

# **Enforcing the Right of Access to Healthcare Services in South Africa**

By

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**DECLARATION**

By submitting this thesis, I Ebi Achigbe Okeng Ebi declare under oath that the work presented in this dissertation is original work and have never been presented to any other University or University of South Africa (UNISA) for that matter. Where the work of other authors has been used, I have endeavoured to provide references correctly and in most case quotations have been made.

Therefore, on the above forgoing I declare that this is an original work of mine which is presented in partial fulfilment of LLM (Constitutional Aspects Regarding the Right to Have Access to Health Care Services).

Sign.....

Dated July 2016

Prof. Magdaleen Swanepoel

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## **DEDICATION**

This research is dedicated to my Mother Teresa Ikwot Ebi Okeng and my beautiful and dependable daughters Abuja Ikwot Ebi and Ekima Kiki Ebi and my very special sisters Ekima Okeng and Mary Okeng. I will forever remain grateful to all of you. And to my father Emmanuel Ebi Oken without I will not have been and for that I remained highly indebted to you forever; and my indebtedness to you all may never be paid in my life time.

To the people of Wanudu and Ukelle, Cross River State, Federal Republic of Nigeria, your protection to ensure my existence has humbled me beyond reproach and I hope someday I shall return to retaliate and reciprocate in quantum..

## **ABSTRACT**

The right to have access to health care services is enshrined in section 27 of the South African Constitution of 1996 as one of the socio-economic rights protected by this Constitution. In order to observe the entitlements in this human right, the South African government has since 1994, embarked on legislation, policies and programmes to improve access to health care services among vulnerable and disadvantaged groups in South Africa. As a result of the measures put in place by the government, enormous progress has been registered since their enforcement, in respect of access to health care services.

However, as evident in some reports such as the 7<sup>th</sup> Report on Economic and Social Rights by the South African Human Rights Commission and studies conducted by the Studies in Poverty and Inequality Institute (SPII), it is revealed that the measures adopted by the government to improve access to health care services have not effectively translated the entitlements of this right to the population of South Africa. This study is motivated by the disclosure of these concerns, irrespective of the measures put in place by the government to achieve universal access to health care services. The study therefore aims at stressing the importance of upholding the right to have access to health care services in the social transformation process of South Africa. In doing so, it will investigate current health care reforms in South Africa and make recommendations on how to effectively interpret and implement section 27 of the Constitution to achieve equal benefits on access to health care services to everyone in South Africa.

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**LIST OF ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
ACPHR	African Charter on Human and People's Rights
AC	African Commission
AMC	African Multilateral Conference
BBF	Black Business Forum
BEE	Black Economic Empowerment Act of 2003
BEMF	Budget and Expenditure Monitoring Forum
BH	Brooklyn Hospital
BMC	Blouberg Medi-Clinic
BR	Bill of Rights
CALS	Centre of Applied Legal Studies
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
DU	Du Noon
EU	European Union
GC	General Comment
HPCSA	Health Professions Council of South Africa
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IFC	International Finance Corporation
IFO	International Financial Organisation
IFWC	International Fresh Water Conference
IMF	International Monetary Fund
ICSI	Intracytoplasmic Sperm Injection
IVS	In Vitro Fertilisation
LHTC	Liver and Heart Transplant Clinic
MC	Multinational Corporation
MDH	Medi-Cross Hospital
MI	Multilateral Institute
MMC	Milnerton Medi-Clinic
NHI	National Health Insurance
NMCH	Nelson Mandela Children's Hospital
PACHPRRW	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women

RDP	Rapid Development Programme
SAC	South African Constitution
SAHRC	South African Human Rights Commission
SCA	Supreme Court of Appeal
SERAC	Social and Economic Rights Action Center
SH	Somerset Hospital
SPII	Studies in Poverty and Inequality Institute
TAC	Treatment Action Campaign
TB	Tuberculosis
TVC	Table View Clinic
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNO	United Nations Organisation
UNDRD	United Nations General Assembly Declaration on the Right to Development
UNGA	United Nations General Assembly
USA	United States of America

## CHAPTER 1: INTRODUCTION

### 1.7 Introduction

The 1996 Constitution of the Republic of South Africa establishes the right to have access to health care services as detailed in section 27 of the aforesaid Constitution. This constitutional dispensation mandates government to take necessary measures to ensure that all South Africans have access to adequate health care services. In this regard, since 1994, the South African government have set out measures to improve the health status of all South Africans. Achieving universal health care in South Africa is therefore a priority for the government and this requires the provision of accessible and necessary services for the entire population without imposing any unaffordable burden on them.<sup>1</sup>

This research seeks to explore the right to have access to health care services in South Africa. It aims to contribute to research upholding health as a human right in South Africa. The focus of this research is on the enforcement of the right to have access to health care services in South Africa. The research will therefore examine the constitutional provision relating to the right to have access to health care services and its application in South Africa. This introductory chapter aims to contextualise this enquiry by first outlining the background to the research problem and the problem statement. This chapter will also provide an overview of the research objectives and the research methodology and data collection methods. Finally, an overview of the contents of each chapter that will be discussed under this study will be highlighted.

### 1.8 Background to Research Problem

In 1994, the first democratic South African government came to power. Under the new democratic dispensation, poverty alleviation and the creation of a better life for all South Africans became the central point of focus as the consequences of the former apartheid system left many in destitute. To achieve this, a new constitution was adopted in 1996, whose goal is to build a democratic state founded on the values of human dignity, the achievement of equality and the advancement of human rights and freedoms as stated in the Bill of Rights of the Constitution.<sup>2</sup> The new Constitution entrenches the right to basic needs including the right to have access to health care services. Section 27 (1) of the Constitution recognises that access to health care service is a basic human

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<sup>1</sup> Toyana HM *A National Health Insurance Management Model to Promote Universal Healthcare in South Africa* Masters of Arts Thesis University of Johannesburg 2013) 17-19.

<sup>2</sup> Deegan H *South African Reborn: Building a New Democracy* (UCL Press Limited 1999) 31.

right. It states that “Everyone has the right to have access to health care services, including reproductive health care.”<sup>3</sup> It further states that it is the government’s responsibility to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.<sup>4</sup>

In South Africa, the right to have access to health care services is therefore a constitutional right. The Constitution compels the government to ensure that all South Africans enjoy the benefit from this right by having access to adequate health care. Therefore, the state bears the primary responsibility for health care delivery and must respect, protect and fulfil this right.<sup>5</sup> To this effect, the government has since 1994 initiated reforms to bring changes to the health sector and address the issue of inequity in respect of access to health care services. Some of the most significant reforms include the replacing of fourteen separate health departments for Bantustans and South Africa with a single national health system with one national department and nine provincial health departments.<sup>6</sup> In addition to this, the government has developed progressive policies and passed series of legislations to address past structural inequities inherent in the apartheid system. Due to these reforms, there has been considerable investment in Public Health Care through increased infrastructure and rapid expansion of health care programmes on epidemics such as Tuberculosis, HIV/AIDS and maternal health related programmatic intervention.<sup>7</sup> This has been followed with increase in utilisation of health care services.<sup>8</sup> In view of this, some available data on the public health care system of South Africa reveals that there is major transformation through health legislation, policy and the delivery of health services.<sup>9</sup> This data has been able to show that there has been an improvement on the level of access to public health facilities. Arguably, this shows

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<sup>3</sup> Section 27 of the Constitution of the Republic of South Africa, as adopted on 8 May 1996 and amended on 11 October 1996 by the Constitutional [http://: www.Justice.gov.za/legislation/constitution /SACConstitution-web-eng.pdf](http://www.Justice.gov.za/legislation/constitution/SACConstitution-web-eng.pdf). (Date of use: 05 November 2015).

<sup>4</sup> Section 27 (2) which states that: “The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.” To this end, this provision therefore requires that the state must not hinder access to health care services but should rather take steps to advance the aforesaid socio-economic rights.

<sup>5</sup> Section 27(2) of the Constitution. Section 7 (2) of the Constitution.

<sup>6</sup> Coovadia H et al “The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges” (2009) *The Lancet* 825, 828.

<sup>7</sup> Nxumalo N, Goudge J and Thomas L “Outreach services to improve access to health care in South Africa: Lessons from three community health worker programmes” (2013) *COACTION* 220.

<sup>8</sup> Nxumalo, Goudge and Thomas (2013) 220.

<sup>9</sup> Lomahoza K *Monitoring the right to health care in South Africa: An analysis of the policy gaps, resource allocation and health outcomes* (Studies in Poverty and Institute on the Progressive Realisation of Socio-Economic Rights September 2013) 16.

government's commitment to fight against unequal access of health care services to ensure that all South Africans benefit from their entitlements under the Constitution.<sup>10</sup>

However, over the years, it has been revealed in some studies that the adoption of progressive policies and legislation has not effectively translated the right to have access to health care services to all South Africans. For instance, the 7<sup>th</sup> Report on Economic and Social Rights by the South African Human Rights Commission revealed that although the Department of Health had developed progressive policies and legislative framework for people to gain access to health care services, there were gaps in the implementation of these policies and legislation at local, provincial and national level.<sup>11</sup> The report further revealed that the gap in the implementation of health policies and legislation among others such as insufficient capacity of qualified persons to offer health care services and limited health care services for the poor and rural population, amounted to social exclusion which is in contravention of the right-based approach.<sup>12</sup> The above challenges are later upheld in a study concluded by the Studies in Poverty and Inequality Institute (SPII) in 2013, whose aim was to monitor the right to health care in South Africa. The study revealed that low health outcomes, massive disease burden, human resource constraint and uneven implementation and monitoring of policies has perpetuated massive health inequities between different provinces in the public health sector as well as between the public and private sector.<sup>13</sup>

In the midst of the above challenges still stands the constitutional commitment to ensure that all South Africans have access to health care services. South Africa's Constitution has been described as a transformative tool in many academic literature and by the courts as it aims to break the country from the shackles of its past grounded by inequality and gross human rights violations and forge a new future for all South Africans.<sup>14</sup> However, evidence of compromising results of social transformation highlighted by the above reports raises doubts as to whether the government has been pro-active to comply with its constitutional mandate and prevent inequality in access to health care access services by South Africans. This study is thus motivated by these concerns and sought to stress the importance of upholding the right to have access to health care services in the social transformation process of South Africa.

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<sup>10</sup> Lomahoza K (2013) 16.

<sup>11</sup> South African Human Rights Commission (SAHRC) *Chapter 8: The Right to Health* (7<sup>th</sup> Report on Economic and Social Rights 2006-2009) 79.

<sup>12</sup> SAHRC (2006-2009) 79.

<sup>13</sup> Lomahoza K (2013) 16.

<sup>14</sup> Klare K "Legal Culture and Transformative Constitutionalism" (1998) 14 *SAJHR* 150. Davis DM "Transformation: The Constitutional Promise and Reality" (2010) 26 *SAJHR* 23-76.

Paying attention to this particular socio-economic right is critical in consolidating and deepening the democratic values of South Africa. The right to have access to health care services can help in the attainment of the goals envisaged by the Constitution. This is because health and human rights are identified as complementary approaches for the advancement of the welfare of human beings.<sup>15</sup> The violation of the right to health may often impair the enjoyment of other human rights such as the right to education, water, food and work.<sup>16</sup> The right to health is therefore dependent on and contributes to the realisation of these other basic human rights.<sup>17</sup> In this regard, the executive, judiciary and the legislature have distinctive roles to play in fulfilling their constitutional mandate to uphold the right to have access to health care services. Furthermore, non-state entities must also observe the duty to ensure that everyone has access to health care services. Finally, civil societies must also play a role in assisting the government to further its constitutional mandated role and to monitor the observance of the right to have access to health care services.

### 1.3 The Problem Statement

As a result of the compounding effects of apartheid, the democratic government of South Africa inherited a fragmented health care system with disparities in health care spending, inequitable distribution of health care professionals and poor access of quality health care in urban and rural areas and between the private and public sectors.<sup>18</sup> These conditions saw the birth of a Constitution that affirms the right to have access to health care services.<sup>19</sup> This constitutional prerogative has been mandated to the National Government to provide conditions which will ensure that all South Africans have access to adequate and quality health care.

However, South Africa is still grappling with challenges of transforming the health care system even with the new constitutional dispensation.<sup>20</sup> Attempts to deal with disparities and to integrate the fragmented health care system have not fully addressed the problem of inequality in the country. The health care system is still highly fragmented within the public sector and between the public and the private sectors and this has entrenched a two tier system.<sup>21</sup> The two-tiered system of health care

<sup>15</sup> Mann JM et al (1994) "Health and Human Right" *An International Quarterly Journal* 8.

<sup>16</sup> Office of the United Nations High Commissioner for Human Rights Fact Sheet No 31 "The Right to Health" <http://www.ochr.org/Documents/Publications/Factsheet31.pdf> (Date of use: 25 May 2015) 6.

<sup>17</sup> Office of the United Nations High Commissioner for Human Rights Fact Sheet No 31 <http://www.ochr.org/Documents/Publications/Factsheet31.pdf> (Date of use: 25 May 2015) 6.

<sup>18</sup> Rispel L and Setswe G "Stewardship: Protecting the Public's Health: Oversight: Principles and Policy" (2007) *South African Health Review* 4.

<sup>19</sup> Section 27 of the Constitution.

<sup>20</sup> Mayosi BM and Benatar RS (2014) 1344.

<sup>21</sup> Human A "A Tale of Two Tiers: Inequality in South Africa's Health Care System" (2010) 2(1) *UBCMJ* 33.

does not embrace the principle of equity and access enunciated in the Constitution. In the circumstances, access to health care services is severely compromised and the highest attainable standard of health care has still not been achieved.

#### **1.4 Aims and Objectives of Study**

The ultimate aim of this study is to provide critical research on the right to have access to health care services to guide scholars, legal practitioner, government organisations and judicial officers on how to best interpret, implement and enforce this right with the objective of achieving the transformative potential of the South African Constitution. With the entrenchment of justiciable socio-economic rights in the 1996 Constitution of South Africa and the important role their interpretation plays in achieving the transformative aspirations of the Constitution, there is dire need for a comprehensive study of these rights as well as making proposals for their realisation. The study will therefore discuss the meaning and content of the right to have access to health care services with reference to the Constitution, case law and other relevant international human rights instruments. This will be done in order to determine whether the incorporation of the right to have access to health care services in the Constitution as one of the socio-economic rights has indeed benefited those who were formerly excluded from this right and result to the social transformation, which the 1996 Constitution is out to achieve.

The study will also investigate whether the content of the right to have access to health care services can have a horizontal application in the context in South Africa to enhance the possibility of achieving this right and realise the transformative goal of the Constitution. The study will further check the progress in the realisation of the right to have access to health care services by looking into some of the measures that has so far been put in place by the government during the period under review and the impact of these measures especially on the groups that were marginalised and excluded from health care services under the system of apartheid. In doing so, the study will also highlight some of the shortcomings of the measures put in place by government and will further identify current challenges in the realisation of the right to have access to health care services and government's response to these challenges.

Furthermore, this enquiry will discuss ways in which section 27(1) (a) of the Constitution can effectively be implemented to fully realise the potentials of the right to have access to health care services in South Africa. In doing so, the enquiry will suggest a substantive approach to be adopted in South Africa's jurisprudence in respect of the right to have access to health care services.



Finally, the study will benefit students and legal practitioners, government, non-governmental organisation and the public at large in that the study will create awareness about the importance of the right to have access to health care services and add knowledge or insight on the role which everyone can play in order that this right can be realised and result to the desired social transformation of South Africa.

The study will focus on the following objectives:

- 1) To analyse the content of section 27(1) of the Constitution relating to the right to have access to health care services.
- 2) To analyse the application of the right to have access to health care services provision in South Africa to state and non-state entities.
- 3) To explore measures put in place by the government following the duty imposed upon the state to progressively realise the right to have access to health care services.
- 4) To evaluate the progress that has been made in respect of the measures put in place by the government.
- 5) To explore the shortcomings of the measures put in place by the government to ensure a progressive realisation of the right to have access to health care.
- 6) To explore ways to effectively monitor the progressive realisation of the right to have access to health care services.
- 7) To explore barriers in achieving universal access to the right to have access to health care services.
- 8) To draw conclusions and make recommendations regarding the progressive realisation of the right to adequate health care.

## **1.5 Research Methodology**

The methodology adopted for this enquiry consists of a review and an analysis of both primary and secondary literature that is relevant to the subject-matter of this study. The study undertakes analysis and review of primary sources of literature such as international and South African case law, international law, Acts of Parliament legislation, Bills, policy documents, regional human right instruments and international human right instruments. This study also consists of a review and analysis of secondary sources of literature. The research is literature based and therefore places considerable reliance on other materials such as textbooks, journals and papers relating to the right to have access to health care services and other academic materials in connection with socio-economic rights in general. Conclusion drawn from reviewing and analysing the information obtained from the aforementioned sources is applied towards answering the research questions.

## 1.6 Overview of Chapters

This study is divided into five chapters. Chapter one will commence with an introduction to this enquiry. As an introductory chapter, it will focus on the scientific and methodological orientation of the study. It will therefore provide a brief background of the research as well as the statement of the problem of the research. Furthermore, this chapter will consider the aims and objectives of this study and will conclude with the methodology adopted for the entire study.

Chapter two will undertake a general analysis of the nature, scope, content and extent of the right to have access to health care services. In doing so, this chapter will discuss the extent to which the Court has given substantive content to the right to have access to health care services. Accordingly, selective jurisprudence of the Court which best illuminates its approach to the right to have access to health care services will be examined. The purpose of doing this is to demonstrate whether the Court's jurisprudence has given proper interpretation or effect to the purposes and values of section 27 of the Constitution. This is because the Court has a duty to elaborate on the meaning of section 27(1) of the Constitution to facilitate the realisation of this right. This chapter will also examine the nature of transformative constitutionalism in relation to the role of the Court in socio-economic rights adjudication. In this regard, the key impediments to the adjudication of socio-economic rights including the right to have access to health care services, being the doctrine of separation of powers and the principle of polycentricism will be examined. Finally, emerging international law instruments, to which the right to adequate health have also been incorporated, will be discussed. To this end, international instruments such as the International Convention on Economic, Social and Cultural Rights (ICESCR) and the African Charter on Human and People's Rights, from which the substantive right to have access to health care services have been developed will also be examined.

Chapter three will examine whether the right to have access to health care services has an indirect application to relationships between non-state entities. The main thrust of the argument here is that non-state entities are increasingly being involved in the delivery of health care services and their actions can also result to the violation of the principles enunciated in section 27 (1) of the Constitution. Therefore, it is justifiable to apply the right to have access to health care services horizontally to hold private parties accountable for actions that result to a violation of this right. This chapter will therefore engage in the discussion of private sector evolution and involvement in the provision of health care services in South Africa. The chapter will further examine the horizontal dimensions of the right to have access to health care services and the extent to which the Court has judicially enforced this right against private entities. Finally, the chapter calls for the development of rules of the common law relating to medical negligence by South African courts as

prescribed by section 8(3) of the Constitution to effectively apply section 27 of the Constitution to horizontal relationships.

Chapter 4 will examine the progressive realisation of the right to have access to health care services. The realisation of this right and other socio-economic rights is crucial for South Africa to overcome the persistent challenges of poverty and inequality and achieve the transformative goal of the Constitution.<sup>22</sup> In doing so, the Constitution mandates the government to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the rights entrenched in the Constitution.<sup>23</sup> Therefore, this chapter will examine the measures which the government has so far put in place in making health care services accessible by all South Africans. In discussing the various legislation and policies adopted by the government to progressively realise the right to adequate health care services as mandated by the Constitution, the study will also examine the appropriateness and the effectiveness of these measures. Particular attention will be given to the National Health Insurance (NHI), which is currently in its first phase of implementation in some pilot districts.<sup>24</sup> This is because the National Health Insurance scope is governed and guided by section 27 of the Constitution. The policy therefore observes the right to have access to health care services as well as other principles including social solidarity, effectiveness, appropriateness, equity, affordability and efficiency.<sup>25</sup> The NHI is therefore considered as instrumental to transform South Africa's health care sector and offer equal benefit of access to quality health care services to all South Africans. In this regard, this chapter will examine whether the current implementation of the NHI has been able to yield any result that is consistent with its objectives and highlight elements hindering efficiency in the aforesaid policy.

The Constitution further mandates the South African Human Rights Commission to monitor and assess the observance of socio-economic rights by state organs.<sup>26</sup> Accordingly, this chapter will examine one of those framework adopted by the Human Rights Commission to monitor the progressive realisation of socio-economic rights. The application of this framework to the context of the right to have access to health care services will be examined to assess the current state of progressive realisation of this right in South Africa.

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<sup>22</sup> Lomahoza K (2013).

<sup>23</sup> Section 27(2) of the Constitution.

<sup>24</sup> National Health Insurance (NHI) Pilot Districts: (Progress Report by Minister of Health) [http:// www. samed.org.za](http://www.samed.org.za) (Date of use: 17 October 2015).

<sup>25</sup> Sekhejane PR "South African National Health Insurance (NHI) Policy: Prospects and Challenges for its Efficient Implementation" (2013) 102 *AISA POLICYbrief* 3.

<sup>26</sup> Section 182 of the Constitution.

Chapter five is an international chapter where I will contrast the constitutional provision on the right to have access to health care services in South Africa with a similar provision embodied in the Constitution of a foreign country. In this study, I have chosen Canada and will examine its jurisprudence on the right to have access to health care services. In doing so, I shall discuss the right to have access to health care services under the Canadian Charter of Rights and Freedom and contrast with the right to have access to health care services under section 27 of the South African Constitution.

Finally, Chapter six will provide a summary of this enquiry and a conclusion. The purpose of this concluding chapter is thus to highlight some important recommendations that will enhance the enjoyment of the right to have access to health care services by all South Africans.

## CHAPTER 2: THE RIGHT TO HAVE ACCESS TO HEALTH CARE SERVICES

### 2.1 Introduction

The fulfilment of the right to have access to health care services is a requirement for the proper enjoyment of fundamental rights and a healthy lifestyle of human existence in civil society. The right to have access to health care services is constitutionally guaranteed under section 27 (1) (a) of the South African Constitution. The right to have access to healthcare services, however, is still the subject of many arguments. This is because accessible health care services are available mostly to those who can afford while the less privileged still have limited access to the aforesaid right. The state is therefore under an obligation to respect, protect, promote and enforce the right in section 27 of the South African Constitution. However, the right to have access to health care services is subjected to limitation clauses set out in section 36 and elsewhere in the Bill of Rights.<sup>27</sup> This enquiry rightly begins with the provisions that guarantee equal enjoyment of all rights by the citizens of South Africa as provided for in section 1 of the Constitution.<sup>28</sup> The protection afforded by the Constitution is available to all citizens in equal proportion no matter the condition of the citizens. One of the greatest fundamental of the South African Constitution that set it apart from other constitutions in the world such as those of the United States, Britain, Germany, and many others is that the South African Constitution contains, among others, the Bill of Rights, which incorporates provisions that protects socio-economic rights, with the right to have access to health care services being one of them. The Constitution provides for and guarantees the right to have access to health care services in relation to all other rights incorporated in the Bill of Rights.

The Bill of Rights is the cornerstone of democracy in South Africa. It enshrines the rights of all people in South Africa as set out in Section 2 of the Constitution and affirms the democratic values of human dignity, equality and freedom.<sup>29</sup> This implies that any interpretation of the Constitution must be in line with the dictates of the provisions of the Bill of Rights. The Courts are empowered with the authority to declare any law that is inconsistent with the Bill of Rights void and invalid to the extent of such inconsistency.<sup>30</sup> They are also empowered to consider international law in their

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<sup>27</sup> Section 27(2) of the Constitution of the Republic of South Africa.

<sup>28</sup> Section 1 of the Constitution reads as follows: "The Republic of South Africa is one sovereign, democratic state founded on the following values: (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms, (b) Non-racialism and non-sexism, (c) Supremacy of the Constitution and the rule of law, (d) universal adult suffrage, a natural common voters roll, regular elections, and a multi-party system of democratic government, to ensure accountability, responsiveness and openness."

<sup>29</sup> Section 7 (1) of the Constitution of the Republic of South Africa.

<sup>30</sup>This Constitution is the supreme law of the Republic. Law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled. Section 2 of the Constitution of the Republic of South Africa.

application of the Bill of Rights.<sup>31</sup> Furthermore, the Constitution states that the Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.<sup>32</sup>

The right to have access to health care services means that everyone has a right to access health care services irrespective of whether they can afford to pay for it or not. No one may be denied this right as enshrined in the Constitution. Health care services should not be available or accessible only by a few who are wealthy or who can afford to pay.<sup>33</sup> It will just be an exercise in futility if the provisions of the Constitution are not complied with by the relevant authorities.<sup>34</sup> The government must within its available resources, therefore make available to everyone health care facilities that can be accessible when the need for such facilities arises. In realising this, the state must therefore take reasonable legislative and other measures, as prescribed by the Constitution to achieve a progressive realisation of Section 27 of the Constitution. In doing so, the right to have access to health care services will not only be regarded as fulfilled, but the people would be constitutionally protected.

