareholders were Community Healthcare Holdings Proprietary Limited (8.9%) and African Rainbow Capital (7.6%).



Tracing the Ownership Chain

The controversial Karpowership connection

Dr Anna Mokgokong, of AfroCentric, was involved in the Karpowership controversy that rocked the country several years ago; the ultimately scuppered 20-year deal struck with the Turkish company to supply three floating generators off South Africa’s coast. In late 2023 it was reported that a clandestine deal had been struck between the Turkish company Karadeniz, one half of Karpowership, and energy company BHI Energy, which is chaired by Mokgokong.¹⁵⁵ This deal sidelined the original black empowerment partner in the deal,



Powergroup SA. In the court battle that followed, it was revealed that the new deal was struck in part because Karadeniz believed that Mokgokong could use her political connections to secure outstanding permits and licenses needed by Karpowership.¹⁵⁶ Mokgokong denied that there was anything untoward about the deal.

Sanlam CEO Paul Hanratty is a director on the Board of AfroCentric. Sanlam’s acquisition of a 60% stake was part of the company’s play to expand its presence in the healthcare sector. Sanlam is one of the oldest insurance companies in South Africa, inextricably linked to the history of apartheid, and built its business by providing white Afrikaans people with life cover. It now has a market capitalisation of R193 billion and operates across the African continent.¹⁵⁷ Today, billionaire Patrice Motsepe is the deputy chairperson of the Sanlam Board. He is the founder and chairman of Ubuntu-Botho Investments, which holds a 13.3% stake in Sanlam—making it one of Sanlam’s largest individual shareholders.¹⁵⁸ In addition to this, Motsepe’s investment holding company, African Rainbow Capital, has a share in Afrocentric, further embedding his presence within the health insurance sector.

According to AfroCentric’s annual report for its year ending 2024, it made a profit of R679 million in its healthcare business, and it declared a final dividend of 11 cents per share, yielding Sanlam around R55 million.¹⁵⁹

INFOBOX

MOMENTUM

Out of the three top medical aid schemes covered here, Momentum has the smallest market share at 6%, but the Momentum Group is a major financial services company in South Africa, making a profit of R3.6 billion in 2024. Its health business—Momentum Health, which administers the medical scheme Momentum Health Solutions—made R255 million in profit that year.¹⁶⁰

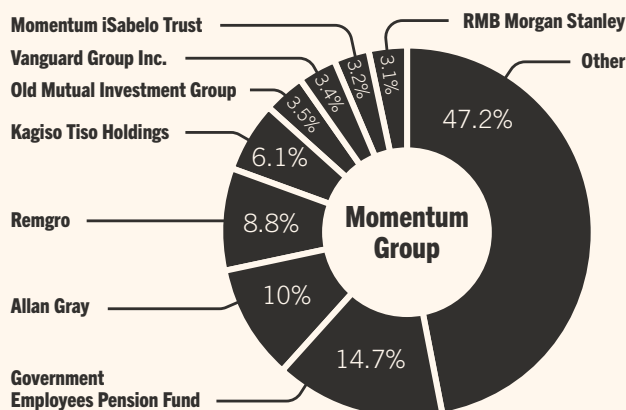
The company has undergone a substantial rebranding over the decades through a series of mergers and acquisitions. Momentum Medical Scheme (Momentum) is an open medical scheme established in 1966 when AVBOB established a life assurance company called Afrikaanse Verbond Lewensversekering Genootskap Beperk, or AVL,¹⁶¹ which then acquired Momentum Assurance Corporation in 1973 and took on the name Momentum Life Assurers Limited.¹⁶²

RMB Holdings acquired Momentum Life in 1992, the same year it established Discovery Limited with Adrian Gore. In April 1998, RMB Holdings and Anglo American merged and formed a new financial services group, FirstRand, which was listed on the Johannesburg Stock Exchange. Momentum acquired Sage Group, a firm specialising in financial, property, and life assurance, for R634 million in 2005 and went on to acquire African Life Health, a medical aid scheme administrator, in 2006.¹⁶³ ¹⁶⁴ Momentum was a subsidiary of the FirstRand Group until the end of November 2010, when Momentum Group and JSE-listed financial services and insurance company Metropolitan Holdings Limited merged.¹⁶⁵

The merger of Momentum and Metropolitan Holdings Limited formed Momentum Metropolitan Holdings Limited, the third largest life insurer in South Africa.¹⁶⁶ In 2024 it changed its name to Momentum Group Limited. Momentum Group is a financial services provider and has several businesses, including Momentum, Metropolitan, Eris Property Group, and Guardrisk. It operates in 11 jurisdictions, namely South Africa, Botswana, Ghana, Lesotho, Mozambique, Namibia, Gibraltar, India, and Mauritius, as well as Guernsey and the UK. The considerable growth in the company has led to a market capitalisation of R49 billion.