It is important to distinguish the right to have access to health care services from the right to emergency medical treatment as the latter only has a limited meaning as illustrated in the case of, *Soobramoney v Minister of Health*.<sup>35</sup> In this case, Chaskalson P stated that: "In our Constitution, the right to medical treatment does not have to be inferred from the nature of the State established by the Constitution or from the right to life which it guarantees. It is dealt with directly in section 27. If section 27(3) were to be construed in accordance with the appellant's contention, it would make it substantially more difficult for the State to fulfil its primary responsibility under section 27(1) and (2) to provide health care services to "everyone" within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the State for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening. In my view, much clearer language than that used in section 27(3) would be required to justify such a conclusion".<sup>36</sup>

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<sup>31</sup> Sloss D *The Role of Domestic Courts in Treaty Enforcement: A Comparative Study* (Cambridge University Press 2009) 475.

<sup>32</sup> Section 39 of the Constitution of the Republic of South Africa.

<sup>33</sup> Section 27 (2) of the Constitution.

<sup>34</sup> Currie I & de Waal J *The bill of rights handbook* (6<sup>th</sup> ed Juta & Co Ltd Wetton 2013) 564, 566.

<sup>35</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)* (CCT32/97)[1997] 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997).

<sup>36</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)*, para 19.

In the *Soobramoney's* case, an old unemployed man, who was a diabetic patient, suffered from ischaemic heart disease and cerebrovascular disease, which caused him to have a stroke during 1996. In that year, his kidneys also failed. Sadly, his condition became irreversible and he was now in the final stages of chronic renal failure. His life could be prolonged by means of regular renal dialysis. He had sought such treatment from the renal unit of the Addington State Hospital in Durban. The hospital could, however, provide dialysis treatment to only a limited number of patients. The renal unit had 20 dialysis machines available to it, and some of these machines were in poor condition. Each treatment took four hours, and a further two hours had to be allowed for the cleaning of a machine, before it could be used again for another treatment. Because of the limited facilities that were available for kidney dialysis, the hospital was unable to provide the appellant with the treatment he had requested. In this regard, the appellant brought an application before the High Court of Durban to compel Addington Hospital to provide him with the required treatment. The appellant's application was dismissed by the Durban High Court and he appealed to the Constitutional Court, which found the Addington standards to be reasonable, and also dismissed the appellant's application on grounds that the non-treatment by Addington Hospital did not amount to any violation of his rights enshrined in the Constitution.<sup>37</sup>

In summarising and analysing the above position by Chaskalson, it means that the government is not obliged to provide health care services at a time required by a particular citizen in order to maintain life, but that value judgment must be the criteria to follow in making decision as to who gets which type of health care services. Furthermore, the state is only obliged to provide healthcare services or facilities and make them accessible by all citizens using available resources. This is because services can only be provided with the resources which are at the disposal of the government. Therefore, the provisions of section 27 would not be considered to be violated as illustrated in the court's decision above, as the government's responsibility is also subject to the limitation set out in section 36.<sup>38</sup> In other words, the government is only mandated to take actions that apply generally to the citizens and which are open and transparent as well as based on the state's available resources. In doing so, the obligations placed upon the government will therefore be seen as fulfilled in line with the provisions of the Constitution.<sup>39</sup>

## **2.2 The Right to Access to Health Care Services**

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<sup>37</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)* para 10.

<sup>38</sup> Section 36 of the Constitution.

<sup>39</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)* para 11. Sections 27 and 36 of the Constitution.

The South African Constitution makes provisions that prohibit discriminatory practices in respect of access to health care services. The Constitution focuses on access to health care services and base this notion on the principle of equality. The full liberties and freedom that are expressed in the constitutional principles and handsomely referred to in the *Certification judgment*, show just how far the courts are willing to go to protect fundamental rights generally.<sup>40</sup> The Constitution forbids the provision of health care services that are linked to affordability by the people. This implies that money should not be a determining factor in the provision of access to health care services. The right to have access to health care services should therefore not be based on whether people have the financial ability. Irrespective of whether people are poor, wealthy, employed or unemployed, everyone should have the same access to health care services as all citizens are equal before the law. In theory, it will be noted that access to health care services as provided for in the Constitution are not discriminatory in any aspect because all the state has to do is to conform with the provisions of section 9, which confirms the right to equality and section 36, which sets out the general limitation clause. However, in practice, this situation is clearly different, because those who can afford health care have enormous purchasing power and exercise the choice of accessing their health care needs from private health care facilities, which are better equipped and have more qualified doctors and personnel tailored to meet their needs at the expense of the poor who have to depend on public health care services.<sup>41</sup>

The right to have access to health care services as provided for in section 27(1), is a socio-economic right and must be afforded its full protection by the law. Millions of people all over the world die of preventable diseases as a result of a lack of access to health services and proper health facilities. Universally the desire by the international community to protect the vulnerable and promote universal access to health prompted the United Nations to enact the Universal Declaration of Human Rights (UDHR). It is a declaration adopted by the United Nations General Assembly (UNGA) on 10 December 1948 at the Palais de Chaillot in Paris. The Declaration arose directly from the experiences of the Second World War and represents the first global expression of rights to which all human beings are inherently entitled.<sup>42</sup> South Africa as a member of the international community has ratified the charter and incorporated it into its Constitution. The

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<sup>40</sup> *Certification of the Constitution of the Republic of South Africa*, 1996 (CCT 23/96) [1996] ZACC 26; 1996 (4) SA 744 (CC); 1996 (10), BCLR 1253 (CC), (6 September 1996) [49]. The method the drafters of the CPs adopted in order to give content to the Bill of Rights was to refer to “all universally accepted fundamental rights, freedoms and civil liberties”. There are two components to this: “fundamental rights, freedoms and civil liberties” and “universally accepted”. Mailula DT ‘Revised Reader for Constitutional Law, Department of Public, Constitutional and International Law’ para 10, 26 and 30.

<sup>41</sup> Section 9 and 36 of the Constitution. *Soobramoney v Minister of Health* para 1.

<sup>42</sup> Booyesen H “Principles of International Trade Law as Monistic System” (2007) *Interlegal* See para 123–199. Dugard J *International Law a South African Perspective* (4<sup>th</sup> ed Juta & Co Ltd 2011) 101 -110.



Constitutional Court, in interpreting the right to have access to health care services in section 27(1), in the *Certification judgment*, stated: “The method the drafters of the CPs adopted to give content to the bill of rights was to refer to ‘all universally accepted fundamental rights, freedoms and civil liberties’. There are two components to this: ‘fundamental rights, freedoms and civil liberties’ and ‘universally accepted.’”<sup>43</sup>

In spite of the constitutional provision relating to access to health care services as well as other international instruments incorporate therein to uphold the provision, a large number of South African households are still without access to healthcare services. As Harris and others put it, South Africa’s history still shapes access to health care services resulting to inequities and distortions.<sup>44</sup> To concur with this view, previous South African studies confirm that poor, uninsured, black African and rural groups still experience an inequitable access to health care services.<sup>45</sup> Accordingly, a good number of people in South Africa may be suffering from diseases which may even result to death as a result of lack of access to health care facilities. On an average, rural women and children bear the greatest burden of the lack of access to health care services due to high travel cost and low income status.<sup>46</sup> In most cases, they have to travel very long distances exacerbated by poor road infrastructures and the nonexistent of a public transport system to get to the nearest health care facility.<sup>47</sup> Therefore, it can justifiably be argued that lack of affordable and accessible health care services has been disastrous to South African rural population.

In view of these inequities, the courts have become involved in order to protect the socio-economic rights of the population enshrined in the Constitution and to make sure that access to health care services being one of them, is available to all who live in South Africa, subject, however, to the limitation clause in section 36. The courts are commended for making decisions that seem to protect fundamental rights and uphold the values of the Constitution and other Conventions of the United Nation as evident in *Grootbloom* and the *TAC* cases. However, the involvement of the courts in the enforcement of socio- economic rights appears also not to have achieved so much in the realisation of the right in section 27 (1) of the Constitution. Courts have achieved very little success in making health care accessible to all who live in South Africa as they have increasingly

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<sup>43</sup> *Certification of the Constitution of the Republic of South Africa* para 49.

<sup>44</sup> Harris B et al “Inequities in access to health care in South Africa” (2011) *Journal of Public Health Policy* 2.

<sup>45</sup> Harris et al (2011) 2. Gilson L and McIntyre D “Post-apartheid challenges: Household access and use of health care in South Africa” (2007) *International Journal of Health Services* 673-691. Coovadia H et al “The health and health system of South Africa. Historical Roots of current public health challenges” (2009) *Lancet* 817.

<sup>46</sup> Goudge J et al “Illness-related impoverishment in rural South Africa: Why does social protection work for some households but not others?” (2009) *Journal of International Development* 231-251.

<sup>47</sup> Visagie S and Schneider M “Implementation of the principles of primary health care in a rural area of South Africa” (2014) *Afr. J Prm Health Care Fam Med.* 2.

restricted their role and limited the purpose of judicial enforcement of socio-economic rights.<sup>48</sup> This is so because the court decisions are seldom carried through by the State, which always hides behind a lack of resources and the principles of separation of powers as reasons for not being able to satisfy certain Court judgments.<sup>49</sup>

Since 1994, there have been several court cases that have served to add to the normative content of the right to have access to health care services. These have thrown light on the concepts of “available resources” and “reasonable measures” in terms of section 27(1)(b) of the Constitution. In the *Sobramoney* case, the Constitutional Court was of the opinion that the scarcity of resources available to the State was a constraint to the enjoyment of the right by the appellants, given the socio-historical context of South Africa.<sup>50</sup> In the *Grootboom* case, the Constitutional Court defined the parameters of what constitutes “reasonable measures”, but did not venture to define the minimum core content. It concluded, however, that measures that do not include meeting the needs of the most vulnerable groups in the society were unreasonable. Furthermore, it was stated that implementation plans that failed to be “reasonable” would not meet the State's obligations in terms of section 7(2) of the Constitution.<sup>51</sup> Another important case is that which dealt with the prevention of mother-to-child transmission of HIV, in which the Treatment Action Campaign requested that, the anti-retroviral drug, Nevirapine, be made available to all HIV-positive pregnant women in the public health sector, which at the time was available only at the 18 pilot sites. In this case, the Constitutional Court upheld the High Court's order to make Nevirapine available to all HIV-positive pregnant women<sup>52</sup>.

Therefore, it appears that the courts have been proactive in protecting the rights in the Bill of Rights as evident in the several decisions such as *Grootboom*, *TAC*, and *Soobramoney*. The executive have in many cases accused the courts of encroaching into their constitutionally protected areas and duties, thereby jeopardising the purpose of separation of powers.<sup>53</sup> The doctrine of separation of powers in South Africa took a centre-stage in a number of Constitutional Court cases. In *South African Association of Personal Injury Lawyers v Heath and*

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<sup>48</sup> Ngang CC “Judicial enforcement of socio-economic rights in South Africa and the separation of powers objection: The obligation to take other measures” (2014) *African Human Rights Law Journal* 655-680.

<sup>49</sup> Mbazira C *Litigating socio-economic rights in South Africa: A choice between corrective and distributive justice* (Pretoria University Law Press 2009) 202.

<sup>50</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)* para 8.

<sup>51</sup> *Government of South Africa and Others v Grootboom and Others* (CCT 11/00) [2000] ZACC 19; 2001(1) SA 46; 2000 (11) BCLR 1169 (4 October 2000) para 29 –35. *Minister of Health and Others v Treatment Action Campaign* (No 1) (CCT 9/02) [2002] ZACC 16; 2002 (5) SA 703; 2002 (10) BCLR 1075 (5 July 2002)19 – 46.

<sup>52</sup> *Minister of Health and Others v Treatment Action Campaign and Others* 32 -36.

<sup>53</sup> Ngang CC (2014) 657.

*Others*,<sup>54</sup> Chaskalson CJ, while comparing the constitutional dispensations of South Africa and United States of America and Australia stated that: 'In all three countries, however, there is a clear though not absolute separation between the legislature and the executive on the one hand, and the courts on the other. In most cases the Constitutional Court has held that the doctrine of separation of powers does not always have to be strictly applied. In the first certification judgment, *Ex parte Chairperson of the Constitutional Assembly of the Republic of South Africa*,<sup>55</sup> the First Certification case, the court stated that: 'There is, however, no universal model of separation of powers and, in democratic system of government in which checks and balances result in the imposition of restraints by one branch of government upon another, there is no separation of powers that is absolute.... The principle of separation of powers, on the one hand, recognises the functional independence of branches of government. On the other hand, the principle of checks and balances focuses on the desirability of ensuring that the constitutional order, as a totality, prevents the branches of government from usurping power from one another. In this sense it anticipates the necessity or unavoidable intrusion of one branch on the terrain of another. No constitutional scheme can reflect a complete separation of powers...' In a constitutional dispensation, the doctrine of separation of powers is not fixed or rigid. The courts are duty bound to develop a distinctively South African model of separation of powers. That is one that fits the particular system of governance provided for in the Constitution and that reflects a delicate balancing, informed both by South Africa's history and its new dispensation, between the need, on the one hand, to control government by separating powers and enforcing checks and balances, and on the other hand, to avoid diffusing power so completely that the government is unable to take timely measures in the public interest. Since 1994 and after the election of the new democratic government and the adoption of the final Constitution, the doctrine of separation of powers has been investigated extensively in various judgments of the Constitutional Court. The judiciary has spent time in developing a home grown model of the doctrine as envisaged by the Constitution. The courts have therefore concluded that there is no absolute separation of power.

However, it is not surprising to find some cases from the Constitutional Court in which the court has applied the doctrine of separation of powers strictly. This is usually in cases that involved the relationship between legislature and the executive. In *De Lange v Smuts No and Others*,<sup>56</sup> for instance, the Constitutional Court held that a member of the executive may not be given the power to commit an un-cooperative witness to prison. This is because the courts have such power to

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<sup>54</sup> *South African Association of Personal Injury Lawyers v Health and Others* (CCT27/00) [2000] ZACC 22; 2001 (1) BCLR 77 (28 November 2000).

<sup>55</sup> *Ex parte Chairperson of the Constitutional Assembly: in re Certification of the Republic of South Africa* 1996 (First Certification judgment) 1996 (4) SA 744 (CC) [13].

<sup>56</sup> *De Lange v Smuts No and Others* (CCT26/97) [1998] ZACC 6; 1998 (3) SA 785; 1998 (7) BCLR 779 (28 May 1998).

send someone to prison. It is a judicial function and not an executive one. In *South African Association of Personal Injury Lawyers v Heath and Others*,<sup>57</sup> the Constitutional Court held that a judicial officer may not be appointed as the head of a criminal investigation unit. This is because the power to investigate and prosecute crimes is an executive function and not judicial function. In *S v Dodo*,<sup>58</sup> the Constitutional court held that while the legislature may determine a minimum sentence for a particular crime, it may not determine the sentence that should be imposed in a particular case. This is because the power to impose a sentence on the offender is a judicial function and not an executive function. In *Executive Council Western Cape Legislature v President of Republic of South Africa*,<sup>59</sup> the Constitutional Court held that while the legislature may not delegate plenary law-making powers to the executive, it may delegate subordinate law-making powers.<sup>60</sup>

### 2.3 Summary of the Right of Access to Health Care Services

The right of access to health care services is a socio-economic right. In the context of South Africa, the Constitutional Court has declared these rights as justiciable and the reason for which they are incorporated in the Constitution.<sup>61</sup> This implies that in South Africa, socio-economic rights can be adjudicated or enforced judicially as political and civil rights. However, some proponents argue that socio-economic rights are in their nature non-justiciable and should not be incorporated in the Constitution.<sup>62</sup> Although these rights including the right of access to health care services are declared as justiciable by the Constitutional Court, they are however subjected to the limitations set out in section 27(2) and section 36 of the Constitution.<sup>63</sup> It is in line with these limitations that Carstens and Pearmain advise that the manner in which the right to health care services is limited is crucial to a proper understanding of the right of access to health care services as the state is only required to take reasonable legislative and other measures, within its available resources to

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<sup>57</sup> *South African Association of Personal Injury Lawyers v Heath and Others* (CCT27/00) [2000] ZACC 22; 2001 (1) BCLR 77 (28 November 2000).

<sup>58</sup> *S v Dodo* (CCT 1/01) [2001] ZACC 16; 2001 (3) SA 382 (CC); 2001 (5) BCLR 423 (CC) (5 April 2001).

<sup>59</sup> *Executive Council of the Western Cape Legislature and Others v President of the Republic of South Africa and Others* (CCT27/95) [1995] ZACC 8; 1995 (10) BCLR 1289; 1995 (4) SA 877 (22 September 1995).

<sup>60</sup> *De Lange v Smuts NO and Others* para 24, *Executive Council of the Western Cape Legislature and Others v President of the Republic of South Africa and Others* para 21 and 109, *South African Association of Personal Injury Lawyers v Heath and Others* para 20, *S v Dodo* para 26.

<sup>61</sup> Certification of the Constitution of the Republic of South Africa para 49.

<sup>62</sup> McLean K *Constitutional Deference, Courts and Socio-Economic Rights in South Africa* (Pretoria University Law Press 2009)109.

<sup>63</sup> Section 36 of the Constitution.

achieve its realisation.<sup>64</sup> Accordingly there is an acknowledgement within the Constitution that the aforesaid rights including the right of access to health care services may not be achieved as a result of limited government resources.

## 2.4 Rationing of Health Care Services: A Constitutional Aspect

When a practical application of section 27 of the South African Constitution is considered, it will appear as if the rationing of access to health care services violates the equality provision of the Constitution.<sup>65</sup> By allowing public and private hospitals to engage in rationing practices might result to inequities in the access to health care services. This inequality is mostly evident in public hospitals where resources are much restricted resulting to severe rationing policies as compared to private hospitals. In public hospitals the equipments do not only suffer from depreciation, but in most cases these equipments are just not sufficient for everyone as evident in the case of *Soobramoney*.<sup>66</sup> Given the conditions of public hospitals, rationing becomes very inevitable and severe. In private hospitals, less severe rationing mechanisms are employed although health care is expensive.<sup>67</sup> This makes accessibility easy to those who can afford private health care facilities. The disparity between the rationing mechanism employed by the public and private hospital therefore could be construed to violate the constitutional provision of section 27. This is because those who can afford private hospitals will easily have access to health care services as compared

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<sup>64</sup> Carstens P and Pearmain D *Foundation Principles of South African Medical Law* (Butterworths Lexis Nexis 2007) 38. Section 27(2) of the Constitution.

<sup>65</sup> Carstens & Pearmain (2007) 45.

<sup>66</sup> *Soobramoney v Minister of Health* para 10. See Sections 26 and 27 of the Constitution; contain the following provisions: 26. Housing (1) everyone has the right to have access to adequate housing. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of this right. (3) . . . 27. Health care, food, water and social security (1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights. (3) No one may be refused emergency medical treatment. For instance in section 7 where the bill of rights is described as the cornerstone of democracy in South Africa and as affirming the democratic values of human dignity, equality and freedom, section 28 which deals with children's rights, and section 29 which deals with education. And in analyzing the above section 26 and 27 Chaskalson P "stated that What is apparent from these provisions is that the obligations imposed on the state by sections 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled. This is the context within which section 27(3) must be construed".

<sup>67</sup> Econex Trade, Competition & Applied Economics *Rationing as a Response to Supply Side Constraints* (NHI Note 5 January 2010) 1.

to the majority whose financial resources are limited and can only attend to public hospitals with its relating features as mentioned above.

In spite of the above, rationing becomes very essential in the light of limited resources available to provide access to health care services. In the context of South Africa, most studies concur with the fact that rationing is inevitable as a result of scarce resources although the severity of rationing is different between public and private hospitals.<sup>68</sup> As rationing becomes a necessity because of scarce resources, the government is then faced with the problem of providing access to health care services to all its citizens as it is faced with the challenge of ensuring efficiency and equality in the implementation of its policy on rationing. Take for instance, a public health care facility or hospital like Addington hospital in Durban in which there are more than one thousand patients waiting to be dialysed at the government public hospitals. Among these people, are a good number of senior citizens ranging from fifty years to a hundred years of age on the one hand, and on the other hand are a group of young people from the age of one month to forty years old. In such a case, the hospital would be faced with the dilemma of considering which of the above age groups should be given a priority when it comes to access dialysis treatment at the hospital. In the *Soobramoney* case, Soobramoney desired a liver transplant. The hospital director and his team refused him the transplant and alleged that Addington Hospital had insufficient resources to provide Soobramoney with dialysis as set out in the affidavit of Dr Naicker.<sup>69</sup> However, this is a 41 years old adult who has worked and paid his taxes for many years and who could have argued that the equipments at the hospital were bought with the money he paid as taxes and therefore should be given the required medical services.

In other words, it would appear that the decisions of the hospitals was not really based on value judgment as it appeared to favour the younger citizens and leaving out senior citizens to face the consequences of their actions. The question that arises from the above illustration or analysis is this. To whom should the hospital provide dialysis? Should the hospital provide dialysis to a young child who has his whole life ahead of him and who may become productive and pay back the kind gesture to the society by contributing immensely to societal growth or to the aging population? Should the younger children among the group of one thousand people be given the priority to be dialysed, the senior citizens like Soobramooney may argue that they have worked hard in making the society a better place by paying their taxes and should accordingly be given priority? Furthermore, they may argue that the dialysis equipment had been bought with the money they paid as taxes, and for this reason, they should be given priority. Moreover, a doctor like the doctor

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<sup>68</sup> Econex Trade, Competition & Applied Economics (2010) 1.

<sup>69</sup> *Soobramoney v Minister of Health* para 2.

at the Addington Hospital whose tasks is to weigh different variables might hold that an alcoholic with liver damage has a better chance of surviving longer than a cancer patient who gets a liver or heart transplant, and would rather give a healthy liver or heart to an alcoholic because he stands a chance of surviving.

These questions are at the heart of the interface of law and medicine. Medical personnel are faced with difficult decisions of this nature on a regular basis. At what point can and should the law interfere with such a decision? These questions were canvassed by the Constitutional Court in the *Soobramoney case*. The Constitutional Court rejected the argument that the applicant's situation fell to be decided under section 27(3), which grants the right not to be refused emergency medical treatment. It held that, given that the appellant suffered from chronic renal failure and that for him to be kept alive by dialysis, he would require such treatment two or three times a week and that his condition was not an emergency calling for immediate remedial treatment. The court said the condition was rather an ongoing state of affairs resulting from an incurable deterioration of the applicant's renal function.<sup>70</sup> The court also rejected the right-to-life argument which claims that on the basis of a right to life, everyone requiring lifesaving treatment and who is unable to pay for such treatment himself is entitled to have the treatment provided at a state hospital without being charged. Chaskalson P observed in this regard that in the Constitution, the right to medical treatment does not have to be inferred from the nature of the state established by the Constitution or from the right to life which it guarantees. It is dealt with directly in section 27 of the Constitution. If section 27(3) were to be construed in accordance with the appellant's contention, it would make it substantially more difficult for the state to fulfil its primary obligations under section 27(1) and (2) to provide healthcare services to "everyone" within its available resources. It would also have the consequences of prioritising the treatment of terminal illness over other forms of medical care and would reduce the resources available to the state for purposes such as preventative health care and medical treatment for persons suffering from illnesses or body infirmities which are not life threatening. According to Chaskalson P, a much clearer language than the one used in section 27(3), is required to justify such a conclusion.<sup>71</sup>

#### **2. 4.1 Rationing of Health Care Services under the 1996 Constitution**

Health care rationing is a term that is related to the right to have access to health care services and arises as a result of limited resources that restrict the supply of access to health care facilities. In the context of South Africa, it has a lot to do with the liability placed on the government to

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<sup>70</sup> *Soobramoney v Minister of Health* para 21.

<sup>71</sup> *Soobramoney v Minister of Health* para 19.

provide access to health care services to the people. The Constitution mandates the government to supply health care services within its available resources. This implies that it is acknowledged by the Constitution that the government's responsibility to make health care services accessible by all South Africans may be affected by budgetary constraints. In this regard, rationing becomes very important since the State is only required to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of the right of access to health care services referred to in section 27(1).<sup>72</sup>

However, rationing of health care services, although could be inferred as constitutionally acknowledged also has its shortcomings as it might result to the disparities mentioned in paragraph 2.4 above. However, an important point to note from the decision in *Soobramoney* is that the court acknowledges rationing of access to health care services as a legitimate and necessary activity and that the constitutional right of access to health care services cannot detract from the hard fact of limited resources.<sup>73</sup> Sachs J observed that "in all the open and democratic societies based upon dignity, freedom and equality with which I am familiar, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to healthcare." He pointed out that "section 39(1) (a) of the Constitution requires us to promote the values that underlie an open and democratic society based on human dignity, equality and freedom when interpreting the Bill of Rights."<sup>74</sup> This is where the Constitution prescribes the role of the government. It states that; "The state must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of the rights in the Bill of Rights."<sup>75</sup> On the question of the meaning of the right to life in the context of life prolonging healthcare services, Sachs J observed that; "However the right to life may come to be defined in South Africa, there is in reality no meaningful way in which it can constitutionally be extended to encompass the right indefinitely to evade death." As Stevens J puts it, dying is part of life, its completion rather than its opposite. We can, however, influence the manner in which we come to terms with our mortality. It is precisely here, where scarce, artificial life-prolonging resources have to be called upon, that tragic medical choices have to be made.<sup>76</sup>

There are therefore circumstances in which, even if the resources may, technically speaking, be available, there is no right to their use for the purpose merely of evading death. The right of a person in a persistent vegetative state to be maintained in that state indefinitely is thus

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<sup>72</sup> De Vos P et al *South African Constitutional Law in Context* (Oxford University Press 2015) 670.

<sup>73</sup> Section 27(2) and 39 of the Constitution. Econex Trade, Competition & Applied Economics (2010) 1.

<sup>74</sup> De Vos P et al (2015) 670.

<sup>75</sup> De Vos P et al (2015) 684.

<sup>76</sup> *Soobramoney v Minister of Health* para 57.



questionable. However, this calls into play the fact that in South Africa, the withdrawal of life support could in certain circumstances amount to criminal conduct due to the fact that euthanasia is not permitted by law.<sup>77</sup> The hard question is that in a country where there is shortage of healthcare personnel to treat a patient, how can one justify keeping such a patient “alive” when the nursing staff and possibly the bed may be required for the purpose of delivery of health care services to other patients who have a good chance of recovery? At present, it appears that an answer to the question of the legal acceptability of euthanasia lies somewhere between the fact that the right to life does not encompass the right to indefinitely evading death and the legal convictions of society upon which issues of wrongfulness depends.

## 2.5 Socio-Economic Rights and the Principle of Separation of Powers

The courts have a history of interfering in the domain of the executive, and there are arguments in favour and against their interference. Without the court acting as a check and balance, the executive will do whatever it pleases and if there were no mechanism available to curtail and check their actions, the people may be at the mercy of whatever action the executive may take, be it good or bad.<sup>78</sup> The court though constitutionally empowered to act as a check and balance, has endured mass attack from the executive and sometimes from numerous quarters of the society, where some people believe that unelected judges should not have the power to question the actions of the elected legislatures and the executive arms of government. The aforesaid can be illustrated in the *Soobramoney case*, being a leading decision not just on the right to have access to health care services, but also a case in which the entire Bill of Rights was brought to question, in relation to the enforcement of socio-economic rights such as the right to housing and the right to water.<sup>79</sup>

In the *Soobramoney case*, the High Court in Pietermaritzburg refused to hold the hospital and the government liable for refusing to perform on Soobramoney a dialysis, citing among other reasons, the doctrine of separation of powers, where one branch of government is prevented from usurping the powers of another branch of government. The duties of the courts are to interpret the laws enacted by the legislators and the executive enforces those laws to the benefits of the citizens in general. Before 1994, in the South African jurisprudence, the parliament or legislators needed only to follow due process in enacting any laws and once that was done the courts were helpless and had to interpret these laws in the form in which they have been enacted by the parliament.<sup>80</sup>

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<sup>77</sup> Milton J *South African Criminal Law and Procedure* (Juta & Co Ltd 2008) 321.

<sup>78</sup> Ngang CC (2014) 660-662.

<sup>79</sup> *Soobramoney v Minister of Health*.

<sup>80</sup> Currie and De Waal (2013) 2-3.

Parliament was supreme and any law that was enacted by it could not be questioned at all if it complied with due process. However, since the advent and introduction of the new constitutional era in South Africa jurisprudence, the powers of parliament have been limited. The new constitutional era dictates that parliament is no longer supreme but has to follow due process procedurally and in content. The court is empowered to strike out laws which are unconstitutional. This implies that any law that is made or passed in parliament must be consistent with the provisions of the Constitution or else it will be struck out for being unconstitutional by the court.<sup>81</sup> The new powers that have been bestowed upon the court mean that the court can now enquire more deeply into the laws passed by parliament and can also enquire how the executive carries out its duties or functions.

However, even with the new dispensation, courts are reluctant to exercise a supervisory authority over the executive in respect of the enforcement of socio-economic rights. The attitude of the courts appears to be rooted in the need to preserve the boundaries of separation of powers among other reasons such as the arguments that the courts are ill-suited to adjudicate socio-economic rights because the litigation of these rights is polycentric.<sup>82</sup> The courts have categorically stated that the right to interpret the laws enacted by the parliament does not include the right to direct and make decisions that will breach the principle of separation of powers. For instance, the courts have been very careful to defer to the executive branch of government with regard to issues on budgetary allocation.<sup>83</sup> This view was also affirmed by the Constitutional Court, during its certification of the draft text of the 1996 Constitution in which the court acknowledged that although socio-economic rights were justiciable, their inclusion in the Constitution would have direct financial and budgetary implications.<sup>84</sup> It is therefore evident from the above argument that the judicial interference to enforce socio-economic rights might distort the doctrine of separation of powers. Therefore, in order to uphold the aforesaid doctrine, the courts have exercised caution in their approach to the issue as can be seen in some recent decisions by the Constitutional Court such as the *Soobramoney*, *TAC* and *Grootboom* cases.<sup>85</sup>

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<sup>81</sup> Section 2 of the South African Constitution. It states that: “*This Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled.*”

<sup>82</sup> Nolan A, Porter B and Langford M “The justiciability of social and economic rights: An updated appraisal” (2007) *Center for Human Rights and Global Justice Working Paper* 16. Fuller L and Winston K “The Forms and Limitation of Adjudication” (1978) 92 *Harvard Law Review* 353.

<sup>83</sup> Mbazira C (2009) 208.

<sup>84</sup> Olivier M “Constitutional Perspectives on the Enforcement of Socio-Economic Rights: Recent South African Experiences Victoria” (2002) *University of Wellington Law Review* 133.

<sup>85</sup> Olivier M (2002) 133.

However, while it is argued that judicial encroachment to the state's obligation to enforce socio-economic rights might distort the functioning of the doctrine of separation of powers and lead to serious financial implications as explained above, it is also argued that the financial and budgetary implications should not be used as a bar to the justiciability of socio-economic rights as similar implications would also be experienced in respect of civil and political rights without any compromise to their justiciability.<sup>86</sup> Thus it is important for the judiciary to step in and enforce these rights as mandated by the Constitution in those instances where the executive and legislative branches of government have ignored their constitutional obligations.<sup>87</sup>

### 2.5.1 The Justiciability of Socio-Economic Rights

From the point of view of politics and economics, there can be considerable argument about the wisdom of requiring the state to deliver a list of socio-economic goods to the populace. For lawyers, however, the principal difficulty with socio-economic rights lies in their justiciability. That is the extent to which they can and should be enforced by a court. The idea of justiciability in the Bill of Rights is that decisions affecting basic rights and liberties should be reviewed by an institution standing outside the political sphere, namely, the judiciary.<sup>88</sup> Attempts to make social, economic and cultural rights parts of the Bill of Rights are usually met with objections that these particular rights are not suited to judicial enforcement.<sup>89</sup>

There are two strains to the argument against judicial enforcement of socio-economic rights. They can be described as the argument on separation of powers and the argument on polycentricism. In respect of the separation of power argument, it is argued that because socio-economic rights are positive rights, claims by individuals and groups over rights such as the delivery of goods by the government will not require the courts to direct the way in which the government distributes the state's resources. For this reason, they are beyond the proper scope of the judicial function. The judiciary is an elite and undemocratically appointed branch of the state. Therefore, it lacks the democratic legitimacy necessary to decide the essentially political question of how to apportion public resources among competing claims and among individuals, groups, and communities in society. It is usually the responsibility of democratically elected representative branches of the state, such as parliament, to engage in particular practices or imposing particular duties or conditions on groups and individuals.<sup>90</sup>

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<sup>86</sup> Olivier M (2002) 133.

<sup>87</sup> Mbazira C (2009) 235.

<sup>88</sup> De Vos P *et al* (2015) 685. Currie and De Waal (2013) 72-82.

<sup>89</sup> Currie and De Waal (2013) 72-82.

<sup>90</sup> Currie and De Waal (2013) 565-567. De Vos P *et al* (2015) 684 and 691.

But this is a thought quite distinct from a situation in which the judiciary has the power to order these branches of state to distribute or spend public resources in a particular manner. As in the separation of powers argument, the argument on polycentricism focuses on the limits of adjudication. As illustrated by Currie and De Waal, Courts typically resolve disputes between two parties, each of whom can represent its interest and find in favour of one party and against the other by application of general principles or rules.<sup>91</sup> The type of situation in which the resolution of disputes usually gives rise to polycentric issues is that in which an individual winner claims victory. That is not suitable for these kinds of issues. They should preferably be reconciliatory in a manner that would bring the parties together in the hope that the issues brought against each other can be resolved in a manner where all of the parties involved are victors. The polycentric task entails the co-ordination of mutually interacting variables. A change in one variable will produce changes in all of the others.<sup>92</sup> A classic example of a polycentric task is the assignment of the players in a football team to their positions. A shift of position of one of the players may have a different set of repercussions on the task being performed by each player. Such tasks are not amenable to being performed by adjudication. Although there are polycentric elements in almost all problems submitted to adjudication, the degree of polycentricity in socio-economic rights litigation is inevitably extremely high. Take, for example, the issue confronted in *Soobramoney*. Faced with considerable budgetary, personnel and infrastructure constraints, the KwaZulu-Natal health department decided to make dialysis treatment available to only those patients who were candidates for kidney transplants. The money and personnel resources saved as a result of this decision were deployed elsewhere to fulfil other pressing needs. By challenging the decision to deny him access to treatment, the applicant was challenging the failure to allocate resources to him. If the Constitutional Court had decided that Mr. Soobramoney and others in his position were entitled to dialysis treatment, the decision would affect not only the individual but also the complex web of mutually interacting resources allocations.<sup>93</sup>

The Constitutional Court discussed the nature of socio-economic rights and the problems associated with judicial enforcement of them in the first *Certification judgment* and responded to some of these arguments.<sup>94</sup> The court stated that it is true that the inclusion of socio-economic rights in the Constitution may result in courts making orders which have direct implications on budgetary matters. However, even when a court enforces civil and political rights such as equality, freedom of speech and the right to a fair trial, the order it makes will often have such implications. A court may require the provision of legal aid, or the extension of state benefits to a class of people

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<sup>91</sup> Currie and De Waal (2013) 566.

<sup>92</sup> Currie and De Waal (2013) 566.

<sup>93</sup> Carstens & Pearmain (2007) 157 – 164.

<sup>94</sup> Mailula DT (2003) para 1.

who formerly were not beneficiaries of such benefits. In our view, it cannot be said that by including socio-economic rights within a Bill of Rights, a task is conferred upon the courts so different from that ordinarily conferred upon them by a Bill of Rights that results to a breach of separation of powers. Nevertheless, we are of the view that these rights are, at least to some extent justiciable.<sup>95</sup> Darby concurs with the Constitutional Court's view and argues that their incorporation into the Bill of Rights as justiciable rights is deemed necessary to render the Constitution instrumental in effecting positive and progressive social change in South Africa, where as a result of its past, a vast majority of its citizens are still impoverished as they were deprived of such rights.<sup>96</sup>

## 2.6 The Right to Access to Health Care under International Human Rights Law

The right to health care is a universal terminology which originated from international instruments such as the International Convention on Economic, Social and Cultural Rights (ICESCR) of which many civilised nations are signatories, with South Africa not being excluded. However, the South African Constitution mandates the government and its institutions to provide access to health care facilities to all who live in it. No one is to be discriminated in the provision of health care services.<sup>97</sup> A number of international and regional instruments protect the right to health, including the Universal Declaration of Human Rights (UDHR), (article 24), the International Covenant on Economic, Social and Cultural rights (article 12), the African Charter on Human and People's Rights (ACHPR) (article 16), and the Convention on the Rights of the Child (CRC).<sup>98</sup> International organisations such as the United Nations Organisation (UNO) considered it necessary to enact the United Nations' Charter on the right to have access to health care because it was becoming a right which some member states were not enforcing to the satisfaction of the people. Therefore, all that was necessary was a mandate to compel member states to include this provision into their various constitutions. A question of concern however, is what quality of access to health care does the Constitution seek to guarantee to the people? Is it just access to medical health, or access that yields and provides abundant results to the people who need these health care services? Health

<sup>95</sup> De Vos P et al (2015) 688. See also Dugard J (2011) 559.

<sup>96</sup> Darby D *Rights Race and Recognition* (Cambridge University Press 2009) 135-136.

<sup>97</sup> De Vos P et al (2015) 677. Currie and De Waal (2013) 570.

<sup>98</sup> The Universal Declaration of Human Rights (UDHR) is a declaration adopted by the United Nations General Assembly on 10 December 1948 at the Palais de Chaillot, Paris. The Declaration arose directly from the experience of the Second World War and represents the first global expression of rights to which all human beings are inherently entitled. The full text is published by the United Nations on its website. In 1966 the General Assembly adopted the two detailed Covenants, which complete the International Bill of Human Rights; and in 1976, after the Covenants had been ratified by a sufficient number of individual nations, the Bill took on the force of international law. De Vos P et al (2015) 676. Currie and De Waal (2013) 571. Dugard (2011) 561.

care services, be it the right to have access to it or health, is a life prerequisite which is in limited supply to the poor and available in abundance to the wealthy, who can afford to pay for it. The right to have access to healthcare as an indispensable tool needed to guarantee a dignified human life is therefore in short supply among the poor and in over-supply in the terrain of those who can afford to pay for health care services. Politics have become deeply entrenched in the provisions of basic amenities. The victims are the people whom the Constitution seeks to protect with the right in section 27. This shortcoming on the part of the health care providers is unfortunately a problem that is plaguing not only South Africa but the entire African continent as evident in the number of innocent citizens who die as result of denial of adequate health care services. These challenges have as a result pushed the framers of the South African Constitution to place emphasis on the right to have access to health care services as against the right to health care envisaged in international instruments such as the International Convention on Economic, Social and Cultural Rights.<sup>99</sup>

The right to have access to health care services appears to elevate health to higher level in that providing health is just not enough in the twenty first century where the demands and needs of the scares amenities or resources have become highly a necessity rather than a luxury. The prominent of most killer diseases such as HIV/AIDS and cancer have brought with them additional burdens to add to those the government traditionally had to battle against in order to provide adequate health care. The race to reach the goal of providing the requisite access to health care service in the modern world is no longer an individual fight that countries have to fight independently. The road to achieving this goal involves working as a team with the co-operation of the international community by acknowledging the value of human existence and the importance of health care services in relation to human life.<sup>100</sup> The right to have access to health care services will therefore be realised if there is the will and commitment of the international community and individual governments to increase efforts to meet the basic health care needs of their people. This can only be made possible by prioritising health care services and health as vital commodities or services in the process of government service delivery. The United Nations through its convention must take the

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<sup>99</sup> *The Right to Health* (World Health Organization). The right to health is an inclusive right. We frequently associate the right to health with access to healthcare and the building of hospitals. This is correct, but the right to health extends further. It includes a wide range of factors that can help us lead a healthy life. The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights, calls these the “underlying determinants of health”. They include: safe drinking water and adequate sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and information; gender equality. See Dugard (2011) 329-343.

<sup>100</sup> UN Committee on Economic, Social and Cultural Rights. *General Comment 14: The Right to the Highest Attainable Standard of Health*, Geneva, Switzerland: United Nations: 2000 UN Document E/C.12/2000/4 [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument). (Date of use: 25 May 2015).

lead, and the whole of government must be mandated to ratify the convention or treaty and to urge various government departments to allocate a reasonable portion of the budget to the provision of health care services. Individual governments must work in collaboration with domestic authorities to pass laws that promote the provision of access to healthcare services to the people who really need it in society.<sup>101</sup> The realisation and acknowledgement of the importance that the right to have access to health care services deserves can help to impose a positive obligation on the State to realise progressively the full provision of access to health care services for all.

## 2.7 The Relationship between Section 27 and other International Instruments

The right to have access to health care is acknowledged as a fundamental human right. This right has expressly and impliedly been supported by international organisations as well as international law instruments to which South Africa is a member and signatory respectively.<sup>102</sup>

An applicable international instrument relating to the enforcement of socio-economic rights is the International Covenant on Economic, Social and Cultural Rights of 1966. The Convention has been ratified by approximately 130 states. South Africa has signed the convention but has not yet ratified same.<sup>103</sup> The substantive rights that are recognised by the Convention are to work under just and favourable conditions of work, rest and leisure, to form and join trade unions and to strike, social security, special protection for the family, mothers and children and adequate standard of living, including food, clothing and housing, physical and mental health, education, scientific and cultural life.<sup>104</sup> The basic obligation imposed by the Convention on a member state is “to take steps to the maximum use of its available resources, with a view to achieving progressively the full realisation of the right by all appropriate means, including particularly the adoption of legislative measures.”<sup>105</sup> This provision has been described as imposing an obligation on member states to move as expeditiously and effectively as possible towards realising the listed objectives. South African courts have generally referred to the ICESCR and the general comments of the CESCR when interpreting socio-economic rights under the Constitution as the Constitution empowers

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<sup>101</sup> Office of the United Nations High Commissioner for Human Rights Fact Sheet No 31 “*The Right to Health*” <http://www.ochr.org/Documents/Publications/Factsheet31.pdf> (Date of use: 25 May 2015).

<sup>102</sup> . Office of the United Nations High Commissioner for Human Rights Fact Sheet No 31 <http://www.ochr.org/Documents/Publications/Factsheet31.pdf> (Date of use: 25 May 2015).

<sup>103</sup> Currie and De Waal (2013) 570.

<sup>104</sup> International Covenant on Economic, Social and Cultural Rights (Adopted and open for signature, ratification by General Assembly resolution 2200A (XXI) of 16 December 1966) Art 6, Art 7, Art 8, Art 9 and Art 10.

<sup>105</sup> Article 2(1) of the International Convention on Economic, Social and Cultural Rights of 1966 (ICESCR).

courts to have regard to international law when interpreting the Bill of Rights.<sup>106</sup> The case of *Government of the Republic of South Africa v Grootboom* is an outstanding example of a case in which various sources of international law was used in defining and interpreting the term ‘progressive realisation’ and ‘within available resources’ as used in section 27(2) of the Constitution.<sup>107</sup>

Other applicable international instruments are the United Nations General Assembly Declaration on the Right to Development 1986 (UNDRD) and the Convention for the Elimination of all forms of Discrimination against Women (CEDAW) to which South Africa is a state party,<sup>108</sup> which expressly states in Article 12 that states must adopt measures to eliminate any discrimination in the field of health care in order to ensure that they have access to health care services.<sup>109</sup> Currie and De Waal argue that in interpreting Article 8 of the UNDRD, the United Nations explicitly includes health care services as a fundamental right to human existence that is needed to sustain and maintain life.<sup>110</sup> The right to have access to health care services is a basic tool that when in adequate supply can protect the poor who really need this necessary tool to survive. However, the problem seems to be the persistent conditions of underdevelopment in most of the provinces or municipalities that cannot meet their budgetary responsibility to millions of people in society. Some of these impediments are not only due to budgetary constraints, but corruption and maladministration play a pivotal role in denying people the promise of constitutionalism and human rights protection. The lack of the basic amenities such as food, water, clothing, housing and medicine inadequate quantity represent a clear danger and a flagrant “mass violation” of human rights and the fundamental rights as provided for in Chapter 2 of the Bill of Rights in the South African Constitution.<sup>111</sup>

The right of access to health care services can also be derived from certain international law instruments. The derivation of rights is defined as a situation where a right flows from something to accumulate to another thing. A derivative right is therefore a right derived from other related or

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<sup>106</sup> Section 39 of the South African Constitution. *S v Makwanyane* 1995 (3) SA 391 (CC). In this case, it was held that courts could consider binding as well as non-binding international law for interpretation.

<sup>107</sup> Mwambene L “Litigating Socio-Economic Rights at the International Level: Introducing the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights” (2009) 2 *ESR Review* 5.

<sup>108</sup> De Vos P *et al.* *South African Constitutional Law in Context* (Oxford University Press 2015) 676.

<sup>109</sup> Convention on the Elimination of All Forms of Discrimination against Women (Adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1997) Art 12.

<sup>110</sup> Currie and De Waal (2013) 592.

<sup>111</sup> Section 27 of the Constitution.



dependent rights.<sup>112</sup> The derivative argument maintains that health is a basic human right and although the International Bill of Rights does not specifically spell out a direct right to health care services, this right could be derived from other rights such as the right to life, the right to adequate standard of living and health.<sup>113</sup> The derivative argument asks the question whether a set of claims that have not been explicitly recognised in legally binding documents might nonetheless be seen as inherent, express or implied rights.<sup>114</sup> By analogy, the derivative argument can also be extended to the right of access to health care services. For instance in Article 24 of the Convention on the Rights of the Child, the United Nations places emphasis on children's right to quality health care.<sup>115</sup> If the derivative argument is applied to this provision by analogy, it might be conclusive to state that although the aforesaid Convention only makes mention of a child's right to quality healthcare, the right of access to health care services could be derived from the aforesaid convention. This argument can further be supported by the fact that official commentary on the convention even sets out principles and premises to realise the above rights to quality health care accorded to children.<sup>116</sup> It maintains therefore that every child has the right to have access to health care services and this right is fundamental to be protected.

The right to have access to health care services can also be derived from the International Human Right Bill (Universal Declaration of Human Rights 1948). This convention does not specifically spell out a direct right to have access to health care services. This right could be derived from other rights listed in the convention. The important and special position granted the right to health and wellbeing can be construed to mean the right of access to health care services.<sup>117</sup> These international instruments can be praised for having laid the foundation for different countries to adopt measures that may be more beneficial to human health. These international conventions create state obligations and support individual rights at the national level. The court in some

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<sup>112</sup> Amanda C "The Human Right to Water-A Right of Unique Status": 'The Legal Status and Normative Content of the Right to Water'" (2005) 9 *International Journal of Human Rights* 389-390.

<sup>113</sup> Turk E and Krajweski M "The right to water and trade in services: assessing the impact of GATS negotiations on water regulations" (Paper presented at the CAT+E conference, "Moving forward from Cancun" Berlin, 30-31 October 2003) 2. Amanda C (2005) 389-390.

<sup>114</sup> Amanda C (2005) 390.

<sup>115</sup> Article 24 of the Convention on the Rights of the Child reads as follows:

"(1) States parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services ... (b) to ensure the provision of necessary medical assistance and healthcare to all children with emphasis on the development of primary healthcare."

<sup>116</sup> Convention of the Rights of the Child: General Comment No.15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health.4-5.

<sup>117</sup> Universal Declaration of Human Rights 1948.

countries has invoked some of these international instruments while addressing legal issues relating to socio-economic rights. For instance, the Constitutional Court of Columbia while delivering its decision in *Decision T-760 of 2008*, reaffirmed the right to health as a fundamental right and further examined the international legal obligation of the State of Columbia in respect of the right to health care and in particular the State's obligation under General Comment Number 14 of UNCESCR.<sup>118</sup> In simple terms, reference to this case law means that the threshold of any national government cannot be lower than what international instruments mandates.<sup>119</sup>

However, when these international instruments are compared with Section 27 of the South African Constitution, it is conclusive to state that the South African Constitution is more comprehensive in respect of its protection of the right of access to health care services. This is because the South African Constitution places much emphasis on the provision of access to health care services. If this position is critically examined, we would realise that it embodies not just the ordinary provisions relating to access to health care services but also provides for quality access that protects and enhances human life and existence. It can further be argued that the benefit realised from the South African provisions appears to be more productive and beneficial than the provisions in international instruments, which advocate only for the right to have access to health. It will also appear from the South African Constitution that if it had not taken the initiative to emphasis on access to health care, the right in section 27 could have been interpreted to mean only the right to health.<sup>120</sup> In stressing out the need for accessibility therefore, makes the South African Constitution more comprehensive than most international instruments although the latter has a direct and indirect impact on health law and policy making in South Africa.<sup>121</sup>

## **2.8 The Right to Health Care under the African Human Rights Charter**

As mentioned above, the South African Constitution is concerned with making health care services accessible to everyone within South Africa. When section 27 of the Constitution is compared with provisions under international instruments, it appears that the South African position is more comprehensive than these international instruments in protecting the right of access to health care services.<sup>122</sup> The government must make health care accessible to all the people. What this entails

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<sup>118</sup> Judgment T-760/08 (Constitutional Court of Columbia, July, 31 2008).

<sup>119</sup> *Soobramoney v Minister of Health*.

<sup>120</sup> Carstens and Pearmain (2007) 25-26.