Momentum Group's shareholders

In terms of the larger Momentum Group, the major shareholders include some familiar names who dominate the private healthcare system, including Remgro and the Vanguard Group. Momentum's latest report lists the following major shareholders:¹⁶⁷



INFOBOX

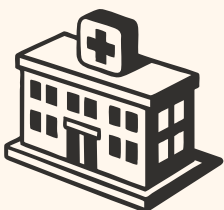
OWNERSHIP

In September 2021, Momentum Metropolitan Health Group (comprising of Metropolitan Group and Momentum Health Solutions) concluded a Broad-Based Black Economic Empowerment (B-BBEE) transaction with the investment arms of two unions: the National Education, Health, and Allied Workers' Union (NEHAWU) and the Police and Prisons Civil Rights Union (POPCRU).¹⁶⁸ The latter received a 32% stake in the health business, while Momentum Metropolitan Health retained the remaining 68%.¹⁶⁹

While the deal is significant in acknowledging and incorporating labour unions in the healthcare sector, analysts argue that the transaction also sets up Momentum for the implementation of the National Health Insurance.¹⁷⁰ It has been argued that the South African government could contract medical schemes to provide services alongside the NHI model, and because POPCRU and NEHAWU are among the largest trade unions in South Africa, this potentially sets Momentum up with influential political muscle to lobby for those contracts.¹⁷¹ The transaction also brought on various black healthcare professionals, such as Lucky Mathebula and Mogologolo Phasha, who have considerable experience in the public healthcare system and pharmaceuticals industry, which also provides Momentum with “a more intimate understanding of the public healthcare sector”.¹⁷²

Like most investors discussed in this profile, the Momentum Group's shareholders have also benefitted immensely.¹⁷³ Momentum has just over 1.3 billion issued shares and paid out 89 cents per share at the end of 2024, amounting to over R1.1 billion paid to shareholders. Remgro alone walked away with R106 million in dividends in 2024.¹⁷⁴

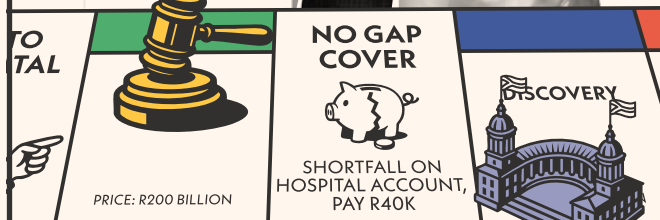
The ownership structures of the top medical aid schemes further demonstrate the trend of the commercialisation and privatisation of healthcare services in South Africa. Private healthcare is increasingly seen through the lens of financial assets that can deliver returns. Large local companies like Remgro, Sanlam, and Ubuntu-Botho Investments, as well as large international investors like the Vanguard Group and BlackRock, have already made billions from their investments in the health sector. This is against a backdrop of rising healthcare costs and the exclusion of many people from decent healthcare.



05

NATIONAL HEALTH INSURANCE

The ongoing battle between private companies and the state over the introduction of the National Health Insurance is a potent example of powerful private actors and the state engaging in open confrontation over national policy. While much lobbying remains behind closed doors, when it fails, corporates often fall back on legal strategies coupled with organised public relations campaigns.¹⁷⁵



The journey of the NHI started as early as 1995, when a Commission of Inquiry into National Health Insurance was established.¹⁷⁶ Progress towards the current Act started in earnest in 2011, when the NHI Green Paper was published for public consultation. This was followed by NHI pilot projects in 2012 and the publishing of the NHI White Paper in 2015. The NHI Bill was proposed and tabled in Parliament in August 2019, but it was only approved by Parliament in 2023 and signed into law by President Cyril Ramaphosa in 2024, just before the national elections that year. The NHIA's date of commencement has not been proclaimed, and it has yet to come into force.