<sup>121</sup> South African Human Rights Commission (*Report and Recommendation based on the submissions and proceedings of the Public Hearing conducted at the national office of the South African Human Rights Commission, Parktown, Johannesburg from 30 May to 1 June 2007*) 21.

<sup>122</sup> Section 27(1) of the Constitution.

is a matter of simple interpretation. That is the people must be able to access health care services irrespective of the part of the country in which they reside. However, the will to make socio-economic rights available to the people has not only been expressed in the South African Constitution. It has also been expressed in regional instruments such as the African Charter on Human and Peoples' Right (ACHPR).<sup>123</sup> The African Charter became the first regional human rights instrument to explicitly guarantee civil and political rights and socio-economic rights as enforceable rights.<sup>124</sup> South Africa has ratified the African Charter on Human and Peoples' Rights and this charter entrenches socio-economic right including the right to health.<sup>125</sup> Article 16 of the African Charter guarantees the right to health by providing that every individual shall have the right to enjoy the highest attainable state of physical and mental health. It further provides that states should take all necessary measures to protect the health of their people.<sup>126</sup> The African Commission on Human and People's Right is the body enjoined to interpret the African Charter and ensure that state's adheres to their obligation under the charter.<sup>127</sup> In 2003 another major step was taken in the realisation of the right to health by the African Union. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women (PACHPRRW) was adopted to ensure that the right of women to health including sexual and reproductive health of women is respected and promoted among member states.<sup>128</sup> In 2008, the Commission met at its 44<sup>th</sup> Ordinary session in Abuja Nigeria. During this session the African Commission (AC), reaffirmed the need to guarantee the right to enjoy the best attainable state of physical and mental health and to ensure that everyone had access to medical care. In doing so, the Commission called on member states to guarantee the full scope of access to medicines as it concluded that access to medicines formed an indispensable part of the right to the highest attainable standard of health.<sup>129</sup> In recent times, the African Commission has through its jurisprudence attempted to clarify the nature of state's obligation in respect of socio-economic rights including the right to health.<sup>130</sup> Although very limited cases relating to a violation to the right to health has been brought before the Commission, the Commission has nonetheless strive to provide a purposive interpretation to the

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<sup>123</sup> African Charter on Human and People's Right 1986.

<sup>124</sup> Durojaye E and Mirugi-Mukundi G "Compendium of documents and cases on the right to health under the African human rights system" (2013) *Community Law Center University of the Western Cape* 2.

<sup>125</sup> Currie and De Waal (2013) 573.

<sup>126</sup> Article 16 of the African Charter on Human and People's Right 1986.

<sup>127</sup> Currie and De Waal (2013) 573.

<sup>128</sup> Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa [http://www.achpr.org/files/instruments/women-protocol/achpr\\_instr\\_proto\\_women\\_eng.pdf](http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf) (Date of use: 27 May 2015).

<sup>129</sup> See Resolution 141 (XXXVIII) 08 of the African Commission on Human and Peoples' Rights: Resolution on Access to Health and needed Medicines in Africa [http://www.old.achpr.org/english/resolutions/resolution141\\_en.htm](http://www.old.achpr.org/english/resolutions/resolution141_en.htm) (Date of use: 27 May 2015).

<sup>130</sup> Durojaye E and Mirugi-Mukundi G (2013) 2.

provision relating to the right of health to the few that have been brought before it.<sup>131</sup> For instance, in *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v. Nigeria*, the African Commission appealed to the government of the Federal Republic of Nigeria to ensure protection of the environment including health and livelihood of the people when the Nigerian government was held to be in violation of Article 16 of the African Charter of Human and Peoples' Rights.<sup>132</sup> Also, in *Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine des Droits de l'Homme, les Temoins de Jehovah / DRC*, the African Commission held that the failure of the government of the Democratic Republic of Congo to provide basic services such as safe drinking water, electricity and the shortage of medicine constituted a violation of Article 16 of the African Charter on Human and Peoples' Right.<sup>133</sup> These decisions demonstrates a commitment by the African Commission to ensure that member states take all necessary measures to protect the right to health of their people.

## **2.9 The Relationship between the Right to Access to Health Care and other Basic Rights in the 1996 Constitution**

Under the South African Constitution, it is clearly demonstrated that no right can be enjoyed to the exclusion of any other right. The Bill of Rights makes no distinction between socio-economic, political and civil rights. These rights are given the same status under the Constitution.<sup>134</sup> It can therefore be said that these rights are interrelated as the right of access to health care services would require that certain other rights enshrined in the Constitution are fulfilled in order for it to be realised. The Constitutional Court's decision in *Grootboom* concurs with this view as the Court stated that the rights in the Constitution are mutually supportive and have a significant impact on the dignity of people and their quality of life.<sup>135</sup> Therefore, the right of access to health care services must be seen in conjunction with other rights of the Constitution. However, as cautioned by Cahill in the context of the right to water and its relationship to other socio-economic rights, I am also of the opinion that the relationship between the right of access to health care services and other basic rights in the Constitution has to be investigated and the parameters of each

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<sup>131</sup> Durojaye E and Mirugi-Mukundi G (2013) 2.

<sup>132</sup> 155/96 *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v. Nigeria* (2001).

<sup>133</sup> 25/89-47/90-56/91-100/93: *Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine des Droits de l'Homme, Les Temoins de Jehovah v DRC* (1995).

<sup>134</sup> Olivier M (2002) 135.

<sup>135</sup> *Government of the Republic of South Africa v Grootboom*. Olivier M (2002) 135.

established in order to define the extent to which they can contribute to the realisation of the right to access health care services in order to ensure an effective implementation of this right.<sup>136</sup>

## 2.10 Positive Obligation in the 1996 Constitution

Under Section 27(2), the State is required to take reasonable legislative as well as other measures to ensure a progressive realisation of the right to access health care services. The phrase “reasonable legislative measures and other measures” is derived from Article 2 of ICESR and an extensive interpretation of the phrase is given in General Comment No.3, in which the UN Committee on Economic, Social and Cultural Rights (CESCR) states that despite the existence of conditions of progressive realisation and availability of resources, states are obliged to take steps to realise the rights within a reasonable short time after the enforcement of the ICESR.<sup>137</sup> In stating this, the Committee requires that states should take concrete and deliberate steps that will meet the obligation of realising socio-economic rights.<sup>138</sup> According to section 27(2), the state is therefore compelled to promote, respect, protect and fulfil the right of access to health care services. In doing so, the state is required to strive towards the fulfilment and improvement in the enjoyment of this right to the maximum extent possible even in the face of resource constraint.<sup>139</sup> This provision suggests a duty for the state either to take positive action to implement the right of access to health care services or to refrain from actions that would limit its realisation.<sup>140</sup> The government therefore has the democratic mandate to formulate policies that would ensure the realisation of socio-economic rights including the right to have access to health care services. In doing this, the state’s responsibilities are being reviewed by the judiciary as empowered by the Constitution. The Constitution empowers the judiciary with the authority to ensure that the rights enshrined in the Constitution are enforced and to adjudicate any dispute that can be resolved by the application of the law.<sup>141</sup> However, as pointed out in *Grootboom*, this obligation imposed upon the state is not an absolute obligation as the extent of the state’s obligation is defined by three essential elements which are (a) the obligation to “take reasonable legislative and other measures”; (b) “to achieve the progressive realisation” of the right; and (c) “within available

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<sup>136</sup> Amanda C (2005) 394.

<sup>137</sup> General Comment No 3 Fifth session (1990) UN doc.E/1991/23.

<sup>138</sup> General Comment No 3 Fifth session (1990) UN doc.E/1991/23.

<sup>139</sup> Chenwi L “Unpacking “progressive realisation”, its relation to resources, minimum core and reasonableness, and some methodological considerations for assessing compliance” (2013) *De Jure* 744-746.

<sup>140</sup> Ngang CC (2014) 662.

<sup>141</sup> See Section 8(1) and Section 34 of the Constitution.

resources.<sup>142</sup> This makes the obligation difficult to be reviewed and adjudicated upon by the judiciary.

In view of the above, the Constitutional Court has developed a standard of review for assessing compliance with Constitutional obligations in the area of socio-economic rights including the right of access to health care services by the government. This standard allows for an assessment of the reasonableness of the measures taken by the government to realise socio-economic rights within its available resources.<sup>143</sup> Another issue of contention has been the question of the extent to which courts may review, reverse or strike out policies decided upon by the government and the parliament to realise socio-economic rights. It is argued that judicial enforcement of socio-economic rights touches upon constitutional issues such as the doctrine of separation of powers which therefore makes such rights non-justiciable.<sup>144</sup> Because of this, courts have become very reluctant in assuming the powers vested upon them by the Constitution.<sup>145</sup> However as pointed out by Ngang, given South Africa's historical background, there is a genuine reason for entrusting the courts with the authority to enforce socio-economic rights including the right of access to health care services in order to protect the vulnerable and marginalised against state repression.<sup>146</sup> This view is affirmed in the judgment delivered in *Grootboom* in which Yacoob J, stated that the application of socio-economic rights is an 'obligation that courts can, and in appropriate circumstances, must enforce'.<sup>147</sup> Therefore, it is necessary for the state's approach towards the realisation of socio-economic rights including the right to access health care services, to be subjected to judicial scrutiny. An interactive commitment between these organs will fulfil the constitutional vision of transformation from socio-economic deprivation to equitable distribution of resources with the aim of advancing the welfare of the poor.<sup>148</sup>

## 2.11 Limitation of Rights under the 1996 Constitution

Section 36 of the Constitution of South Africa states that

- (1) The rights in the Bill of Rights may be limited only in terms of the law of general application to the extent that the limitation is reasonable and justifiable in an open and

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<sup>142</sup> *Government of the Republic of South Africa v Grootboom* para 38.

<sup>143</sup> Coomans F "Reviewing Implementation of Social and Economic Rights: An Assessment of the "Reasonableness" Test as Developed by the South African Constitutional Court" (2005) 65 *Heidelberg Journal of International Law* 168.

<sup>144</sup> Currie and De Waal (2013) 72-82.

<sup>145</sup> Liebenberg S *Socio-economic rights: Adjudicating under a transformative Constitution* (Juta & Co Ltd 2010) 25.

<sup>146</sup> Ngang CC (2014) 663.

<sup>147</sup> *Government of the Republic of South Africa v Grootboom* para 94.

<sup>148</sup> Mbazira C (2009) 1.

democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including—

- (a) the nature of the right;
- (b) the importance of the purpose of the limitation;
- (c) the nature and extent of the limitation;
- (d) the relationship between the limitation and its purpose; and
- (e) less restrictive means to achieve the purpose.<sup>149</sup>

The Constitution therefore confers rights on individuals but it also authorises the limitation of these rights in the limitation clause as seen in the provision above. According to this provision socio-economic right including the right of access to health care services may be limited by a law of general application, provided that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. This implies that the rights in the Bill of Rights cannot be limited for just any reason as pointed out by Currie and De Waal.<sup>150</sup> The Constitution therefore uses the limitation clause in a two stage constitutional analysis which looks first at whether there has been a violation of the right guaranteed under the Constitution and secondly, whether the violation can be justified under the limitation clause.<sup>151</sup> These stages are classified by Woolman as the fundamental right stage and the limitation stage. According to him the fundamental stage entails an inquiry into the nature of the right limited and its importance in an open democratic society based on freedom and equality. Under this stage the burden of proof lies on the applicant to show that there has been a violation of the state's constitutional duty to fulfil socio-economic rights.<sup>152</sup> On the other hand the limitation stage directs our attention primarily, and if not exclusively, to the reasonableness and justifiability of a limitation in an open democratic society based on human dignity, freedom and equality.<sup>153</sup> This stage entails that the person of authority advocating for limitation provide reasons to justify the limitation.<sup>154</sup> This stage therefore encompasses an analysis of the reasonableness and the justification of the limitation, in the context of a democratic society based on human dignity, equality and freedom. That is the respondent must satisfy the entire limitation clause's requirement as provided in section 36 of the

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<sup>149</sup> Section 36(1) of the Constitution. Currie and De Waal (2013) 101.

<sup>150</sup> Currie and De Waal (2013) 151.

<sup>151</sup> Orago NW "Limitation of Socio- Economic Rights in the 2010 Kenyan Constitution: A Proposal for the Adoption of a Proportionality Approach in the Judicial Adjudication of the Socio-Economic Rights Disputes" (2013) 5 *PELJ* 199.

<sup>152</sup> Woolman S "Out of Order? Out of Balance? The Limitation Clause of the Final Constitution" (1997) *SAJHR* 108.

<sup>153</sup> Woolman S (1997)108.

<sup>154</sup> Orago NW (2013) 200.

Constitution.<sup>155</sup> An issue of contention in court however is whether the standard of determining the reasonableness under section 27(2) of the Constitution is a similar standard used in determining the reasonableness and justifiability of the limitation under section 36(1). In this regard, Iles argues that the limitation analysis under section 27(2) is totally distinct from the limitation set out in section 36. In his opinion, the former is aimed at the examination of a plan for the realisation of socio-economic rights while the former is not aimed at realising rights but an examination of the measures that limit rights.<sup>156</sup> The standard of reasonableness therefore relates to a measure that is aimed at limiting a right which as required by the Constitution must serve a purpose which is worthwhile and important in a constitutional democracy.<sup>157</sup>

### 2.11.1 Application of the Limitation Clause to Socio-economic Rights

Interestingly, the limitation clause has not been applied in certain important decisions relating to the enforcement of socio-economic rights in South Africa. In *Grootboom* and in the *Treatment Action Campaign* cases, the Constitutional Court made no reference to the general limitation clause.<sup>158</sup> In *Grootboom*, despite finding that the State's housing programme fell short of the obligations imposed by section 26(2), the possibility of justifying these shortcomings in terms of section 36 was not canvassed. Similarly, no attempt was made in the *Treatment Action Campaign* case to justify the deficiencies in the State's programme for the prevention of mother-to-child transmission of HIV as legitimate limitations of the right to health care. The reason why the limitation clause was inapplicable in these cases is, of course, that none of these cases involved the use of a law of general application to infringe rights.<sup>159</sup> The problem with the State's programme in *Grootboom* was precisely that of the absence of legislative or other measures providing for emergency relief.<sup>160</sup> Similarly, in the *Treatment Action Campaign* case, the violation of section 27(2) was caused by a failure to develop a comprehensive programme to combat mother-to-child transmission of HIV.<sup>161</sup> The court have also acknowledged the difficulty of applying section 36 in cases relating to the enforcement of socio-economic rights due to the internal limitation requirement which requires the state to go no further than to take reasonable legislative and other measures within its available resources to achieve a progressive realisation of any socio-economic

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<sup>155</sup> Cheadle H "Limitation of Right" in Cheadle H, Davis DM and Haysom N (eds) *South African Constitutional Law: The Bill of Rights* (LexisNexis Butterworths Durban 2002) Chapter 30, 9-11.

<sup>156</sup> Iles K "Limiting Socio-Economic Rights: Beyond the internal limitation clauses" (2004) *SAJHR* 456-457.

<sup>157</sup> Currie and De Waal (2013) 166.

<sup>158</sup> *Government of the Republic of South Africa v Grootboom, Minister of Health and Others v Treatment Action Campaign and Others*.

<sup>159</sup> Currie I and De Waal J *Bill of Rights Handbook* (5<sup>th</sup> ed Juta & Company 2005) (Reprinted 2008) 594.

<sup>160</sup> *Government of the Republic of South Africa v Grootboom* para 69.

<sup>161</sup> *Minister of Health and Others v Treatment Action Campaign and Others* para 38.



rights in the case of *Khosa v Minister of Social Development, Mahlaule v Minister of Social Development*.<sup>162</sup> However, Pieterse believes that it is necessary to apply section 36 to the enforcement of socio-economic rights if the limitations of such duties are to uphold constitutional values.<sup>163</sup> In his opinion, the violation of socio-economic right should not be analysed using the principle of reasonableness only but must be justified with reference to an open and democratic society based on human dignity, equality and freedom, and that a proportionality test taking into account all relevant factors must be considered.<sup>164</sup> Pieterse views has been applied in the case of *Jaftha v Schoeman*, where the court held that where the state limits negative socio-economic obligations in section 26(1) and 27(1), such limitation must be justified under section 36 of the Constitution.<sup>165</sup>

## 2.12 Remedies

In the context of socio-economic rights, establishing an appropriate and an effective remedy is a very big challenge.<sup>166</sup> In South Africa the courts have been vested with powers to grant appropriate remedies in relation to the enforcement of socio-economic rights. When dealing with constitutional matters, they have been mandated to declare invalid any law or conduct that is inconsistent with the Constitution to the extent of its inconsistency and are further mandated to make any order that is just and equitable.<sup>167</sup> In addition to this, the courts are further empowered to develop any effective remedy that will uphold the values of the Constitution.<sup>168</sup> So far, the Constitutional Court has taken the responsibility of developing a new remedy and has applied this approach to the case of *Occupiers of 51 Olivia Road and Others v City of Johannesburg and Others* relating to the right of access to adequate housing.<sup>169</sup> In this case, the Court issued an interim order in which the parties were ordered to 'engage with each other meaningfully' and report back to the Court.<sup>170</sup> Furthermore, the courts have employed a structural interdict to enforce a positive obligation. In *Grootboom v Oostenberg*, the court applied an extensive use of the structural interdict to enforce a

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<sup>162</sup> *Khosa and others v Minister of Social Development, Mahlaule and Another v Minister of Social Development* 2004 6 SA 505 (CC) para 105-107.

<sup>163</sup> Pieterse M "Towards a useful role for section 36 of the Constitution in social rights cases? *Residents of Bon Vista Mansions v Southern Metropolitan Local Council*" (2003) SALJ 45-46.

<sup>164</sup> Pieterse M (2003) 47.

<sup>165</sup> *Jaftha v Schoeman* 2005 2 SA 140 (CC).

<sup>166</sup> Chenwi L "A new approach to remedies in socio-economic rights adjudication: *Occupiers of 51 Olivia Road and Others v City of Johannesburg and Others*" (2009) 2 *Constitutional Court Review* 371.

<sup>167</sup> Section 38 of the Constitution.

<sup>168</sup> Currie and De Waal (2013) 594.

<sup>169</sup> *Occupiers of 51 Olivia Road and Others v City of Johannesburg and Others* 2008 5 BCLR 475 (CC).

<sup>170</sup> *Occupiers of 51 Olivia Road and Others v City of Johannesburg and Others* para 5.

positive obligation.<sup>171</sup> In this case, the High Court found that the conditions under which the squatters had been living were a violation in terms of section 28(1) (c) of the rights of children in the shelter. Accordingly, the court granted an order declaring that the applicant's children were entitled to be provided with shelter in terms on section 28 of the Constitution and that their parents were entitled to be accommodated with the children and further directed the state to provide such accommodation and to report to the court upon implementation of the court's order.<sup>172</sup> On appeal, however, the Constitutional Court held that the High Court's interpretation of section 28(1) (c) was incorrect as this provision did not impose an obligation on the state to provide shelter to those of the respondents who were children and, through them, their parents as this will put the applicants into a preferential position *vis-à-vis* similarly situated people who were not party to the litigation.<sup>173</sup> In the circumstances, the Constitutional Court held that, it was 'necessary and appropriate' to award a declaratory order.<sup>174</sup> In the *Treatment Action Campaign* case, the Constitutional Court outlined its remedial options in the area of socio-economic rights but did not grant a structural interdict as the Court stated that there was no ground to believe that the government would not respect the court's order.<sup>175</sup> As pointed out by Currie and De Waal, since the *Treatment Action Campaign* case, courts have increasingly used structural remedies to enforce positive obligations in respect of socio-economic rights.<sup>176</sup> Even with the willingness to utilise the structural interdict remedy, Mbazira argues that the Constitutional Court has conceptualised structural interdict to be used only as a last resort as the Court has been sceptical about this remedy in socio-economic cases because of its reluctance to be involved in protracted litigation and implementation of orders as well as for the sake of maintaining the boundaries of separation of powers.<sup>177</sup> However, some academic commentators believe that it is important for the court to develop an effective remedy in respect of the adjudication of socio-economic cases as these cases has to do mostly with the poor who often lack access to basic services.<sup>178</sup> In doing so, the transformative agenda of the Constitution will be achieved.

## 2.13 Conclusion

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<sup>171</sup> *Grootboom and Others v Oostenberg Municipality and Others* 2000 (3) BCLR 277 (C).

<sup>172</sup> *Grootboom v Oostenberg Municipality* 26-27.

<sup>173</sup> *Government of the Republic of South Africa and Others v Grootboom and Others* para 94-96.

<sup>174</sup> *Government of the Republic of South Africa and Others v Grootboom and Others*, para 96.

<sup>175</sup> Currie and De Waal (2013) 580. De Vos et al (2015) 596. *Minister of Health and Others v Treatment Action Case and Others* para 21.

<sup>176</sup> Currie and De Waal (2013) 597.

<sup>177</sup> Mbazira C (2009) 206.

<sup>178</sup> Chenwi L (2009) 372.

It can be deduced from the foregoing discussion that access to health care service in South Africa is a constitutional and a fundamental human right which is also affirmed in court decisions as well as other international human rights instruments to which South Africa is a signatory. However, the findings in this chapter reveal that despite the constitutional provision in section 27, inequities still exist in South Africa with regard to the accessibility of health care services. These findings concur with most South African studies, which reveal that access to health care services is still very limited in supply to the disadvantaged population of South Africa. Therefore, in achieving the right under section 27, it will require a comprehensive approach in undoing the aforesaid status quo.<sup>179</sup> That is, the government will have to adopt reasonable legislative and other possible measures, within its available resources, to ensure that the right to have access to health care service is protected and enjoyed by everyone. Health care services must be accessible by everybody irrespective of whether they can afford to pay for the services or not. No one should be denied this right on the basis of race, sex and religion, as this will amount to a violation of the constitutional provision in section 27 and render the provision worthless. The government is therefore called upon in this enquiry to make available to everyone health care facilities that can be accessed when the need for such health care services arises. Healthcare should not be available only to the wealthy at the expense of the poor, who constitute the majority in South Africa. Government must use its resources and through its programmes to make health care services accessible to the most vulnerable members in society. In doing so, the people will be constitutionally protected in respect of their rights under section 27 of the Constitution and the transformative agenda of the Constitution will be achieved.

In the next chapter, I shall be reviewing the horizontal application of the right of access to health care services in South Africa to determine whether section 27 of the Constitution can be enforced against non-state parties to enhance the goal of this provision. The concept of privatisation which has resulted in the private sector also becoming a key player in the provision of health care services in South Africa will be discussed and through this discussion, I shall establish how courts have applied section 27 of the Constitution to horizontal relationships. The concept of medical malpractice in South Africa will also be examined in this chapter. The reason for examining medical malpractice under this chapter is because over the years, South Africa has experienced a steep rise in medical malpractice litigation as a result of professional misconduct by some health care professionals and through these cases, some element of the horizontal application of the right of access to health care services have been established. Therefore I shall investigate under this chapter whether the steep rise in medical malpractice litigation which South Africa has

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<sup>179</sup> Harris B *et al* (2011) 18.

experienced over the years fostered the right to have access to health care and uphold the values of the Constitution.

## CHAPTER THREE: EXPLORING THE HORIZONTAL APPLICATION OF THE RIGHT TO HAVE ACCESS TO HEALTH CARE SERVICES IN SOUTH AFRICA

### 3.1 Introduction

Horizontal application of the Bill of Rights refers to the application of the provisions of the Bill of Rights to non-state entities. Traditionally, the state has been identified for carrying the obligation to protect, promote, respect and fulfil human rights. In this regard, human rights have largely been applied only to relationships involving the state. It is usually perceived that relationships involving non-state actors are based on a degree of parity between free and autonomous parties.<sup>180</sup> Furthermore, a dominant view holds that state / individual relationships involves unequal power dynamics between parties and that the state has more potential to abuse its position of authority at the detriment of an individual's interest.<sup>181</sup> In the context of socio-economic rights, it is generally accepted that it would be inappropriate to impose extensive positive duties on non state actors to realise socio-economic rights to the general public.<sup>182</sup> However, limiting the application of human rights only to vertical relationships has not been sufficient to ensure the protection of these rights.<sup>183</sup> Non-state actors such as multinational corporations have increasingly been involved and continue to commit massive violation of human rights.<sup>184</sup> These developments provide a basis for the application of human rights to relationships involving private actors.

In this regard, under the 1996 Constitution of South Africa, the possibility exists for socio-economic rights to have a certain degree of horizontal application of the Bill of Rights. Unlike its predecessor, the Interim Constitution of 1993, the 1996 Constitution is not only confined to a direct vertical application of the Bill of Rights but the Constitution further permits an indirect application of the Bill of Rights in horizontal cases.<sup>185</sup> As private parties increasingly become involved in the provision of some basic socio-economic services, the Constitution realises the need for horizontality as there may be circumstances where private parties will render positive duties to facilitate access to socio-

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<sup>180</sup> Chirwa D "Non-State Actors' Responsibility for Socio-Economic Rights: The nature of their obligation under the South African Constitution" (2002) *ESR Review* 1.

<sup>181</sup> Chirwa D (2002) 1.

<sup>182</sup> Liebenberg S "South Africa's Evolving Jurisprudence on Socio-Economic Rights" An effective tool in challenging poverty?" (2002) 6 *Law, Democracy and Development* 165.

<sup>183</sup> Chirwa D (2002) 2.

<sup>184</sup> African Commission decision on *Communication 155/96-Social, Economic and Cultural Rights Centre and Centre for Economic and Social Rights v Nigeria*.

<sup>185</sup> Currie and De Waal (2013) 45. Section 8(2) and Section 39 (2) of the Constitution.

economic services either by virtue of a special relationship or a monopoly over the supply of a particular service.<sup>186</sup>

In South Africa, private parties are also undertaking the delivery of health care services. With the advent of privatisation and deregulation of the public and private health care sector respectively, South Africa has witnessed the proliferation of a large, developed, resource intensive and highly specialised private health sector, which is dominated by medical schemes funded primarily by contributions from employers and employees.<sup>187</sup> Private health care facilities have spanned throughout the country including large multinational pharmaceutical companies with some holding exclusive patent rights over the provision of a particular service relating to health care to ensure affordability to communities across South Africa.<sup>188</sup> With the important role played by the private health sector in the provision of health care services, it is necessary to provide an effective remedy against the violation of socio-economic rights including the right to have access to health care. Accordingly, the 1996 Constitution of South Africa has an extensive framework through which section 27 (1) (a) of the aforesaid Constitution can be enforced against private entities.

This chapter will discuss the horizontal application of the constitutional right to have access to health care services in South Africa. The central focus of the chapter will be on the mechanisms by which private entities that are in violation of section 27 (1) (a), may be held accountable under the 1996 Constitution and their application in the context of South Africa. The chapter will also review the privatisation of health care services in South Africa to highlight the evolution of private entities in the provision of health care services in South Africa. It is important to discuss the privatisation of health care services in this chapter because privatisation is the process through which the private sector has become increasingly involved in the provision of health care services in South Africa. Accordingly, the role played by the private health sector in the provision of health care services is of paramount importance and cannot be ignored. In discussing privatisation, the interrelationship between privatisation and socio-economic rights will be elaborated to demonstrate how the concept has affected the delivery of socio-economic rights and services. This interrelationship is highlighted in order to illustrate the necessity to invoke the Bill of Rights between private relationships to avoid any violation of the constitutional provisions relating to the right to have access to health care. Finally, this chapter will discuss the potential of developing the common law as a remedial paradigm to give effect to certain horizontal dimensions of the right to have access to health care services. South African common law of contract and delict provides a detailed

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<sup>186</sup> Liebenberg S (2002) 166-167.

<sup>187</sup> McIntyre D, Doherty J and Gibson L "A tale of two visions: the changing fortunes of Social Health Insurance in South Africa" (2003) *Health Policy Plan* 47-58.

<sup>188</sup> Liebenberg S (2010) 330-31.

framework for the regulation of entitlements in the private health care sector and as stipulated by Pieterse, developing the common law is likely to be a comfortable exercise for South African Courts as they have in many years been engaged in this activity.<sup>189</sup> Accordingly, this enquiry will review the possibility of developing existing South African common law principles and specifically the standard of care required in cases dealing with alleged medical negligence to serve as remedial avenue through which the right to have access to health care services can be enforced against private entities to protect the public from any infringements of this right.

### **3.2 The Evolution of Non State Actors in the Provision of Health Care Services in South Africa.**

In South Africa, private entities have increasingly become involved in the provision of health care services since the advent of privatisation of the health care sector in the 1980's. Privatisation is a narrow economic process whereby material ownership, facilities and financing are being transferred from the state to the private sector. The concept entails the transfer of power, control, responsibility and management from the public sector to the private sector.<sup>190</sup> As mentioned above, privatisation became a common phenomenon in the 1980's, as it was used as a condition for the release of aid funds and debt relief to some developing countries by Bretton Wood institutions such as the World Bank (WB) and the International Monetary Fund (IMF). These institutions became disgruntled in the management of the affairs of state own enterprises.<sup>191</sup> As such, privatisation became a tool of economic reforms used by the above institutions to improve efficiency in the delivery of basic services and ultimately enhanced access to these services including health care services.<sup>192</sup> It was believed that through this policy, there would be an increase in government revenues through an increase in production that would lead to an improvement in the provision and delivery of socio-economic services and utilities like health care.<sup>193</sup>

In view of the above, the South African government embraced privatisation in the belief that it would lead to an improvement of access to health care services. Privatisation of health care in

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<sup>189</sup> Pieterse M "Indirect Horizontal Application of the Right to have Access to Health Care Services" (2007) *South African Journal on Human Rights* 160.

<sup>190</sup> Van Rensburg HCJ and Fourie A "Privatisation of Health Care Services in South Africa: In whose Interest? (1988) *Curationis* 1.

<sup>191</sup> Hurd I (2014) 73.

<sup>192</sup> Chirwa D "Privatisation and Socio-Economic Rights: Making Human Rights work in a globalising world" (2003) *Human Rights Dialogue* [www.carnegiecouncil.org/publications/archive/dialogue/2\\_09/articles/939.html](http://www.carnegiecouncil.org/publications/archive/dialogue/2_09/articles/939.html) 29 (Date of use: 02 July 2015).

<sup>193</sup> Chirwa D (2003) 29.

South Africa therefore started to take shape in the 1980's. During this period, health care which was predominantly financed and controlled by the state witnessed a shift in management. Finance and control passed on from the state to private hands.<sup>194</sup> The transformation efforts in the health sector have continued to span over the years and have further included numerous structural, legislative, policy changes, implementation of programmes for priority health conditions and improvement of access to health care services.<sup>195</sup> Today, South Africa has a large, developed, resource intensive and highly specialised private health sector which is dominated by medical schemes funded primarily by contributions from employers and employees.<sup>196</sup> In 2006, it was estimated that approximately 56% of health care expenditure was funded from private sources.<sup>197</sup> With this development, the country has witnessed some positive developments and improvements in the access of health care services and in the lives of many South Africans.<sup>198</sup> However, the problem of acute inequalities remains a reality in the context of South Africa. The democratic government of South Africa inherited a highly fragmented health care system with disparity in health care spending, inequality in the distribution of health care professionals and limited access to health care in the private and public sector.<sup>199</sup> These disparities still exist and continue to be a serious impediment to an equitable health system in South Africa as argued by many.<sup>200</sup> Furthermore, the private health sector continues to face a number of challenges including affordability and decreasing access to health care as a result of rising costs.<sup>201</sup> In view of these shortcomings, some academic commentators have been sceptical of privatisation especially with regard to health care services. Their scepticism originates from the narrowness of the concept as they argue that it has no moral and practical justification in contemporary South Africa.

In this sub-section, we shall review the interrelationship between privatisation and socio-economic rights and discuss the impact of this relationship on the right to have access to health care services. The specific objective of this study is to establish whether privatisation of health care services in South Africa has led to an improvement of the right to have access to health care services or whether it has led to a denial of the right to access health care services. Provided the

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<sup>194</sup> Van Rensburg HCJ and Fourie A (1988) 3.

<sup>195</sup> Schneider H, Barron P and Fonn S "The promise and practice of transformation in South Africa's health system" in Buhlungu S et al (eds) *State of the Nation: South Africa 2007* (Human Science Research Council 2007) 291-292.

<sup>196</sup> McIntyre D, Doherty J and Gibson L (2003) 47-58.

<sup>197</sup> Rispel L and Setswe G (2007) 3-17.

<sup>198</sup> Rispel L and Setswe G (2007) 3-17.

<sup>199</sup> Gibson L and McIntyre D "The Legacy of Apartheid" in Evans T et al (eds) *Challenging inequities in health: from ethics to action New York* (Oxford University Press 2001) 3-11.

<sup>200</sup> Rispel L and Setswe G (2007)3-17.

<sup>201</sup> Van Rensburg HCJ and Fourie A (1988) 1.



concept has led to a denial of the right to have access to health care, this sub-section will demonstrate this fact as a necessity for the horizontal application of section 27(1)(a).

### 3.2.1 Health Care Privatisation Evolution and Features in South Africa

As seen above, privatisation of health care in South Africa gained its roots within South Africa in the 1980's. Before this time, the health care system in South Africa was increasingly under the management of the state and regarded as state property.<sup>202</sup> Health care was much more socialised than privatised as it was financed and controlled by the state. However in 1985, privatisation was embraced and accepted as part of the economic policy of South Africa.<sup>203</sup> The concept was motivated by neo-liberal ideas whose proponents believed that the policy would increase productivity and efficiency and introduce a greater choice while improving the quality of health care.<sup>204</sup> On this basis, the South African government at the time endorsed privatisation and instituted a comprehensive review of the health sector through the Commission of Inquiry into Health Services (hereinafter referred to as the Browne Commission). When it finally reported in 1986, the Browne Commission highlighted the overall problems of excessive fragmentation of control of health services and a lack of policy direction which resulted to misallocation of resources, duplication of services and poor communication between administrative tiers.<sup>205</sup> In view of the above shortcomings envisaged under the more socialised health care sector, the commission recommended the privatisation of the non-core public health sector functions and the deregulation of the private health sector.<sup>206</sup> As such, the then government of South Africa in statements contained in the recommendations of the Browne commission, endorsed and approved privatisation as a policy in respect of the health care sector.<sup>207</sup> Privatisation gave the private health sector a last and prominent position in the provision of health care in South Africa.<sup>208</sup> The mid 1980's was further characterised by the deregulation of the private health sector which saw the deregulation of the medical schemes industry driven by medical cost escalation and the

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<sup>202</sup> Van Rensburg HCJ and Fourie A (1988) 3.

<sup>203</sup> Jerome A "Privatisation and Regulation in South Africa. An Evaluation" ( Paper delivered at the 3rd International Conference on Pro-Poor Regulation and Competition Issues, Policies and Practices September 2004 Cape Town-South Africa) 7-9.

<sup>204</sup> Chapman A "The Impact of Reliance on Private Sector Health Services on the Right to Health" (2014) *Health and Human Rights Journal* 122-134.

<sup>205</sup> Schneider H, Barron P and Fonn S ( 2007) 291-292.

<sup>206</sup> Schneider H, Barron P and Fonn S (2007) 292.

<sup>207</sup> Naylor CD "Privatisation of South African Health Services – Are the Underlying Assumptions Correct?" (1987) *SAMJ* 673.

<sup>208</sup> Ngwenya C "The Historical Development of the Modern South African Health-Care System: From Privilege to Egalitarianism" in Van Der Walt AJ (ed) *Theories of Social and Economic Justice* (SUN PRESS 2005) 109.

emergence of a non-employment-linked or an open medical scheme and the movement of for-profit commercial insurers.<sup>209</sup>

With the advent of the democratic government in South Africa, private health care continues to play a dominant role in a wider health care economy especially with amendments to the Medical Scheme Act,<sup>210</sup> which allowed contracting and vertical integration between medical schemes and private health care providers.<sup>211</sup> As discussed above, South Africa has a large private health sector made up of private health care providers, institutions that represent health professionals and private health facilities.<sup>212</sup> It was estimated in 2013, that there were 7,529 general practitioners, 6,729 specialists and 77,569 nurses actively working in the private health sector.<sup>213</sup> It was further estimated that there were approximately 3500 privately run clinics as well as 300 private hospitals and day clinics with a total of 34,000 beds in the private health sector in 2013.<sup>214</sup> The private health sector is further dominated by medical schemes funded primarily by contributions from employers and employees.<sup>215</sup> Accordingly, alongside the abovementioned private health care facilities, there is a large industry responsible for the funding and administration of private health care. In 2013, it was again estimated that 25 open and 67 restricted medical schemes, were involved in administering private health care among other health insurers.<sup>216</sup>

It can be deduced from the foregoing that the private health sector plays a pivot role in assisting the government to fulfil its constitutional mandate of providing quality health care and in ensuring that all South Africans have access to health care services. It is further estimated that approximately half of the national health expenditure is being spent on the private health care sector.<sup>217</sup> In this regard, the role played by the private health sector in South Africa cannot be ignored. This sector has grown and developed in South Africa as a response to the historical path of policy in the health care sector and as a result of the short comings envisaged in the public

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<sup>209</sup> Söderlund N, Schierhout G and Van Den Heever A "Private Healthcare in South Africa: Technical Report to Chapter 13 of the 1998 South African Health Review" (1998) *Health System Trust* 3.

<sup>210</sup> Medical Scheme Act No.131 of 1998.

<sup>211</sup> Söderlund N, Schierhout G and Van Den Heever A (1998) 3.

<sup>212</sup> Rispel L and Setswe G (2007) 4.

<sup>213</sup> Econex Trade, Competition & Applied Economics *The South African Private Healthcare Sector: Role and Contribution to the Economy* (A study conducted by Econex on behalf of South African Private Practitioners Forum (SAPPF) and HealthMan (Pty)Ltd November 2013) 6.

<sup>214</sup> Econex (2013) 6.

<sup>215</sup> Rispel L and Setswe G (2007) 4.

<sup>216</sup> Econex (2013) 6.

<sup>217</sup> Econex (2013) 6.

health care sector.<sup>218</sup> The private health care sector has therefore risen to satisfy the demand for quality health care services and has further developed to enhance access to health care services in South Africa. Notwithstanding the above, the focus on the next paragraphs is to investigate whether privatisation has enhanced the right to have access to health care services or have led to a denial of the aforesaid right. The goal of these paragraphs that follows is to explore the relevance of the concept in relation to the provision of health care services to establish whether the private health sector is truly a national asset that has contributed to the values of the South African Constitution.

### **3.2.2. Reasons advocated for the Privatisation of Healthcare Services in South Africa**

Many specific reasons have underlined the privatisation of health care services in South Africa. As pointed out by Van Rensburg and Fourie, a key reason for privatisation of health care services in South Africa is the fact the extensive involvement of the government in the economy is seen to be undesirable and should be scaled down to accelerate economic growth and development.<sup>219</sup> Aligned with this argument, most proponents in favour of privatisation believe that privatisation will enhance operational efficiency, economic growth, and development.<sup>220</sup> Privatisation is therefore intended to improve the performance of public enterprises by focusing attention on financial performance and removing the enterprise from state control.<sup>221</sup>

Furthermore, the rising demand for quality health care is another factor seen to have motivated the privatisation of health care services in South Africa.<sup>222</sup> The demand for health care services in the public sector is reported to have exceeded the limited ability of the sector to supply adequate health care. Again, public hospitals are reported to be beleaguered with maladministration, rude staff, resource scarcity, bad working conditions and long queues at emergency wards.<sup>223</sup> A recent study by Econex also discloses that service delivery and the state of health care facilities in the public sector have deteriorated over the last two decades and the lack of quality services in the public sector is seen as one of South Africa's health reform challenges.<sup>224</sup> In view of all the above shortcomings relating to the public health sector, there have been an increase in the demand for

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<sup>218</sup> Econex (2013) 61.

<sup>219</sup> Van Rensburg HCJ and Fourie A (1988) 3.

<sup>220</sup> Chirwa D "Socio-Economic Rights and Privatisation of Basic Services in South Africa, A Theoretical Framework" (2004) *ESR Review* 5.

<sup>221</sup> Chirwa D (2004) 224.

<sup>222</sup> Van Rensburg HCJ and Fourie A (1988) 3.

<sup>223</sup> Burger R "How Poor is the Pro-poor is the South African Health System" (2006) *Stellenbosch Economic Working Paper* 11. Bateman C "Crowded Wards, Lousy Admin Contribute to Death and Suffering" (2010) *SA Medical J* 414-8.

<sup>224</sup> Econex (2013) 53.

private health care by more affluent sectors of the society and some public medical practitioners have even moved to establish practices within the private sector.<sup>225</sup>

Another argument in favour of privatisation is the inability of public utilities to raise capital for investment. It is argued that the public sector has limited capital and its investment options are undermined by short-term political expediency.<sup>226</sup> Increased capital investment is needed to manage population growth and urbanisation. Of particular importance is the fact that the escalating cost of providing health care cannot be borne by the government alone. On the other hand, privatisation is seen to provide a promising opportunity for investment as it plays a vital role in attracting investment to the economy.<sup>227</sup>

Privatisation of health care is further expected to lead to reduced fiscal benefits and national debts.<sup>228</sup> It is argued that privatisation raises revenue for the government in the form of proceeds from the sale of public enterprises and removes the burden on governments to finance investments in the health care sector. This should allow governments to spend more on services or service of foreign debts.<sup>229</sup>

Again in South Africa, privatisation is seen as a means to provide service delivery to previously disadvantaged communities or people.<sup>230</sup> It is therefore viewed as an important resource for black empowerment in that it bridges societal inequalities and provides equal access to socio-economic services including access to health care services.<sup>231</sup>

Finally It is also argued that privatisation of healthcare will bring to an end the financial-draining practice of state subsidies to state-owned companies.<sup>232</sup> Governments bail out poorly-run businesses with resources that could be used for the provision of access to healthcare service, which will in turn protect the rights enshrined in section 27(1) (a) of the Constitution.<sup>233</sup>

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<sup>225</sup> Van Rensburg HCJ "The Health and Human Resources for Health-Status, Trends and Core Issues" in HCJ Van Rensburg HCJ (ed) *Health and Health Care in South Africa* (2004)351-2, 354-67.

<sup>226</sup> Chirwa D (2004) 224-225.

<sup>227</sup> Econex (2003) 41.

<sup>228</sup> Chirwa D (2004) 226.

<sup>229</sup> Chirwa D (2004) 226.

<sup>230</sup> Chirwa D (2004) 226.

<sup>231</sup> Chirwa D (2004) 226.

<sup>232</sup> Sunita Kikera, Nellis J and Shirley M *Privatisation: The Lessons of Experience* (1992) 29.

<sup>233</sup> Sunita Kikera, Nellis J and Shirley M (1992) 29.

### 3.2.3 Interrelationship between Privatisation and the Right to have Access to Health Care Services

Privatisation is often seen as a panacea for all the ills associated with a country's public sector. It is regarded as indispensable to achieving efficiency, devolving responsibility to the individual and reducing the state's burden.<sup>234</sup> However, there is increasing disenchantment with the concept. Whether privatisation does in practice result in enhanced enjoyment of socio-economic rights and an increase in access to these rights including the right to have access to health care services is highly debatable.<sup>235</sup> The initial trend of privatisation has therefore lost its momentum and there is growing resentment and questioning of the benefits of privatisation by both populist and intellectuals' voices in the face of some high profile failures in infrastructure and concerns that privatisation does not produce macroeconomic and distributional gains equivalent to its microeconomic benefit.<sup>236</sup>

In the context of health care, there are those who argue that paradoxically the privatisation of health care services in South Africa has accentuated rather than ameliorated the state's burden in the provision of health care services.<sup>237</sup> These opponents have argued that with increasing privatisation, South Africa runs the risk that several structural characteristics or demise of the country's public health sector will even manifest themselves stronger.<sup>238</sup> For instance, before the privatisation of health care services, a perverse asymmetry historically existed in the health care sector in South Africa in which health resources were disproportionate to the percentage of the population that it serves.<sup>239</sup> With the advent of privatisation, this problem has further deepened as research shows that the private sector commands over half of South Africa's budget allocated to health care but provides coverage to a mere 17% to 20% of the population.<sup>240</sup>

Another argument against the privatisation of health care in South Africa is the argument that privatisation is prompted by profit motive.<sup>241</sup> It is often argued that private firms are interested in profit making and have no social objectives because they are not bound by any promises made to the people except those made to their investors, whose interests are more paramount and

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<sup>234</sup> Chapman A (2014) 122-33.

<sup>235</sup> Chirwa D (2004) 226.

<sup>236</sup> Jerome A (2004) 2.

<sup>237</sup> Ngwena C and Cook R (2005) 130.

<sup>238</sup> Vans Rensburg HCJ and Fourie A (1988) 5.

<sup>239</sup> Ngwena C and Cook R (2005) 130.

<sup>240</sup> Ngwena C and Cook R (2005) 130. See also Econex (2013) 6 and 18.

<sup>241</sup> Ngwena C and Cook R (2005) 130.

important to them.<sup>242</sup> Apart from a few not-for-profit entities that exist in the private health care sector, most private health care facilities invest in health care not to provide adequate health care but for profit motives.<sup>243</sup> As such, the private health sector, prompted with this profit motive often devised expensive medical schemes that focus on curative care and are heavily biased against the poorly remunerated sections of the population and only accessible to mostly rich urban dwellers.<sup>244</sup> This is evident with the number of challenges faced by the private health sector today including pressure on rising costs, affordability and decreasing access to health care.<sup>245</sup>

Again, it is argued that the privatisation of health care services has made the health care system more inclined and susceptible to inequity and discrimination.<sup>246</sup> Despite many transformative policies put in place by the post apartheid government of South Africa since 1994, wide scale disparities continue to exist between the public and the private health sector in respect of the quality of health care and racial representation.<sup>247</sup> In this regard, many have argued that disparities in health care spending, health care professionals and access to health care between the private and public health sector are one of the most serious impediments to an equitable health care system in South Africa.<sup>248</sup>

Finally in South Africa, the efficiency of private hospitals in relation to their treatment of certain diseases has been opened to questioning in some instances. For instance, it has been argued that private doctors are significantly less experienced in diagnosing TB as they normally do not deal with the disease.<sup>249</sup> In this regard, Barker cautions against accepting as common wisdom the efficiency of the private sector in the delivery of health care services as the arguments for privatisation are just in line with a much wider shift towards neo-liberal political views.<sup>250</sup>

In view of some of the shortcomings relating to the privatisation of health care services in South Africa, some scholarly writers have advised that South Africa should go about cautiously with the privatisation of its health care sector as it entails a lot of injurious side effects which can be at the

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<sup>242</sup> Chirwa D (2004) 227.

<sup>243</sup> Chapman A (2014) 122-33.

<sup>244</sup> Ngwena and Cook (2005) 130.

<sup>245</sup> Rispel L and Setswe G (2007) 5.

<sup>246</sup> Van Rensburg HCJ and Fourie A (1988) 5.

<sup>247</sup> Rispel L and Setswe G (2007) 5.

<sup>248</sup> McIntyre D, Valentine N and Cornell J "Putting Health back onto the social policy agenda: experience from South Africa" (2002) *Soc Sci Med* 54: 1637-56.

<sup>249</sup> Malan M "When Public Healthcare Trumps Private" *Mail & Guardian* 3 June 2011 <http://www.mg.co.za/article/2011-06-03>.

<sup>250</sup> Barker C *The Health Care Policy Process* (London Sage Publications 1996) 154.

expense of many groups in the country.<sup>251</sup> Even if the privatisation of health care services were to achieve the benefits advocated by its exponents, there is however no guarantee that the achievement of these objectives will automatically lead to accessibility of health care services by all peoples especially the vulnerable groups.<sup>252</sup> In fact, global trend towards privatisation in health systems poses significant risk to the equitable, availability and accessibility of health facilities especially for the poor and marginalised groups.<sup>253</sup> Accordingly, it is justifiable to state from the foregoing discussion that allowing a dominant role for the private sector to provide health care services will complicate efforts to promote and protect the right to have access to health care services enshrined in section 27 of the Constitution. This therefore demonstrates the need to enhance within the Constitution a frame work which allows for the horizontal application of socio-economic rights.

### **3.2.4 Assessing the Impact of Privatisation on the Right to have Access to Health Care Services**

Universal access to health care services forms the basis of the South African Constitution. With the advent of privatisation, the private sector has played an increasing role in the realisation of the right to have access to health care services in South Africa. The private health sector has assisted the government to provide health care facilities. In doing so, the private health sector has ensured that the burden to provide health care services is lifted off the shoulders of the government which is often underscored with problems of limited resources.<sup>254</sup>

In spite of the above, the private health sector continues to face a number of challenges, including the pressure of rising costs, affordability and decreasing access to health care services.<sup>255</sup> To achieve universal health care, the rights to have access to health care services must be realised across the country and within societies so that those who need health care must be able to have access to it, irrespective of their socio-economic status or their ability to pay.<sup>256</sup> However, one of the resultant effect of the privatisation of health care services has been the reduction of access to health care services which contravenes the provision of section 27(1) (a) of the Constitution.

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<sup>251</sup> Van Rensburg HCJ and Fourie A (1988) 5.

<sup>252</sup> Chirwa D (2004) 230.

<sup>253</sup> Chapman A (2014) 122-33.

<sup>254</sup> McIntyre D "Private sector involvement in funding and providing health services in South Africa. Implications for equity and access to health care" (2010) *EQUINET Discussion Paper Series 84* Health Economics Unit (UCT) ISER Rhodes University EQUINET: Harare 1.

<sup>255</sup> Rispel L and Setswe G (2007) 5.

<sup>256</sup> Harris B et al "Inequities in access to health care in South Africa" (2011) *Journal of Public Health Policy* 119.