The Department of Health argues that the National Health Insurance will pool funds to provide universal access to quality, affordable healthcare to South Africans.¹⁷⁷ The NHI is proposed as a way to address and curb the extreme inequality prevalent in the country's healthcare system, through the creation of a public health fund that would cover the needs of all South Africans.¹⁷⁸ The promise is that the gap in quality and cost of care between the private and public systems will be narrowed and that the socioeconomic status of individuals will not affect the kind of healthcare they receive, with people able to access a doctor or a hospital (public or private) closer to where they live or work without paying for services.¹⁷⁹

But the government itself has been divided on the NHI. In September 2023, President Ramaphosa stated the government's commitment to implementing the NHI. Yet this was just days after Minister of Finance Enoch Godongwana said that the NHI Bill still had "a lot of things missing", while the Bill was being debated by the National Council of Provinces.¹⁸⁰ Godongwana's hesitation about the Bill also highlighted the tension between Treasury and the national health department as it pertains to the power to tax the public, which requires approval from Parliament.

Estimates regarding the actual cost of the NHI vary, but it will require a huge increase in public funding of healthcare. The most conservative estimate is that an extra R400 billion per year would be required to fund the scheme, which is more than 15% of the current national budget and would represent a 125% increase of the current health budget.¹⁸¹ Critics suggest that the massive tax

increases required to fund this are not feasible and that the Act was rushed through Parliament without proper debate and consensus on the funding model, nor updated modelling or cost estimates. This is a key argument of the Board of Healthcare Funders (BHF) in its application to the Constitutional Court to challenge the NHIA.¹⁸²

Private medical schemes have much higher cost estimates. In March 2025 Momentum Health estimated that the NHI Fund would require R1.3 trillion to cover benefits annually based on private medical scheme pricing and tariffs.¹⁸³ However, it should be recalled that these estimates reflect the exorbitant cost of private medical services in South Africa, explained in large part by the concentration of ownership in the sector.

On the part of the state, Minister Godongwana announced that just R9.9 billion would be allocated to the NHI's implementation between 2025 and 2028.¹⁸⁴ This makes up approximately 1% of the total health budget of R941.5 billion that National Treasury has allocated for the next three years.¹⁸⁵ This means that the funding model for the NHI remains unresolved.

INFOBOX

National Health Insurance in practice

The National Health Insurance Act (NHIA) creates a single National Health Insurance Fund (NHI Fund) to procure health services for all South African citizens, permanent residents, and refugees; and offers emergency services to asylum seekers and undocumented persons.¹⁸⁶ The NHI Fund will be governed as a separate institution under the Public Finance Management Act of 1999 (PFMA).¹⁸⁷ This means that the fund must adhere to the requirements set by National Treasury.¹⁸⁸

The National Health Insurance is based on what's called the single user, single payer model.¹⁸⁹ Section 1 of the NHIA defines the pooling of funds as the "aggregation of financial resources for the purpose of spreading the risk across the population so that individual users can access health services without

financial risk".¹⁹⁰ The NHI Fund would thus be the single purchaser and the single payer of healthcare services in South Africa.

Services to be covered by the NHI Fund will be determined by the Benefits Advisory Committee, which must be made up of persons with technical expertise in medicine, public health, health economics, epidemiology, and the rights of patients, and one ministerial representative.¹⁹¹ The NHIA also requires the Minister of Health to establish a Healthcare Benefits Pricing Committee whose members must have a wide range of expertise.¹⁹²

However, one of the important criticisms of the NHIA is that there is not currently sufficient clarity on the services that will be provided, and how goods will be procured. Civil society organisation the Health Justice Initiative expressed concern to Parliament that the system proposed remains confusing and unclear in many instances, especially in relation to the selection, procurement, and pricing of medicines and the systems to access medicines.¹⁹³

Section 57(1)(b) of the NHIA provides that the insurance scheme "must be gradually phased in using a progressive and programmatic approach based on financial resource availability". This is a clear acknowledgment of the fundamental shift that such a scheme introduces.



PRIVATE COMPANIES PUSH BACK

The National Health Insurance has been challenged by corporate interests, business lobby groups, and political parties.¹⁹⁴ Several medical aid schemes, including Discovery, Bonitas, and Momentum, made submissions outlining their concerns regarding the NHI Bill during the public participation period.