Privatisation has reinforced the legacy of South Africa's apartheid past which continues to shape the provision of health care services between the private and the public sector as racial, socio-economic and rural-urban differentials in health outcomes in both sectors remains very outstanding and challenging.<sup>257</sup> The great disparity in the quality and the provision of health care between these sectors is amongst one of South Africa's greatest challenges.<sup>258</sup> In 2006, it was estimated that approximately 56% of South Africa's health care expenditure was funded from private sources but only one fifth of the population had routine access to private health care providers.<sup>259</sup> Most recent studies about the private health sector also affirm this statistic as it is estimated that approximately 16% or 17% of South Africa's population benefits from the private health sector as beneficiaries of medical schemes.<sup>260</sup> This therefore shows that with almost half of the national health care expenditure being spent on private health care, the amount of resources allocated to the private sector is disproportionate to the percentage of the population that it serves. This argument is however disputed in a study by Econex, which discloses that the said argument is a misconception influenced by statements made by the Department of Health found on the first page of the NHI Green Paper.<sup>261</sup> In this study, it is further disputed that, although the statement that in 2012/2013, approximately 17% of South Africa's population benefited from the private health sector as beneficiaries of medical schemes was correct, the aforesaid statement was erroneously interpreted to mean that the private sector only serves 17% of the population.<sup>262</sup> Furthermore, the studies continues to stipulate that if an account of all those who had access to private health care by means of out-of-pocket spending was considered, it would reveal that in 2012, the private health care sector provided primary health care to an estimated 28% to 38% of the South African population.<sup>263</sup>

Notwithstanding the above justification, the reality remains that with the ongoing shift in the provision of health care services away from the socially valued services to a market commodity,

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<sup>257</sup> Harris B et al (2011) 119-120.

<sup>258</sup> Human A "A Tale of Two Tiers: Inequality in South Africa's Health Care System" (2010) *UBCMJ* 33.

<sup>259</sup> Blecher M and Harris S "Health Care Financing" in Ijumba P and Padarath A (eds) *South African Health Review Durban: Health Trust Systems* (2006) 32.

<sup>260</sup> Econex (2013)18.

<sup>261</sup> Department of Health (National Insurance in South Africa Policy paper August 2011) 10. The Department of Health included on the first page of the NHI Green paper that "*A larger part of financial and human resources for health is located in the private sector serving a minority of the population. Medical schemes are the major purchasers of services in the private sector, which covers 16.2% of the population. The public sector is under-resourced relative to the size of the population that it serves and the burden of disease. The public sector has disproportionately less human resources than the private sector yet it has to manage significantly higher patient numbers.*"

<sup>262</sup> Econex (2013)18.

<sup>263</sup> Econex (2013)18.



unaccountable increases in the costs of health care has been encountered which has resulted to an escalation of medical insurance premiums in South Africa.<sup>264</sup> The cost hikes for health care has therefore impacted the affordability of medical schemes and resulted to inequities and reduced access to private health care facilities especially by poor and other vulnerable and marginalised groups.<sup>265</sup> This infringes greatly the provisions of the Constitution relating to the right to have access to health care services and equality.<sup>266</sup> This is because one of the obligations set out in the Constitution is to progressively realise the right to have access to health care services without any form of discrimination unless it can be justified as being fair under the Constitution. However, where a policy is being pursued that has the effect of benefiting a particular group of people because of their socio-economic status and excluding others, this obligation is considered to be violated.

It can therefore be deduced from the foregoing discussion that the private sector involvement in the funding and the provision of health care have had a profound effect on equity and the right to have access to health care services in South Africa. Although human right approach assumes that states are responsible for shaping and implementing the delivery of health care services to ensure consistency with human rights requirements,<sup>267</sup> the obligation to protect and promote access to socio-economic rights should also demand that private parties such as multinational corporations must be prevented from interfering or compromising equal access to health care services. Accordingly, it is essential that private entities contributing to the provision of health care services in South Africa comply with the constitutional obligation under section 27 (1) (a) and other relevant provisions in the country's Constitution.

### **3.3 The Horizontal Application of the Bill of Rights to Private Relationships under the South African Constitution.**

In contrast to the 1993 Constitution of South Africa, the 1996 Constitution makes provision for the application of the Bill of Rights to horizontal relationships in certain circumstances.<sup>268</sup> Before then, the Interim Constitution only provided in its section 7(1) that the Bill of Rights binds 'all legislative and executive organs of the state at all levels of government.'<sup>269</sup> Accordingly, the Interim

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<sup>264</sup> Benatar SR "The Challenges of health disparities in South Africa" (2013) *South African Medical Journal* 154.

<sup>265</sup> Grover A "Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health to the United Nations General Assembly, UN doc A/67/150 (2012) para 3".

<sup>266</sup> Section 27 and Section 9 of the Constitution.

<sup>267</sup> Chapman A (2014) 122.

<sup>268</sup> Currie and De Waal (2013) 5.

<sup>269</sup> Section 7(1) of the 1993 Constitution.

Constitution omitted its application to the judiciary, which generated mixed judicial pronouncement as to whether the Bill of Rights was applicable to horizontal relationships.<sup>270</sup> In order to resolve the ambiguities regarding the application of the Bill of Rights to horizontal relationships, this scuffle was laid to rest in the defamation case of *Du Plessis v De Clerk*.<sup>271</sup> This case is the landmark decision dealing with the issue of horizontal application under the Interim Constitution. In this case, the Constitutional Court acknowledged that the interim Bill of Rights did not apply to direct horizontal relationships and was only relevant in the development and application of the common law which governs relationships between private parties.<sup>272</sup> A majority in the Court therefore held that the Bill of Rights could apply indirectly to proceedings between private parties according to the provisions of Section 35(3) of the Interim Constitution.<sup>273</sup> Accordingly, the Constitutional Assembly agreed to a formulation which subjected private power to constitutional scrutiny.<sup>274</sup> Shortly thereafter, the 1996 Constitution was adopted in which the Constitutional Court explicitly recognised that section 8 of the aforesaid Constitution could have a direct horizontal application. The Constitutional Court accordingly found this provision to be consistent with other constitutional principles including the separation of powers, with which the 1996 Constitution had to comply.<sup>275</sup> In doing so, the Constitution Assembly was confronting South Africa's tragic past and realised the need to commit individuals to the rebuilding of ethical relationships destroyed during the apartheid era by utilising legal duties to improve their communities.<sup>276</sup> Furthermore, the Constitution Assembly saw the possibility of creating a more just and equal society in the medium term through the application of the Bill of Rights to horizontal relationships as enormous wealth resided in the private sector unlike the state, which is always faced with limited resources.<sup>277</sup> Accordingly, the demand for horizontality became apparent due to the oppressive nature of South Africa's history and can be justified on such grounds.

### **3.3.1 The Constitutional Framework relating to the Horizontal Application of Socio-Economic Rights**

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<sup>270</sup> Chirwa (2002) 3.

<sup>271</sup> *Du Plessis & Others v De Clerk & Another* (CCT8/95) [1996] ZACC 10; 1996 (3) SA 850; 1996 950 BCLR 658 (15N May 1996).

<sup>272</sup> *Du Plessis & Others v De Clerk & Another* para 62.

<sup>273</sup> *Du Plessis & Others v De Clerk & Another* para 63.

<sup>274</sup> Davis D *Democracy and Liberation* (Juta & Co Ltd Cape Town 1999)106.

<sup>275</sup> *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa* para 53-56.

<sup>276</sup> Friedman N "Human Rights and the South African Common Law: Revisiting Horizontality" (2012) *Centre for Socio-Legal Studies University of Oxford* 4-5.

<sup>277</sup> Friedman N (2012) 5.

As mentioned above, the 1996 Constitution explicitly recognises certain duties which may apply directly to relationships involving private parties. Section 8 of the 1996 Constitution contains provisions which contrast those of its predecessor. Section 8(1) of the 1996 Constitution expressly states that the Bill of Rights binds the 'legislature, the executive, the judiciary and all organs of state'.<sup>278</sup> This provision therefore obliges courts to ensure that their decisions are consistent with the provisions of the Bill of Rights.<sup>279</sup> This provision standing alone would be construed to allow the automatic application of horizontal obligation on private parties by courts.<sup>280</sup> Moving further from the above provision, section 8 (2) explicitly subject natural and juristic persons to the provisions of the Bill of Rights.<sup>281</sup> This provision states the extent to which rights and duties imposed on such rights may apply to private parties. In doing so, the provision acknowledges that individuals would not bear positive obligations in the same way as the state and whether they bear duties, the extent of those duties will depend on the nature of the rights that are involved.<sup>282</sup> This provision therefore accords a margin of judicial discretion in terms of the application of particular obligations to different private parties.<sup>283</sup> Furthermore, the provision expressly gives recognition to the possibility of juristic persons such as multinational companies to have positive or negative duties in certain circumstances to facilitate the actual realisation of a particular socio-economic right such as the right to have access to health care services. It is in line with such recognition that Liebenberg describes the unique character of the South African Constitution in allowing direct horizontal application to certain rights in the Bill of Rights as a novelty in comparative Constitutional Law.<sup>284</sup>

Furthermore, section 8(3) of the Constitution explains how rights must be applied when it has been established that a right in the Bill of Rights is applicable. This provision enjoins courts to apply or develop when it becomes necessary, common law rules to the extent that the legislation does not give effect to that right in order to provide an effective remedy for socio-economic rights violations by private parties in terms of section 8(2) of the Constitution.<sup>285</sup> This implies that whenever the

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<sup>278</sup> Section 8 of the Constitution.

<sup>279</sup> Section 2 of the Constitution.

<sup>280</sup> Nolan A "Holding non-state actors to account for constitutional economic and social rights violations. Experiences from South Africa and Ireland" (2014) *Oxford University Press* 78.

<sup>281</sup> Section 8(2) of the Constitution which states that "A provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right."

<sup>282</sup> Friedman N (2012) 6.

<sup>283</sup> Nolan A (2014) 78.

<sup>284</sup> Liebenberg (2002) 7-8.

<sup>285</sup> Section 8(3) The provision states that 'When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court

validity of a law or conduct has been judged in terms of section 8(2) and the Bill of Rights has been invoked, a court would then proceed to determine whether this law or conduct is consistent with the Constitution, failing in which event the provision of section 8(3) will become applicable.<sup>286</sup> The provision therefore indicates that the Bill of Rights would seldom apply directly to a private dispute in certain circumstances. Accordingly, courts are directed to vindicate the Bill of Rights either by way of legislative enactment or through the development of common law rules that will generate effective remedies against private rights infringements.<sup>287</sup> Section 8(3) is further linked to the requirement in section 39(2) in that in determining the validity of any legislation or in developing any common law rules to enforce a right, the court in question must do so in line with the object and purport of the Bill of Rights.<sup>288</sup>

Moving beyond section 8 of the Constitution, there are many other provisions embedded in the Constitution that also favours the horizontal application of the Bill of Rights to private relationships. For instance section 32(1) (b) explicitly applies to private relationships as it requires that everyone should have the right of access to any information that is held by another person and which is required for the exercise or protection of any rights.<sup>289</sup> In addition to this, section 9(4) also expressly demonstrates its favour to horizontal application by directing that no person may unfairly be discriminated directly or indirectly against anyone on grounds including race, gender, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.<sup>290</sup> In the same vein, section 29(3) of the Constitution also has a direct horizontal application in that it places an obligation on persons who establish independent educational institutions to ensure that they maintain standards of education which are not inferior to those of comparable public institutions and are further required not to discriminate on the basis of race to promote equality.<sup>291</sup> Section 13 also provides that no one may be subjected to slavery, servitude and forced labour.<sup>292</sup> This provision implies that the right is not

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(a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1).

<sup>286</sup> Friedman N (2012) 8.

<sup>287</sup> De Waal J, Currie I and Erasmus G *The Bill of Rights Handbook* 4ed (2001) 37. Liebenberg S "Socio-Economic Rights" in Chaskalson M et al (eds) *Constitutional Law of South Africa* (2ed OS Juta & Co Ltd 2003) 46. Pearmain DL "Contracting for Socio-Economic Rights: A Contradiction in Terms" (2006) *THRHR* 289-90.

<sup>288</sup> Section 39(2) of the Constitution.

<sup>289</sup> Section 32 of the Constitution. Chetty D R *The Horizontal Application of the South African Bill of Rights* (LLM thesis University of Natal-Durban 1998) 23.

<sup>290</sup> Section 9 of the Constitution. Chetty DR (1998) 22.

<sup>291</sup> Section 29 of the Constitution. Welch AR (2005) 63.

<sup>292</sup> Section 13 of the Constitution. Chetty DR (1998) 22.

only binding upon the state but it is binding on other persons whether natural or juristic. All the above provisions demonstrate the effort by the Constitution to ensure that the Bill of Rights is enforceable against private parties.

### 3.3.2 The Horizontal Application of Socio-Economic Rights in the Constitution

It is evident from the foregoing discussion that under the 1996 Constitution, juristic persons are entitled to comply with the rights contained in the Bill of Rights in terms of section 8(1) or in terms of section 8(2) and section 8(3) of the Constitution. They are further entitled to comply with the rights in the Bill of Rights only to the extent required by the nature of the rights and the nature of that juristic person.<sup>293</sup> In this regard, it is conclusive to suggest that the above provisions especially section 8(2), permits the application of socio-economic rights to private individuals. However, this suggestion has met with spirited resistance from some leading South African academics who are opposed to a direct horizontal application of the Bill of Rights and have based their objections on a number of factors.<sup>294</sup> In the opinion of Currie and De Waal, a direct application of the Bill of Rights to private disputes, will seldom provide any advantage to a litigant. In this regard, they believe that in accordance with the principle of avoidance, indirect application, whether in the context of socio-economic rights or civil rights will be preferred over direct application.<sup>295</sup> In the context of socio-economic rights, some scholarly writers have made reference to the duty of the state to take reasonable legislative measures in order to realise the rights relating to housing and health in section 26(2) and section 27(2) respectively to mean that these duties are meant to be rendered exclusively by the state.<sup>296</sup> According to Ellman, the language of the relevant provisions of the constitution does not compel the extension of horizontality and socio-economic rights to a vast range of activities by private parties. He justifies this argument by stating that socio-economic rights provisions under the Constitution are qualified as applicable to the state exclusively since the constitution mandates only the state to adopt reasonable legislative measures in the realisation of socio-economic rights.<sup>297</sup> This view has been upheld by other critics who argue that the state is better placed to achieve socio-economic rights on a progressive basis. The context in which they

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<sup>293</sup> Section 8(4) of the Constitution.

<sup>294</sup> Chirwa (2002) 4.

<sup>295</sup> Currie and De Waal (2013) 45.

<sup>296</sup> Nolan (2014) 80.

<sup>297</sup> Ellman S "A constitutional confluence: American "state action" law and the application of South Africa's socio-economic rights guarantees to private actors" in Andrews P & Ellman S (eds) *The post-apartheid constitutions: Perspectives on South Africa's basic law* (2001) 468.

base this argument is that the state is the sole provider of basic goods and services, which is necessary to uphold certain constitutional values such as equality.<sup>298</sup>

However, with the advent of privatisation, private entities have emerged and are actively participating in the provision of some basic goods and services which are central to human survival. The actions of these private entities will also have profound implications on socio-economic rights making it necessary for these entities to comply with the constitutional obligations relating to these rights.<sup>299</sup> Accordingly, some scholarly writers have supported the direct horizontal application of socio-economic rights in respect of private disputes. In the opinion of some of these scholarly writers, those provisions of the constitution that explicitly recognises that some duties may apply directly to private disputes would become superfluous, if private parties could simply ignore their constitutional mandate under these provisions without any consequences.<sup>300</sup> Furthermore, Liebenberg asserts that there are context in which, it is appropriate to impose positive duties on private parties to protect and facilitate people's access to the enjoyment of socio-economic rights.<sup>301</sup> For instance, it would be necessary to impose positive duties on private individuals or multinational corporations that maintain or hold a monopoly over the provision of certain socio-economic goods and services. This is because a dangerous imbalance, which has the potential of leaving the consumers powerless in defending their interest, would exist if consumers are not protected against any imminent infringement of their constitutional rights by such individuals or multinational corporations.<sup>302</sup> Throughout the years, several commentators have shown their support to the above argument and have stated that pharmaceutical companies should bear the responsibility for any significant impact of their action on the enjoyment of the right to have access to essential medicines.<sup>303</sup> In this regard, it becomes very essential for non-state actors actively participating in the supply of some socio-economic goods and services to be subjected to constitutional scrutiny under section 8(2) given the important role played by these rights in facilitating social equality.<sup>304</sup>

### 3.3.3 Judicial Enforcement of Socio-Economic Rights on Non-State Actors

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<sup>298</sup> Chirwa (2002) 4.

<sup>299</sup> Welch AR "Obligation of State and Non-state Actors Regarding the Human Right to Water Under the South African Cohabitation" (2005) *Sustainable Development Law & Policy* 62.

<sup>300</sup> Welch AR (2005) 63.

<sup>301</sup> Liebenberg S (2010) 330.

<sup>302</sup> Nolan (2014) 83.

<sup>303</sup> Ellman S (2001) 468. Liebenberg S (2010) 330-31.

<sup>304</sup> Chirwa (2002) 4.

Post-apartheid exigencies characterises the South African society and has influenced the construction of the 1996 Constitution of South Africa. Against this backdrop, some scholarly writers believe that the horizontal application of the Bill of Rights became apparent.<sup>305</sup> As such judicial enforcement becomes very essential as it defines the court's role and commitment to fulfilling the transformative vision of the Constitution, which is to achieve an equitable distribution of resources and advancing the welfare of the previously disadvantaged and other vulnerable and marginalised group of people.<sup>306</sup> In terms of section 8(2), private parties can now look forward to the Constitution for remedial protection when they are not adequately protected under the common law. Regrettably, the judiciary has been reluctant to undertake any major doctrinal reforms in order to give effect to the values of the Constitution.<sup>307</sup> Thus far, there has only been a few cases in which, courts in South Africa have addressed the issue of horizontal application of socio-economic rights. Also there have been very few cases where a direct application of socio-economic rights to private disputes has been considered by South African courts. The case of *Khumalo v Holomisa* represents the first case where the Constitutional Court had to consider horizontality in the context of South Africa.<sup>308</sup> In this case, the Constitutional Court disagreed with the applicant's argument that because the Bill of Rights applies to all law and binds the judiciary in terms of section 8(1), the substantive provisions of the Bill of Rights should be taken to apply to all law governing disputes involving private actors and did so on the ground that if the effect of section 8(1) and section 8(2) read together were to be that the common law would in all circumstances result to the direct application of the Constitution, then the provision of section 8(3), would become redundant and apparently have no purpose.<sup>309</sup> However, the court ruled that the right to freedom of expression was of direct horizontal application in the case in question and in doing so the court considered the intensity of the right of freedom of expression and the potential infringement of that right by persons other than the State or organs of State and found the above right to be consistent with section 8(2) and capable of having a direct horizontal application.<sup>310</sup>

In view of socio-economic rights, prior to the Constitutional Court's decision in the abovementioned case, the said court had at least acknowledged that some of the duties imposed by socio-economic rights are binding on private parties.<sup>311</sup> In *Grootboom*, the Constitutional Court held that section 26(1) imposes a negative obligation upon the State and all other entities and persons to

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<sup>305</sup> Friedman N (2014) 4.

<sup>306</sup> Mbazira (2009) 17.

<sup>307</sup> Liebenberg (2014) 62.

<sup>308</sup> *Khumalo v Holomisa* [2002] ZACC12; 2002(5) SA 401; 2002 (8) BCLR 771.

<sup>309</sup> Nolan (2014) 78.

<sup>310</sup> *Khumalo v. Holomisa* [2002] ZACC12 para 33.

<sup>311</sup> Nolan (2014) 81.

desist from preventing or impairing the right to have access to adequate housing.<sup>312</sup> Specifically, the court stated that “[a] right of access to adequate housing also suggest that it is not only the State who is responsible for the provision of houses, but that other agents within our society, including individuals themselves, must be enabled by legislative and other measures to provide housing.”<sup>313</sup> This position was later confirmed in the submission made on behalf of the *amicus curiae*, in the case of *Ntombizodwa Yvonne Maphango & Others v Aengus Lifestyle Properties (Pty) Ltd*, where Barnes and Jele, while making reference to the Constitution Court’s ruling in *Grootboom*, submitted that it was clear that section 26(1) imposes a negative duty on the state and private entities not to deprive people of their existing access to adequate housing.<sup>314</sup> Furthermore, they submitted that, it was clear that the negative duty not to infringe on people’s right of existing access to adequate housing was capable of being abused not only by the state but also private individuals. In doing so, they arrived at a conclusion that if the negative obligation to abuse this right was not given a horizontal application in terms of section 8(2), the constitutional vision of achieving transformation in both the private and public spheres would be frustrated.<sup>315</sup> Accordingly, the role played by private actors in the provision of housing was acknowledged in *Grootboom* as well as in the *amicus curiae* submission in *Maphango*. Chirwa convincingly describes this acknowledgement as a confirmation that private actors have positive obligations in respect of socio-economic rights.<sup>316</sup> The South African courts have also had to consider the horizontal application of socio-economic rights in the case of *President of the Republic of South Africa & Anor v Modderklip Boerdery*.<sup>317</sup> In this case, the High Court held that the right of access to adequate housing is not one enforceable against an individual land owner in terms of the Constitution.<sup>318</sup> On appeal however, the Supreme Court of Appeal, rejected this decision of the High Court as Justice Harms stated that although horizontality was not applicable to the case in question, but circumstances may arise where the right would be enforced horizontally.<sup>319</sup>

The Constitutional Court has been able to hold that socio-economic rights impose an obligation to non-state actors in only one of its decisions. In the case of *Governing Body of Jumia Musjid Primary School & Others v Essay and Others*,<sup>320</sup> the Constitutional Court deviated from the ruling

<sup>312</sup> *Government of the Republic of South Africa v Grootboom and others*, para 34.

<sup>313</sup> *Grootboom* para 35.

<sup>314</sup> *Ntombizodwa Yvonne Maphango and Others v Aengus Lifestyle Properties (Pty) Ltd* (CCT57/11) (CC) [2012] ZACC 2; 2012; (3) SA 531 (CC); 2012 (5) BCLR para 4.3.

<sup>315</sup> *Ntombizodwa Yvonne Maphango and Others v Aengus Lifestyle Properties (Pty) Ltd* para 4.4.

<sup>316</sup> Chirwa (2002) 3.

<sup>317</sup> *President of the Republic of South Africa & Anor v Modderklip Boerdery* (CCT 20/04)13 May 2005.

<sup>318</sup> *Modderklip Boerdery (Pty) Ltd v Modder East Squatters & Anor* 2001 (4) 385 (W) at 394J-395A-B.

<sup>319</sup> *Modderklip Boerdery (Pty) Ltd v Modder East Squatters & Anor* para 31.

<sup>320</sup> *Governing Body of the Juma Musjid & Others v Essay No and Others* (CCT 29/10) [2011] ZACC 13.



of the High Court which found that the Defendant trust owed no constitutional obligation to the Governing Body of the school or to the learner at the school as the trust was not exercising a public function. In emphasising the Trust's own constitutional rights to property, the High Court stated that rather the obligation to respect the learner's right to basic education was an obligation that members of the Executive Council for Education (MEC) had to observe.<sup>321</sup> The Constitutional Court on its part ruled that the Trust had a negative constitutional obligation to respect and not to infringe the rights of learners to basic education under section 29 of the Constitution although it further held that the primary positive obligation to provide basic education to the learners rested on the MEC.<sup>322</sup>

The Constitutional Court further dealt with arguments against the direct horizontal application of socio-economic rights on private parties. For instance, the Constitutional Court addressed the argument of potential intrusion of direct horizontal application on the autonomy of private constitutional duty-bearers.<sup>323</sup> In this regard, the Court stated that the purpose of section 8(2) of the Constitution is not to obstruct private autonomy or to impose on private parties the duties of the State in protecting the Bill of Rights but rather to require private parties not to interfere with or infringe the enjoyment of a right.<sup>324</sup> However, the Court also highlighted the fact that the historical distinction between the private sector and public sector, whose purpose was to enable the private sector to engage in socio-economic activities without any state interference, often shelter the ability of private entities to render duties usually carried out by the state.<sup>325</sup> Following the Constitutional Court's approach to this issue of private autonomy, it can be said that the court was critical of the abilities of private entities to perform State duties under certain circumstances. As a result, the court acknowledged that the active participation of private entities had the potential to also affect the enjoyment of socio-economic rights and must be subjected to constitutional scrutiny. Therefore, by implication, the Court's conduct favoured the direct horizontal application of positive obligation upon private entities although the case in question centered on a negative obligation on the part of a non-state actor.

### **3.3.4 The Horizontal Dimensions of the Right to have Access to Health Care**

As far as the right to have access to health care services is concerned, there appears to be some consensus among commentators that section 27(1) (a) of the Constitution is capable of being

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<sup>321</sup> Nolan (2014) 83.

<sup>322</sup> *Juma Masjid* 58 and 60.

<sup>323</sup> Nolan (2014) 84.

<sup>324</sup> *Juma Masjid* 58.

<sup>325</sup> *Juma Masjid* 58.

applied horizontally and that the right to have access to health care services may be enforced against private health care providers to prevent them from disrupting, denying, impairing or obstructing existing access to health care services.<sup>326</sup> Commentators generally agree that the obligation to respect, promote and fulfill socio-economic rights under section 7(2) of the Constitution must apply horizontally, if private parties are to have any remedy against any unlawful private interference with the exercise of their rights.<sup>327</sup> In the opinion of Van Der Walt, it would be inappropriate to preclude socio-economic rights from applying in private disputes since this would remove the protection awarded by the aforesaid rights from the very context where the consequences of socio-economic rights violations are felt.<sup>328</sup> Should the analogy of this argument be extended to section 27(1) (a), the implication would be an enforceable obligation on private parties to prevent them from infringing the right to have access to health care services without any constitutional justification.<sup>329</sup>

Secondly, the equality threshold underlying the determination of the right to have access to health care services embodied in section 9(4) of the Constitution also appears to suggest that section 27(1)(a), is capable of being applied horizontally.<sup>330</sup> Section 9(4) prohibits and prevents unfair discrimination.<sup>331</sup> If this provision is interpreted in conjunction with section 27(1) (a), which entitles everyone to the right to have access to health care services, it would imply that individuals should be able to demand access to health care from private health care in cases where any arbitrarily denial of this right will amount to unfair discrimination.<sup>332</sup> There is further consensus that the right not to be refused emergency medical treatment in section 27(3) can be enforced horizontally although the content and scope to enforce this obligation against private health care entities remains unclear as the Constitutional Court provided only a restrictive interpretation of the obligation imposed by the aforesaid provision in the *Soobramoney* case.<sup>333</sup> The restrictive interpretation provided by the Constitutional Court leaves private health providers in doubts in respect of the scope and content of their obligation under section 27(3) of the Constitution.<sup>334</sup>

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<sup>326</sup> Liebenberg S (2003) 17-19. Pieterse M (2007) 165.

<sup>327</sup> Pieterse M (2007) 165.

<sup>328</sup> Van der Walt "Progressive Indirect Horizontal Application of the Bill of Rights: Towards Co-operative Relation between Common-Law and Constitutional Jurisprudence" (2001) *SAJHR* 341,353.

<sup>329</sup> Chirwa (2002) 4.

<sup>330</sup> Chirwa (2002) 4. Pieterse M (2014)146.

<sup>331</sup> Section 9(4) of the Constitution.

<sup>332</sup> Pieterse M "Legislative and Executive Translation of the Right to have Access to Health Care Services"(2010) *w, Law Development and Democracy* 1 19.

<sup>333</sup> Carstens and Pearmain (2007)160-161. *Soobramoney v Minister of Health* para 17-2 1, 35-36.

<sup>334</sup> Pieterse M Can Rights Cure? *The Impact of Human Rights Litigation on South Africa* (PULP 2014)146.

The courts have so far not provided much clarity on the nature and extent of the horizontal dimensions of the right to have access to health care. Some commentators have attributed this to the fact that the Constitutional Courts 'reasonableness' approach to socio-economic rights adjudication developed in the *Grootboom* and applied in subsequent cases such as the *Treatment Action Campaign* and the *Soobramoney*, focuses almost exclusively on the content of the measures taken by the state to enforce section 27(2) and leaves no room for the deliberation on other obligations which may arise under section 27(1) (a) of the Constitution.<sup>335</sup>

However, one reference to the possibility of applying section 27(1)(a) horizontally could be seen in the remarks of Madala J in the case of *Soobramoney v Minister of Health* in which the said Judge, acknowledged the important role played by the private health sector in providing complex medical treatment when the state is out of resources.<sup>336</sup> In his remark, the aforesaid Judge stated that he regarded allegations that the appellant was not informed of his options to access the private health care sector as a serious indictment for the private sector although he concluded that the private health sector was not a party to the case before the court and as such could not be condemn without being heard.<sup>337</sup> In saying this, the learned Judge recognizes the active participation of the private health sector in the provision of health care services and further points out the possibility of enforcing positive and negative obligations under the right enshrined in section 27(1)(a) against the private health sector. Does the above allusion therefore imply that in subsequent cases, South African courts have regarded private health care providers as constitutionally obliged to facilitate access to health care services?

Thus far, judicial review has been very limited in respect of the enforcement of the right to have access to health care services on private entities by South African courts. There has only been one case where the courts have made an attempt to enforce the right to have access to health care services horizontally. In *Strydom v Afrox Healthcare*, the High Court of Pretoria viewed section 27(1)(a) as indirectly applicable to private hospitals and held that the right of access to health care services awarded patients a legitimate expectation that the service to which they are accessing would be rendered with diligence by a professional and trained health care personnel.<sup>338</sup> According to Pieterse, the ruling of the High Court in this case amounts to the most definite affirmation of the horizontal dimensions and implicit quality standards contained in section 27(1)(a) in South African jurisprudence.<sup>339</sup> Although this ruling was subsequently overturned by the

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<sup>335</sup> Pieterse M (2014) 143.

<sup>336</sup> *Soobramoney v Minister of Health* para 48. Pieterse M (2014)143.

<sup>337</sup> *Soobramoney v Minister of Health* para 48.

<sup>338</sup> *Strydom v Afrox Healthcare Bpk* [2001] 4 All SA 618 (T), 626b-h; 627Ff-g.

<sup>339</sup> Pieterse M (2007)167.

Supreme Court of Appeal (SCA), stating that exclusion clauses in themselves do not deny access to health care or condone any negligent behaviour, the SCA however assumed in favour of the applicant that the right to have access to health care services could be applied horizontally but left open the question of whether section 27(1) (a) presupposed a minimum level care.<sup>340</sup> The assumption by the Supreme Court therefore confirms Pieterse's assertion that despite the Constitutional Court's construction of section 27(1) (a), there may be scope for the horizontal application of some of the obligations that may arise out of the right to have access to health care and that it would be possible for courts to indirectly enforce certain aspects of section 27(1) (a), without disrupting, the spirit, purport and object of the provision.<sup>341</sup>

### 3.4 Judicial Enforcement of Section 27(1) (a) against Private Entities

In terms of section 8(2) and section 8(3), of the Constitution, the regulation of the private health sector is made possible and should be facilitated through legislation and the application and development of the common law to enable compliance with private constitutional obligations.<sup>342</sup> The duty to protect socio-economic rights therefore places an obligation on the legislature to enact and enforce the necessary legislation to regulate and enable private actors to fulfill their constitutional obligations especially in the context of the privatization of many social services as pointed out by Liebenberg.<sup>343</sup> Where a particular socio-economic right is not offered adequate protection in the legislation or the existing common law, the courts are enjoined to develop the new remedies to give effect to the horizontal application of the socio-economic right.<sup>344</sup> So far courts have undertaken the development of the common law relating to the rules of eviction in respect of section 26 (1) of the Constitution.<sup>345</sup> Regrettably, there has been little development in South Africa regarding the development of the common law to enforce the right to have access to health care services horizontally. In the one case where South African courts have been called upon to develop the common law in order to give effect of the right to have access to health care services in the private sphere, they have failed to do so.<sup>346</sup> As seen above, the Supreme Court of Appeal overturned the judgment of the High Court and left open the question whether private hospitals were bound by section 27(1)(a) of the Constitution and instead enquired as to whether the clause was contrary to public policy, which it claimed had to be understood in the light of constitutional

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<sup>340</sup> *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA) paras 13, 15, and 19-21.

<sup>341</sup> Pieterse (2007) 167,168.

<sup>342</sup> Section 8 of the Constitution.

<sup>343</sup> Liebenberg (2010) 332.

<sup>344</sup> Section 8(3) of the Constitution.

<sup>345</sup> Brand D "The right to food" in Brand D and Heynes C (ed) *Socio-Economic Rights in South Africa* (PULP 2005) 175.

<sup>346</sup> Pieterse M (2014)147.

values including those associated with section 27(1)(a) and also in the light of the constitutional values of contract.<sup>347</sup>

Notwithstanding the reluctance of the courts to develop remedies that align with the values associated with section 27(1) (a), Pieterse believes that the preferred way for courts to give horizontal effect to the right to have access to health care or other socio-economic rights is by judicial application or development of the common law. He argues that South African current state of common law already gives effect to constitutional socio-economic guarantees or requires only minimal development to cater for constitutional entitlements.<sup>348</sup> In the context of the right to have access to health care services, he points to the framework regulating entitlements between the doctor-patient relationships under South African law of contract and delict, which to some extent he believes also cater for constitutional health entitlements.<sup>349</sup> In the next sub-section, I shall explore the current state of the common law in South Africa to see the remedies it offers which can give effect to the horizontal application of the right to have access to health care services. In this enquiry, I shall focus on the common law regulation of the doctor-patient relationship through the concept of medical negligence to demonstrate its potential as a remedial avenue through which section 27(1)(a) can be enforced against private entities or individuals to actualize the right to have access to health care services.

### **3.4.1 The Right to have Access to Health Care Services and the Common Law on Medical Negligence**

Under the existing South African common law, a legal duty exists whenever a hospital or health care provider undertakes care and the treatment of a patient.<sup>350</sup> That is once a health care practitioner or provider agrees to treat a patient, they enter into a contractual relationship with that patient.<sup>351</sup> The duty of health care professionals to care for patients or to act in their best interest and maintain the highest possible standard of conduct and integrity is embodied in the contractual relationship existing between the parties. An infringement of this duty might give rise to a claim requiring the patient to establish that the health care practitioner was negligent in rendering the aforesaid duty. If it could be established that the health care practitioner was negligent, he would be liable for medical negligence. This duty to act using the highest possible standard therefore appears to directly implicate private health care practitioners in the constitutional right to have

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<sup>347</sup> *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA) para 15, 17, 18 and 22.

<sup>348</sup> Pieterse M (2007)178.

<sup>349</sup> Pieterse M (2007)178.

<sup>350</sup> McQuoid-Mason M (2011) "Medical Ethics and the Payment of Fees before Treatment" Vol 101 No 11 *SAMJ* 798.

<sup>351</sup> McQuoid-Mason M (2011) 798-799.

access to health care as there are remarks by South African courts which suggest that the enjoyment of the right to have access to health care is significantly compromised where quality standards are not adhered to or are not enforced.<sup>352</sup> In the paragraphs that follow, I will be reviewing the concept of medical negligence to establish how the existing South African common law provides a remedial avenue through which the right in section 27(1) (a) can be enforced horizontally.

### 3.4.2 The Common Law doctrine of Medical Negligence

Medical negligence is a conduct that falls short of an acceptable standard that is required from a health care professional.<sup>353</sup> Negligence constitutes the basis of a claim relating to medical malpractice. It is the leading ingredient which must be established in order to hold a medical practitioner liable for an act of misconduct.<sup>354</sup> A medical professional should not be held to be negligent simply because he did something wrong in the course of performing his duties.<sup>355</sup> Where the actions of a health care practitioner have caused harm or injury to a patient but all of the surrounding circumstances giving rise to a claim of medical negligence are not established, liability cannot be established from such act or omission. The test therefore is whether the practitioner exercised reasonable skill and care or whether or not his conduct fell below the standard of a reasonably competent practitioner in his field. If the error is one which a reasonably competent practitioner would not have made, it will amount to medical negligence.<sup>356</sup> The said test as formulated in *Van Wyk v Lewis*<sup>357</sup> is fundamentally an objective test which entails that the health care practitioner ought to have foreseen the possibility of harm or injury caused to the patient in the circumstances as a reasonable person in his or her capacity would have seen that possibility.<sup>358</sup> However, the test also contains subjective elements when negligence is observed from an expert's perspective. That is, if the expert is a medical practitioner, the standard expected is that of a reasonable medical practitioner in the same circumstances.<sup>359</sup> It is indicative from the above test of negligence that what is required from the health care practitioner is not the highest

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<sup>352</sup> *Strydom v Afrox Health Care* para 626b-e; 627f-g. *Korf v Health Professional Council of South Africa* 2000 (1) SA 1171 (T), 1179B-D.

<sup>353</sup> Bal BS "An introduction to medical malpractice in the United States" (2009) *Clin Orthop Relat Res* 10.1007/s11999-008-0636-2 324.

<sup>354</sup> Bal BS (2009) 324.

<sup>355</sup> Carstens and Pearmain (2007) 619-623.

<sup>356</sup> Carstens and Pearmain (2007) 264.

<sup>357</sup> *Van Wyk v Lewis* (1924) AD 438.

<sup>358</sup> Carstens and Pearmain (2007) 621.

<sup>359</sup> Carstens and Pearmain (2007) 621.

possible degree of professional care and skill but whether he applied reasonable skills and care in treating the patient.<sup>360</sup>

### 3.4.3 Establishing Negligence under the Common Law

Medical malpractice cases proceed on the basis that the health care practitioner was negligent in treating the patient. However, it is not sufficient to conclude that a medical practitioner was negligent simply because the result or the expected outcome was not achieved. Negligence must not only be alleged but must also be proven by investigating and examining the available facts and evidence.<sup>361</sup> For example, where a health care practitioner forgets surgical equipment or cotton wool in the body cavity after a medical procedure, it is not yet conclusive evidence of medical negligence on the part of the health care practitioner. Certain factors will have to be taken into consideration including the experience of the practitioner, the complexity of the medical procedure as well as other surrounding circumstances in order to reach a conclusive decision that may amount to provable negligence by the health care practitioner.<sup>362</sup> To establish medical negligence therefore, the onus is on the patient to prove that the health care practitioner was negligent.<sup>363</sup> In doing so, four elements must be established to hold the health care practitioner accountable for his or her actions. These elements are set out as below.

#### 3.4.3.1 Duty of Care

In order to succeed in a claim relating to medical malpractice, the claimant would need to indicate that a duty of care was owed to him by the health care practitioner. As seen above legal duty exists whenever a hospital or health care provider undertakes care and the treatment of a patient.<sup>364</sup> In South Africa, these duties are set out in the National Health Act.<sup>365</sup> Apart from the above, the Health Professional Council of South Africa (HPCSA) has also set out ethical guidelines for health care providers and professionals to observe in the course of providing health care

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<sup>360</sup> Carstens and Pearmain (2007) 621-622.

<sup>361</sup> Bal BS (2009) 342.

<sup>362</sup> Carstens and Pearmain (2007) 639.

<sup>363</sup> Carstens P “Judicial Recognition of the Application of the Maxim Res Ipsa Loquitur to a Case of Medical Negligence: *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* (2009/52394) [012] ZAGPJHC 208:2All SA 356 (GSJ) (24 October 2012)” (2013) *Obiter* 348-358.

<sup>364</sup> McQuoid-Mason M “Medical Ethics and the Payment of Fees before Treatment” (2011) *SAMJ* 798.

<sup>365</sup> National Health Act 61 of 2003 (published in Government Gazette No 26595 of the Republic of South Africa Vol 469 on 23 July 2004 Chapter 2).

services to users.<sup>366</sup> While in this contractual relationship, the ethical and legal principles regarding the relationship come into play and are binding on the health care professional. As a result, the health care practitioner is under obligation to observe these principles and act in the patient's best interest. A breach of the terms of this contractual relationship may give rise to legal implications. Professional negligence may therefore be established when the health care professional negligently fails to observe these ethical and legal duties.<sup>367</sup>

#### **3.4.3.2 Violation of the Standard of Care**

As in most professions, the medical profession has codes of conduct and a standard of behaviours for practitioners to observe. It will be acceptable conduct on the part of the health care practitioner if this conduct adheres to the standards set out by these codes. However, any action by any medical practitioner that is below the standard of care expected of him or her will be unacceptable and may attract sanctions prescribed by the code of conduct. According to the Health Professions Council of South Africa, health care professionals are required to be subscribed to certain rules of conduct in the course of performing their duties.<sup>368</sup> The National Health Act also prescribes certain standards to be observed by health care professionals in the course of performing their duties.<sup>369</sup> This is known as the standard of care. To succeed in a claim of medical malpractice, the claimant must establish that the health care practitioner has breached the duty of care embodied in the contractual relationship binding the parties. If it is determined that the standard of care has not been met, then negligence may be established.<sup>370</sup>

#### **3.4.3.3 An Injury Caused by Negligence**

For a medical malpractice claim to be valid, it is not sufficient that a health care professional has simply violated the standard of care. The patient must also prove that he or she sustained an injury that would not have occurred had it not been for negligent action by the health care professional.<sup>371</sup> An unfavourable outcome by itself will not result to malpractice. The patient must prove that the negligence caused the injury. If there is an injury without negligence or negligence that did not

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<sup>366</sup> Ethical and Professional Rules of the Health Professional Council of South Africa GN R717 (Published in Government Gazette 29079 of 4 August 2006, as amended by GN R68 in Government Gazette 31825 of 2 February 2009).

<sup>367</sup> McQuoid-Mason M (2010) 574.

<sup>368</sup> Ethical and Professional Rules of the Health Professional Council of South Africa.

<sup>369</sup> National Health Act 61 of 2003 *Chapter 2*.

<sup>370</sup> Bal BS (2009) 342.

<sup>371</sup> Bal BS (2009) 342.



result to an injury, no case of medical malpractice will be established. There must therefore exist a nexus. That is, a link between the negligent acts by the medical practitioner and the injury caused to the patient before the patient can succeed in holding the health care practitioner liable.<sup>372</sup> Therefore, for a professional conduct by a health care professional to amount to medical negligence, the patient must establish that the conduct by the health care professional's action resulted to injury and the patient must show a causal link between the action and the injury.

#### **3.4.3.4 Negligence by a Medical Practitioner Must Result in Significant Damages**

To succeed in a claim relating to medical malpractice, the claimant must prove that the injury caused by the health care practitioner's action resulted to significant damages. For there to be any viable medical malpractice issues, the patient must show significant damages that resulted from the negligent action by the health care practitioner. The patient must show that the injury caused by the health care professional resulted to disability, loss of income, unusual pain, suffering and hardship, or significant past and future earnings.<sup>373</sup>

### **3.5 Judicial Development of the Common Law to give effect to the Horizontal Application of the Right to Have Access to Health Care services**

As discussed above, if a right that binds private party can be established under section 8(2) of the Constitution, section 8(3) enjoins courts to consider whether there are existing common law rules or to develop existing common law to cure any deficiency in the rule, in the absence of any adequate legislation to give effect to that right.<sup>374</sup> Furthermore, the courts are required to apply or develop the existing common law in so far as it is reasonably possible to protect and give effect to the rights and fundamental constitutional values.<sup>375</sup> In this regard, Pieterse has opined that the task of establishing the desired quality or standard of care in cases dealing with medical negligence is therefore sufficiently flexible to accommodate quality concerns inherent in the right to have access to health care under section 27(1)(a).<sup>376</sup> The main advantage of delictual claims of this nature is that the victim is awarded damages for the loss he or she has suffered which serves as an effective means of achieving accountability.<sup>377</sup> Accordingly, the standard of care required in medical negligence cases strikes a fair balance between competing interest of health care

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<sup>372</sup> Bal BS (2009) 342.

<sup>373</sup> Bal BS (2009) 342.

<sup>374</sup> Section 8(2) and 8(3) of the Constitution.

<sup>375</sup> Section 39(2) of the Constitution. Liebenberg S (2010) 333.

<sup>376</sup> Pieterse M (2007) 174.

<sup>377</sup> De Beer RJ and Vettori S (2007) 20.

professionals and patients and makes the existing common law a remedial avenue through which the obligation in section 27(1) (a) can be enforced by way of indirect horizontal application.<sup>378</sup>

However, it is important to note that any possible application or development of the existing common law must resonate with the fundamental principles of the Constitution and promotes its spirit, purport and object.<sup>379</sup> In this regard, Pieterse warns of certain practical impediments which might diminish the effectiveness of the standard of care rule if courts might consider a possible application in the context of section 27(1) (a) of the Constitution. He has pointed that the exclusion clauses as observed in the case *Afrox Healthcare v Strydom* are contrary to public policy and should be avoided in contracts in order to resonate with the values of section 27(1)(a) of the Constitution.<sup>380</sup> Some scholarly writers also concur with this view by stating that these clauses prevent patients from availing themselves to available remedies where the quality guarantee underlying their right to have access to health care services has been infringed.<sup>381</sup> Such clauses are very common in South Africa as a great majority of private health care providers indemnify themselves against damages resulting from negligence administered by their personnel and are arguably an impediment to the effectiveness of relevant common law principles which can be applied or developed to enforce the right of access to health care services horizontally.<sup>382</sup>

Furthermore, Pieterse has pointed to the existing imbalance of scientific knowledge between the patient and the doctor as an impediment to the effectiveness of existing common law rules, which according to him can be resolved by applying the maxim of *rep ipsa loquitur* in alleged cases relating to medical negligence.<sup>383</sup> The *rep ipsa loquitur* maxim is a doctrine that infers negligence from the very nature of the accident in the absence of direct evidence on how any defendant behaved.<sup>384</sup> The doctrine does not create presumption of negligence nor does it transfer the onus from the plaintiff to the defendant but serves as an aid to the plaintiff in appropriate cases to argue by inferential reasoning that the facts established allow for the inference of negligence.<sup>385</sup> Pieterse believes that the application of this maxim to medical negligence cases will significantly enhance the potential of section 27(1) (a) to address the existing imbalance between the doctor and patient relationship and make the existing common law rule effective in addressing any infringement of the

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<sup>378</sup> Pieterse M (2007) 175.

<sup>379</sup> Section 39(2) of the Constitution.

<sup>380</sup> Pieterse M (2007) 177.

<sup>381</sup> Brand D "Disclaimer in Hospital Admission Contracts and Constitutional Health Rights" (2002) *ESR Rev* 22.

<sup>382</sup> Pieterse M (2007) 177.

<sup>383</sup> Pieterse M (2007) 175.

<sup>384</sup> Patel B "Medical negligence and *res ipsa loquitur* in South Africa" (2008) *SAJBL* 57.

<sup>385</sup> *Goliath v MEC for Health in the Province of Eastern Cape* (1084/2012) [2013] ZAECGHC 72 (14 June 2013).

right to have access to health care by private entities.<sup>386</sup> Unfortunately, this maxim is of no application in medico-legal cases in South Africa. South African courts have literally refused to apply the aforesaid maxim due to the sympathetic conditions under which health care professionals operate in the country.<sup>387</sup> In this regard, it is important that courts in South Africa change the manner in which they currently deal or apply certain legal principles and follow the example of a possible development of the common law as highlighted by Pieterse. In doing so, they would serve to enhance access to health care services and upheld the transformative vision of the Constitution with regards to equality.

### 3.6. Conclusion

In this chapter, I have explored the horizontal application of the right to have access to health care services, which proceeded with privatisation as the process through which non-state actors have become increasingly involved in the delivery of health care services in South Africa. With the increased participation of the private sector in delivering health care in South Africa, their actions could have profound effects on the right to have access to health care services. Accordingly, I have demonstrated that the South African Constitution has acknowledged the role of private entities and has not limited its operation upon the State in actualising the right to have access to health care services. The Constitution explicitly or by implication recognises that certain obligation engendered in the right to have access to health care services may be enforced upon private entities depending on the nature of their participation in the realisation of section 27(1)(a). The large role of the private health sector in delivering health care services can thus be ameliorated in South Africa through legislative interventions and the development of the common law as prescribed by the Constitution.<sup>388</sup>

However, apart from the right to have access to adequate housing, courts have been very reluctant to enforce section 27(1)(a) horizontally using the mechanism put in place by the Constitution.<sup>389</sup> In the case of *Afrox v Healthcare Care v Strydom*, where the Supreme Court of Appeal was expected to uphold the values of the Constitution and enforced the right to have access to health care services horizontally, the court declined to do so.<sup>390</sup> In this regard, there have been an attempt to develop the common law standard of care rule in cases where medical

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<sup>386</sup> Pieterse M (2007) 175.

<sup>387</sup> Thompson HS (2008) 59.

<sup>388</sup> Section 8 of the Constitution.

<sup>389</sup> *Government of the Republic of South Africa v Grootboom and others* para 34.

<sup>390</sup> *Afrox v Healthcare Care v Strydom*.

negligence is alleged as an avenue through which section 27(1)(a) can be applied horizontally.<sup>391</sup> It should be noted that post-apartheid national exigencies characterises the construction of the South African society and it is against this backdrop that many scholarly writers believe that the Constitution had not only incorporated socio-economic rights but the demand for horizontality became apparent.<sup>392</sup> As such, if health rights in South Africa are to be taken very seriously, courts should then act to ensure that the private sector respect, promote and fulfil the right to have access to health care services to the extent that they are participating in their delivery. In doing so, they will play a complementary role in the process of social transformation and improve the quality of life of the peoples in South Africa.