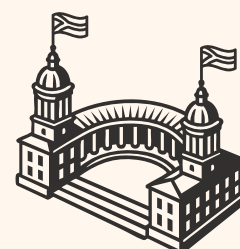
Apart from criticising the absence of a proper funding model and highlighting the costs of the NHI plan, a key focus of the schemes has been defending their continued role in the healthcare system. In February 2022, Bonitas contested the proposed amendments to the Medical Schemes Act, arguing that allowing medical schemes to only provide complementary cover is unconstitutional.¹⁹⁵ Bonitas proposed that medical schemes should play the role of assisting the NHI administratively, and maintain their central role in the healthcare system.¹⁹⁶

In 2019, Discovery was careful to say it is “supportive of structural change” with regard to the healthcare system but criticised the proposal to limit the role of medical schemes as this would place unnecessary burden on the NHI.¹⁹⁷ In its 2023 annual report, it maintained that the NHI would not work without collaboration from the private sector and that funding the NHI through tax increases on a small base would not be sufficient.¹⁹⁸

Discovery also argued that it is unconstitutional to limit the rights of individuals by dictating which benefits they can access privately after they have contributed to the NHI.¹⁹⁹ Discovery and other medical schemes claim to champion a person’s right to choose the type of healthcare they receive by stating that the National Health Insurance Act limits this choice. However, when these companies use this public benefit argument, it is important to remember that the Council for Medical Schemes found that the schemes often unfairly deny access to treatment or medication due to their members, who had to pay R40 billion out of pocket in 2023.²⁰⁰

In December 2023, Adrian Gore said that the NHI system should be introduced but that the government should rescind the threat that medical aid schemes would be effectively shut down in the future.²⁰¹ Momentum released a statement, in August 2022, in which it emphasised that the implementation of the NHI would require collaborative efforts from the government and private actors.²⁰²

In December 2023, the NHI Bill was approved by all but one province, the Western Cape. Then chair of the National Council of Provinces, Amos Masondo, requested a delay in the process of voting to consider a letter from Business Unity South Africa and Business for South Africa, which expressed concern that the NHI in its current form would not be good for the country and that the country does not have the resources to implement the NHI.²⁰³



Parliament’s tick-box consultation

A key criticism of the National Health Insurance (NHI) in its current form is that the Act passed by Parliament reflected almost no changes based on the extensive input from stakeholders. Parliament received over 100,000 written submissions and heard from 130 individuals in oral hearings. Many expressed deep concerns about the proposed NHI governance system, including the concentration of power in the Minister of Health.²⁰⁴ Most of the submissions seem to have been ignored completely.

Reflecting on this, a group of public health academics have said: “During the parliamentary hearings on the NHI Act, a wide range of groups—from doctors and nurses to civil society and the private sector—made detailed submissions. Yet the act shows almost no real changes. It is hard to believe that the insights of so many public health experts and community members could be dismissed as unworthy of inclusion”.²⁰⁵

INFOBOX

THE BATTLES GO TO THE COURTS

In May and December 2024, following the president's signing of the National Health Insurance Act, the Board of Healthcare Funders of South Africa (BHF), the Health Funders Association (HFA) and the South African Private Practitioners Forum (SAPPF) respectively filed applications to have the president's decision assenting to the NHIA reviewed and set aside.²⁰⁶ The HFA is a not-for-profit association of medical schemes and administrators.²⁰⁷ The SAPPF is a platform supporting private practitioners in South Africa and says it has made opposing the NHI its top priority for 2025.²⁰⁸ The BHF is a representative body of medical scheme funders.²⁰⁹

Aside from setting aside the president's assent to the NHIA, the applications also asked the court to declare the NHIA invalid and direct the president to reconsider the NHI Bill. The BHF and SAPPF's substantive issues with the NHIA are as follows:

- The NHIA prohibits private healthcare companies from providing services that are provided for or covered by the NHIA, which they argue prohibits the right to healthcare in section 27 of the Constitution²¹⁰ as well as the rights to dignity,²¹¹ bodily autonomy,²¹² and freedom of association.²¹³
- The source and allocation of financial resources required for the NHI Fund to function are not adequately prescribed or clear.

This reflects the major concerns of the medical schemes. The state says that private medical aid schemes will continue to play a role but in a different capacity and will cover the services that would not be reimbursed by the NHI Fund.²¹⁴ The reality is that their role would be massively curtailed. Section 33 of the NHIA prohibits medical schemes from reimbursing members for services that are available through the NHI only once it is fully implemented in around a decade's time.²¹⁵

Adrian Gore has argued that this would dissuade health professionals from working in South Africa, undermine investment in the healthcare sector, and inadvertently reduce access to quality healthcare. It appears true that healthcare professionals are disturbed about the uncertainty created by the proposed NHI. In 2022, a survey by the South African Medical Association of its 12,000 members found that 38% were considering emigration due to the introduction of the NHI.²¹⁶

Many of the concerns raised in these court applications and by the private medical schemes are reasonable. However, as this chapter has argued, the objections come from a few powerful players who profit enormously from a broken healthcare system. While the NHI debate has raged, shareholders in private hospital groups and medical aid administrators have walked away with billions of rands in dividends. They thus profit from

a failing system that cannot cater to all and are happy to maintain the status quo.

The Department of Health has been largely dismissive of the complaints of the private companies, arguing that "at the centre of those opposed to the introduction of the NHI are private profit interests involved in the exploitation of the healthcare needs of the people for self-enrichment".²¹⁷ This position seems to be the driving force behind the defence of the NHI in court by the state. It raises the concern that it has contented itself with a fight in court instead of a genuine effort to explore amendments that would address the serious concerns about the NHIA, especially issues around costing and coverage.



The political landscape has changed since the NHIA was signed on the eve of the national elections in 2024. Currently, South Africa has a coalition government with one of its largest minority members being the former opposition party, the Democratic Alliance (DA). The DA had opposed the NHI alongside big business lobby group BUSA and threatened a court challenge. However, it has since indicated that it intends to use other avenues and its presence in the governing coalition to challenge the NHI in its current form and that it will not proceed with a court challenge.²¹⁸

Nonetheless, the Western Cape government—led by the DA—did launch a court challenge against the NHI at the Constitutional Court in September 2025. It argues that the NCOP “failed to consider the views of the people of the Western Cape when it deliberated on the NHI Bill and did not meet its obligation to facilitate meaningful public participation.”²¹⁹

If the governing coalition is not able to make meaningful progress in addressing issues with the NHIA and reaching common ground, the future of the NHI and South Africa’s healthcare system will play out in the courts.



CONCLUSION

South Africa's healthcare system is trapped by corporate ownership, high costs, and weak regulation. Breaking this cycle is essential for equity and justice.

The healthcare system is plagued by the same legacies of injustice that afflict most of post-apartheid South Africa. A key part of this system is that private healthcare is used for profit taking by a small group of powerful financial actors in South Africa and across the world that see healthcare as little more than a collection of assets to trade. This commodification of healthcare is a global phenomenon and tracks the rise of mega corporations and declining public welfare systems. However, South African medical corporations not only reflect this trend but in some instances, like in the case of Mediclinic and Discovery, have also exported their version of the model to global centres of wealth in Switzerland, the UAE, the United Kingdom, and the United States.

The state has failed to adequately regulate the private sector's conduct in the health sector. The result is a private healthcare sector that services less than 20% of the population but receives most of the resources out of private pockets. The lack of regulation has allowed the big private hospital groups and medical aid companies to concentrate power in the sector. This monopoly solidifies the exorbitant costs of care, which continue to be out of reach for most people but guarantee high profits and financial benefits to these companies and their investors.

With both the public and private sectors contributing to it, South Africa's broken healthcare system has been in dire need of intervention, which has come in the form of the controversial National Health Insurance Act. Many stakeholders have raised legitimate concerns around the implementation of the NHI, its funding model, and the potential for corruption. Yet the suite of legal challenges in court on behalf of private actors also shows that the powerful companies and individuals leading the sector are willing to fight tooth and nail to protect the section of the health market that they have cornered for profit. How legitimate concerns about the NHIA are addressed may define the healthcare system for generations to come.

There is a chance to end the system that only benefits a few companies and instead build one that provides more equitable access to a reasonable standard of care. What is clear is that the status quo is making South Africa sick.

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