In the next chapter, we shall discuss efforts undertaken by the state to actualise the right to have access to health care services. The Constitution requires that the state adopts reasonable legislative and other measures which are necessary for everyone to have access to health care services.<sup>393</sup> In this regard, the next chapter shall examine the efforts taken by the State to achieve a progressive realisation of the right to have access to health care services by considering several legislative enactments within South Africa.

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<sup>391</sup> Pieterse M (2007) 173-178.

<sup>392</sup> Nolan A (2014) 76.

<sup>393</sup> Section 27 (3) of the Constitution.

## CHAPTER 4: PROGRESSIVE REALISATION OF THE RIGHT TO HAVE ACCESS TO HEALTH CARE SERVICES

### 4.1 Introduction

Health care is a fundamental human right just like any other socio-economic right.<sup>394</sup> It is indispensable for the enjoyment of other human rights as they are interrelated.<sup>395</sup> Therefore, every human being is entitled to the enjoyment of the highest standard of health that will enable him to live a life of dignity. In South Africa, the government has the primary responsibility to fulfil the right to have access to health care services. According to section 7(2) of the Constitution, the State is obliged to respect, protect, promote and fulfil all rights in the Bill of Rights.<sup>396</sup> The obligation therefore to protect refrains the State from denying anyone access to the right to have access to health care services. The obligation further enjoins the state, in terms of Section 27(2) to take reasonable legislative and other measures within its available resources to ensure that everyone within the country has access to health care services. In doing so, the state must therefore provide the necessary framework which will translate into actualisation, the right in section 27(1) of the Constitution.

Thus far, the government has committed itself to upholding, promoting and protecting the right in section 27(1) of the Constitution. In 1997, policy goals were identified in the White Paper for the transformation of the health system in South Africa.<sup>397</sup> Among these goals were the integration of the activities of the private and public health care sector in order to maximise the effectiveness and efficiency of all available health care resources.<sup>398</sup> Other goals relevant to the fulfilment to the right in section 27(1) of the Constitution included, an equitable distribution of health care personnel throughout the country, establishing health care financing policies to promote equity between people living in rural and urban areas and between people served by the public and private health sectors and development of human resource available to the health sector.<sup>399</sup> Between 1994 and 2015, new legislations and regulations have been enacted as well as other measures put in place

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<sup>394</sup> Pereira A "Live and let Live: Healthcare is a Fundamental Human Right Human Right" (2004) *Connecticut Public Interest Law Journal* 481.

<sup>395</sup> General Comment 14 (Committee on Economic, Social and Cultural Rights, The Right to the highest attainable standard of health Twenty-second session 2000 U.N. Doc. E/C.12/2000/4 2000 REPRINTED IN Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies U.N. Doc. HRI/gen/1/Rev 6 (2003)) 85.

<sup>396</sup> Section 7 of the Constitution.

<sup>397</sup> Department of Health (*White Paper for the Transformation of the Health System of South Africa* 1997) Section 1.1.2.

<sup>398</sup> Pearmain D "Health Policy and Legislation" in *South African Health Review* (Health System Trust 2007) 21.

<sup>399</sup> Pearmain D (2007) 21.

to ensure that everyone has access to health care services. A further commitment by the government has been to adopt and implement a National Health Insurance scheme to bring about reforms in the present health care system which remains fragmented both within the public health sector and between the public and private health care sector.<sup>400</sup>

The goal of this chapter is to discuss some of the measures, being key policies and laws the state has developed and implemented to progressively realise the right to have access to health care services in South Africa. The chapter therefore focuses on the extent of legislative and executive translation of the right to have access to health care services in terms of section 27(1) of the Constitution. In doing so, the chapter will also make an appraisal of the measures put in place by the government to guarantee the enjoyment of the aforesaid right. The chapter further discusses the development of a monitoring tool by the Studies in Poverty and Inequality Institute (SPII) to monitor and evaluate the progressive realisation of socio-economic rights. The aforesaid tool has been endorsed by the South African Human Rights Commission with the constitutional mandate to monitor and evaluate the progress made to realise socio-economic rights and has been applied to evaluate progress made in respect of the right to have access to health care services.

#### **4.1.1 The Use of a ‘Progressive Realisation’ Standard as Measuring Tool for State’s Compliance with Socio-Economic Rights Obligations**

In section 27 of the Constitution, the obligation for the realisation of socio-economic rights is premised on a standard of “progressive realisation” subject to government’s available resources. This standard is also entrenched in the ICESCR, the foundational binding instrument entrenching socio-economic rights and generating state obligations for their realisation.<sup>401</sup> Article 2(1) of the ICESCR states that

“Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.”<sup>402</sup>

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<sup>400</sup> Lomahoza K (2013) 1-16.

<sup>401</sup> United Nations High Commissioner for Human Rights (UNOHCHR) *Economic, social and cultural rights: A handbook for National Human Rights Institutions* (2005) 5.

<sup>402</sup> Article 2(1) of the International Convention on Economic, Social and Cultural Rights.

Accordingly, the South African Constitution has also upheld this standard and the Constitutional Court have further adopted the same interpretation given to the standard by the CESCR in *Grootboom* where the court held as follows:

“Although the Committee’s analysis is intended to explain the scope of the state’s parties’ obligations under the Covenant, it is also helpful in plumbing the meaning of “progressive realisation” in the context of the Constitution. The meaning ascribed to the phrase is in harmony with the context in which the phrase is used in our Constitution and there is no reason not to accept that it bears the same meaning in the Constitution as in the document from which it was clearly derived.”<sup>403</sup>

The rationale behind the “progressive realisation” standard is that based on the perceived nature of socio-economic rights, they entail highly resourced-dependant positive obligations, and thus require that States only take steps to progressive realise these rights within its available resources.<sup>404</sup>

However, the difficulty in implementing the “progressive realisation” standard, coupled with the monitoring and evaluation challenges it encompasses, has resulted to criticisms, with the proponents of these criticisms arguing that it is the major reason for the endemic neglect in the realisation of socio-economic rights nationally and internationally.<sup>405</sup> In this regard, Robert Robertson argues that the use of the standard of “progressive realisation” as a yardstick for measuring States’ compliance with their socio-economic rights obligations is problematic as it has eluded adequate definition through the years, and that authoritative bodies and rights advocates have been unable to develop adequate indicators to usefully operationalise it.<sup>406</sup> He suggests the need for development of the content to the standard and contends that if the content of the standard is not developed, the assessment of State performance in the realisation of socio-economic rights will lack vigour and socio-economic rights will be viewed as idealistic, rhetoric and lacking in legal obligations.<sup>407</sup> Audrey Chapman has also contended that the standard of ‘progressive realisation’ is inexact and difficult to monitor and thus making it difficult to hold States

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<sup>403</sup> *Government of the Republic of South Africa v Grootboom & Others* para 45.

<sup>404</sup> Sepulveda M *The nature of the obligation under the International Convention on Economic, Social and Cultural Rights* (INTERSENTIA 2003) 256.

<sup>405</sup> Sepulveda M (2003) 133.

<sup>406</sup> Robertson RE “Measuring state compliance with the obligation to devote the “maximum available resources” to realising economic, social and cultural rights” (1994) *Human Rights Quarterly* 693- 694.

<sup>407</sup> Robertson RE (1994) 694.

accountable for the delay of implementation of socio-economic rights.<sup>408</sup> She further argues that the standard assumes differentiated content of rights and obligations for States depending on their relative level of development and availability of resources and thus necessitating the development of a multiplicity of performance standards for substantive socio-economic rights in relation to the varied social, developmental and resource context of each member states under the ICESCR.<sup>409</sup>

However, even though some commentators find the “progressive realisation” standard to be problematic, it is important to note that under the ICESCR, certain immediate obligations has also been incorporated into the standard such as the obligation to realise the minimum core content of socio-economic rights.<sup>410</sup> Unfortunately, the immediate nature for the realisation of the minimum core obligations was disputed by the Constitutional Court when it rejected the minimum core approach to socio-economic rights.<sup>411</sup> The Court’s concerns were the difficulty of determining the minimum contents of socio-economic rights, the fact that societal needs are diverse and people are differently situated and that the court was not institutionally competent to make such decisions without raising democratic concerns.<sup>412</sup> To this end, it is imperative to establish the meaning of the “progressive realisation” standard from a South African perspective and in the context of the socio-economic right under consideration in order to resolve the controversies surrounding the concept.

#### **4.1.2 The Meaning of Progressive Realisation in relation to the right to have access to health care services.**

What is apparent is that the obligation imposed on the State in terms of section 27 of the Constitution is dependent on the availability of resources. This implies that the realisation of the right to have access to health care services may be limited as a result of the lack of resources. Given the scarcity of resources and the significant demands on them, an unqualified obligation to meet this right makes it incapable of being fulfilled.<sup>413</sup> In this regard, the entrenchment of the progressive realisation standard in the South African Constitution is also due to the recognition that

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<sup>408</sup> Chapman AR “A “violation approach” for monitoring the International Covenant on Economic, Social and Cultural Rights” (1996) *Human Rights Quarterly* 23.

<sup>409</sup> Chapman AR (1996) 31.

<sup>410</sup> See Limburg Principles, principle 25, which provides that “States Parties are obligated, regardless of the level of economic development, to ensure respect for minimum subsistence rights for all.”

<sup>411</sup> *Government of the Republic of South Africa v Grootboom & Others* para 33.

<sup>412</sup> *Government of the Republic of South Africa v Grootboom & Others* para 32-33.

<sup>413</sup> Currie & De Waal (2013) 581.



full realisation of socio-economic rights could not be achieved over a short period of time.<sup>414</sup> Thus the progressive realisation standard is intended to be a flexibility device reflecting the realities of a developing country like South Africa and the difficulties it may encounter in achieving the full realisation of socio-economic rights.<sup>415</sup>

However, it is possible for the state to use this qualification as an excuse not to undertake necessary measures to realise the substantive socio-economic rights entrenched in the Constitution. These concerns have also been raised under the ICESCR, for which reason, the CESCR has stressed that the standard should not be interpreted to leave States' socio-economic rights obligations bereft of content, but that it obliges States to move as expeditiously, and as effectively, and as possible towards meeting their goal of the full realisation of socio-economic rights.<sup>416</sup>

The CESCR has however, failed to specify how "expeditious and effective" progressive implementation should be, but has remarked that there is a strong presumption that retrogressive measures are prohibited.<sup>417</sup> This principle of non-retrogression has been criticised for being "an extremely crude and unsatisfactory yardstick for measuring compliance with progressive achievement of the Covenant".<sup>418</sup> It has been argued that it creates an incentive for states parties not to implement the ICESCR to their highest ability, or to try out various strategies for implementation of the rights in case they are held to an unsuccessful programme.<sup>419</sup> Furthermore, it is argued that the principle of non-retrogression creates a legal duty of not moving backwards rather than the positive one of moving forwards, which progressive realisation implies.<sup>420</sup> In this regard, the CESCR has been very assertive against retrogressive measures in its General Comment, delineating very stringent conditions for such retrogressive steps to be acceptable.

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<sup>414</sup> Sepulveda M (2003) 256. See paragraph 9 of General Comment 3, to which the Constitutional Court also refers, elaborates on the nature of the obligation. It states that "The concept of progressive realisation constitutes a recognition of the fact that full realisation of all economic, social and cultural rights will generally not be able to be achieved in a short period of time. Nevertheless, the fact that realisation, over time, or in other words progressively, is foreseen under the [ICESCR] should not be misinterpreted as depriving the obligation of all meaningful content. ...".

<sup>415</sup> CESCR General Comment 3 para 9. *Soobramoney v Minister of Health (Kwazulu- Natal)* 1998 (1) SA 765 (CC) para 11.

<sup>416</sup> CESCR General Comment 3 para 9.

<sup>417</sup> Chenwi L "Unpacking "progressive realisation", its relation to resources, minimum core and reasonableness and some methodological consideration for assessing compliance" (2013) *De Jure* 744-746.

<sup>418</sup> Mary Dowell-Jones *Contextualising the International Covenant on Economic, Social and Cultural Rights: Assessing the Economic deficits* (2004) 52.

<sup>419</sup> Mary Dowell-Jones (2004) 52.

<sup>420</sup> Mary Dowell-Jones (2004) 52.

However, it is argued that these arguments rather overplays the significance of the principle of non-retrogression within the obligation of progressive realisation and diverts attention from the goal-orientated nature of the obligation, which is to move as expeditiously and effectively as possible towards realising socio-economic rights.<sup>421</sup>

In essence, the progressive realisation obligation goes further than achieving the minimum essential elements of the socio-economic rights and encompasses an obligation for a State to ensure the widest possible enjoyment of these rights on a progressive basis.<sup>422</sup> It requires a State to strive towards fulfilment and improvement in the enjoyment of socio-economic rights to the maximum extent possible, even in the face of resource constraints.<sup>423</sup> The fact that the full realisation of most economic, social and cultural rights can be achieved only progressively does not therefore alter the nature of the legal obligation of the State which requires that certain steps be taken immediately and others as soon as possible. Accordingly, the burden is on the State to demonstrate that it is making measurable progress towards the full realisation of the rights in question.

The dual nature of the obligation of progressive realisation was previously recognised in the Limburg Principles of 1988.<sup>424</sup> Paragraph 16 maintains that all states parties “have an obligation to begin immediately to take steps towards full realisation” of the rights in the ICESCR.<sup>425</sup> This is reinforced by paragraph 22, which stipulates that “some obligations under the Covenant require immediate implementation in full” by states parties.<sup>426</sup> As mentioned above, while the ICESCR provides for progressive realisation, it also imposes on states parties various obligations which are of immediate effect. The immediate obligations of states parties under the Covenant include the obligation to guarantee that the socio-economic rights will be exercised without discrimination and the obligation to take deliberate, concrete and targeted steps towards the full realisation of same.<sup>427</sup>

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<sup>421</sup> CESCR General Comment No 3 para 9 General Comment No 13 para 45 General Comment 14 para 32

<sup>422</sup> Chenwi L (2013)744.

<sup>423</sup> Chenwi L (2013) 743.

<sup>424</sup> Economic Social and Cultural Rights (ESCR) “*Limburg Principles on the implementation of the International Covenant on Economic, Social and Cultural Rights Thursday November 16 2006*” <http://www.ecsr-net.org/resorces/limburg-principles-implemetation-international-convenant-economic-social-and-cultural> (Date of use: 14 August 2015).

<sup>425</sup> Limburg Principles para 16 <http://www.ecsr-net.org> (Date of use: 14 August 2015).

<sup>426</sup> Limburg Principles para 16 <http://www.ecsr-net.org> (Date of use: 21 August 2015).

<sup>427</sup> CESCR General Comment No 2: Non-discrimination in Economic, Social and Cultural Rights (article 2(2) of the ICESCR) 2 July 2009 E/C 12/GC/20 para 7.

In *Grootboom*, the Constitutional Court held that the understanding and meaning of the term progressive realisation as contained in article 2(1) of the ICESCR bore the same meaning in the context in which it was used under the South African Constitution. In this regard, the Court observed that the right to housing could not be realised immediately and that the state must take steps to uphold the values of the Constitution and effectively meet the basic needs of the people.<sup>428</sup> Notwithstanding this, the Court added that progressive realisation means, “accessibility should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and, where possible, lowered over time.”<sup>429</sup> In stating the above, the court was of the opinion that the right to housing which was the issue in question had to be accessible not only to a larger number of people but to a wide range of people as time progresses.<sup>430</sup>

In subsequent cases however, the Constitutional Court has not engaged with the definition it provided for the term progressive realisation under *Grootboom*. In *President of the Republic of South Africa and Anor v Modderklip Boerdery (Pty) Ltd*, the Court held that the term progressive realisation required careful planning and fair procedures made known to those who are mostly affected with the problem of housing and that in doing so, orderly and predictable processes were instrumental.<sup>431</sup> The Court further stated that progressive realisation required the state to adopt measures which are flexible and could adapt to changing situations.<sup>432</sup> The Constitution further adopted a restrictive approach in respect of the term progressive realisation in *Mazibuko v City of Johannesburg*, in which the Court stated that the concept “recognises that policies formulated by the state will need to be reviewed and revised to ensure that the realisation of social and economic rights is progressively achieved.”<sup>433</sup> In stating this, the Court was of the opinion that the revision of policies over years was consistent with the obligation to ensure a progressive realisation of socio-economic rights.<sup>434</sup> The Court was further of the view that progressive realisation meant a constant increase of access to a right on a progressive basis especially for the poor, disadvantaged and other vulnerable groups.<sup>435</sup> However the approach followed by the Court in the aforesaid case has been criticised for being too restrictive and problematic in that constant revision of policies will not

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<sup>428</sup> *Government of the Republic of South Africa v Grootboom* para 45.

<sup>429</sup> *Government of the Republic of South Africa v Grootboom* para 45.

<sup>430</sup> *Government of the Republic of South Africa v Grootboom* para 45.

<sup>431</sup> *President of the Republic of South Africa v Modderklip Boerdery (Pty) Ltd* para 49.

<sup>432</sup> *President of the Republic of South Africa v Modderklip Boerdery (Pty) Ltd* para 49.

<sup>433</sup> *Mazibuko v City of Johannesburg* para 40, 60.

<sup>434</sup> *Mazibuko v City of Johannesburg* para 40, 67, 162 and 163.

<sup>435</sup> *Mazibuko v City of Johannesburg* para 97.

enhance the enjoyment of a particular socio-economic right as this has only the effect of only improving the policy.<sup>436</sup>

It is therefore indicative from the above that the ambiguity surrounding the definition of this term also undermined efforts to effectively implement and enforce socio-economic rights.<sup>437</sup> In this regard, some academic commentators are of the opinion that the progressive realisation assertion requires the state to strive towards the fulfilment and enjoyment of socio-economic rights to the maximum extent possible, even in the face of scarce resources.<sup>438</sup> In the context of section 27 of the Constitution, the state must therefore take concrete action to reduce any structural inequality plaguing the health care system and adopt measures that give appropriate treatment to the most vulnerable and marginalised group of people in South Africa.

#### **4.2 The Role Played by Courts in Ensuring a Progressive Realisation of Socio-Economic Rights.**

In South Africa, courts have played a significant role in ensuring a progressive realisation of socio-economic rights. The judicial enforcement of socio-economic rights by the courts has contributed to the effectiveness of the constitutional guarantee of these rights. Yacoob J acknowledged the role of the Courts in guaranteeing the fulfilment of socio-economic rights in *Grootboom* in which he stated that:

*“I am conscious that it is an extreme difficult task for the State to meet these obligations in the conditions that prevail in our country. This is recognised by the Constitution which expressly provides that the State is not obliged to go beyond available resources or to realise these rights immediately. I stress however, that despite all these qualifications, these are rights and the Constitution obliges the State to give effect to them. This is an obligation that Courts can, and in appropriate circumstances, must enforce.”*<sup>439</sup>

The role of the courts was later affirmed in *Treatment Action Campaign*, in which the Constitutional Court held that:

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<sup>436</sup> Chenwi L (2013) 748-749.

<sup>437</sup> Chenwi L (2013) 768-769.

<sup>438</sup> Dawson H and McLaren D “Monitoring an Evaluating the Progressive Realisation of Socio-Economic Rights in South Africa” (2015) *Studies in Poverty and Inequality Institute Working Paper* 6.

<sup>439</sup> *Government of the Republic of South Africa v Grootboom* para 94.

*“The state is obliged to take reasonable measures progressively to eliminate or reduce the large areas of severe deprivation that afflicts our society. The courts will guarantee that the democratic processes are protected so as to ensure accountability, responsiveness and openness, as the Constitution requires in its section 1. As the Bill of Rights indicates, their function in respect of socio-economic rights is directed towards ensuring that legislative and other measures taken by the state are reasonable.”*<sup>440</sup>

In outlining the role of the courts, the Constitutional Court also stated that:

*“The primary duty of courts is to the Constitution and the law... Where state policy is challenged as inconsistent with the Constitution, courts have to consider whether in formulating and implementing such policy the state has given effect to its constitutional obligations. If it should hold in any given case that the state has failed to do so, it is obliged by the Constitution to do so.”*<sup>441</sup>

In accordance with this role, the courts have demonstrated themselves to be willing to enforce positive obligations arising from certain socio-economic rights in a few cases that have been brought before them. In *Grootboom*, the Court developed and applied a test for reasonableness as a guide to determine whether the government programme were consistent with constitutional requirement.<sup>442</sup> Although some commentators have been critique of the reasonable approach in that socio-economic rights are non-justiciable because of their budgetary consequences and that any justiciability will encroach into the legislative and executive terrain, the courts have proceeded to apply the aforesaid test to determine and evaluate government’s action in enforcing socio-economic rights.<sup>443</sup> In *Grootboom* for instance, the Constitutional Court, separated out its analysis of whether the State’s housing programme complied with the obligation of progressive realisation from its analysis or reasonableness. In this regard, the Court found the state’s housing programme to be unreasonable as it made no provision for access to housing for people in desperate need. The Court held that a government programme *“must clearly allocate responsibilities and tasks to the different spheres of government and ensure that the appropriate financial and human resources are available.”* The court further held that *“a co-ordinated state housing programme must be a comprehensive one determined by all three spheres of government in consultation with each other as contemplated by Chapter 3 of the Constitution.”*<sup>444</sup> The court continued to state that

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<sup>440</sup> *Minister of Health v TAC* para 36.

<sup>441</sup> *Minister of Health v TAC* para 99.

<sup>442</sup> 7<sup>th</sup> Report on Economic and Social Rights, South African Human Rights Commission 2006-2009 10.

<sup>443</sup> *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744(CC) para 77.

<sup>444</sup> *Government of the Republic of South Africa and Others v Grootboom* para 40.

the programme must further be coherent and capable of facilitating the realisation of a socio-economic right in question and that the promulgation of legislation was not sufficient to fulfil the constitutional requirement of reasonableness.

Despite the Court's effort to ensure the observance of socio-economic rights by State and non-State entities by utilising the test of reasonableness and in defining the concept in conjunction with the progressive realisation notion, it is argued that they remain difficult legal concepts in its application to certain socio-economic rights.<sup>445</sup> Within the context of socio-economic rights such as the right to water, those factors that should be weighed up to determine what is reasonable will require a contextual specific inquiry taking into consideration, among other things, available resources, social and political elements.<sup>446</sup> Nevertheless, it is argued that the relationship between progressive realisation and reasonableness offer a valuable framework for the interpretation of lags and further provides a framework for those who are in the position to evaluate the implementation of key socio-economic rights.<sup>447</sup> Therefore, while there might be some criticism directed at the Constitutional Court in respect of its reasonableness approach, the aforesaid Court has and will continue to play an important role in ensuring that the provision in the Bill of Rights are effectively guaranteed for the benefit of the people of South Africa.

### **4.3 Measures Put in Place by the State in Order to Realise the Right to Have Access to Healthcare Services**

Throughout the years, government has strived towards the fulfilment and improvement in the enjoyment of the right to have access to health care services to the maximum extent possible in the face of limited resources.<sup>448</sup> The government has initiated legislative and other measures to comply with its constitutional duties under section 27 of the Constitution. Laws and policies have been legislated dealing with different aspects of health care. These policies and laws describe in detail the meaning of the constitutional right to have access to health care services and who must implement them and how they should be implemented.<sup>449</sup> The policies and laws further comply with international standards and are able to realise some essential elements embodied in the right to have access to health care services.<sup>450</sup> These essential elements of the right to health are not

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<sup>445</sup> Pejan R, Du Toit D and Pollard S "Using progressive realisation and reasonableness to evaluate implementation lags in the South African water sector" (2011) *Lags-paper-IUCN-submission* 10.

<sup>446</sup> Pejan R, Du Toit D and Pollard S (2011)10.

<sup>447</sup> Pejan R, Du Toit D and Pollard S (2011)11.

<sup>448</sup> De Vos P *Health Care Rights* (Community Law Centre University of the Western Cape 2007) 289.

<sup>449</sup> De Vos P (2007) 189.

<sup>450</sup> De Vos P (2007) 282.

expressly mentioned in section 27 of the Constitution. They can be infer from paragraph 12 of General Comment No.14 on the right to health adopted by the Committee on *Economic, Social and Cultural Rights* and include availability, accessibility, appropriateness and acceptability.<sup>451</sup> Although these elements are not expressly mentioned in the South African Constitution, by analogy it can be said that they are not excluded from a progressive realisation approach to enforcing the right to have access to health care services. By this, I imply that in adopting policies and laws the government may have been guided by these elements to ensure that these policies are able to meet the needs of the population and result to a transformation of the health sector. In the paragraphs that follow, I will examine in this chapter, the progressive realisation approach adopted by the government to fulfil its obligation under section 27 of the Constitution and whether the measures adopted so far has been able to result to a translation of the right to have access to health care services.

#### **4.3.1 National Health Act 61 of 2003**

The National Health Act 61 of 2003 (NHA), is arguably the most important act passed by the Parliament of South Africa to give effect to the right to have access to health care services as guaranteed under section 27 of the Constitution.<sup>452</sup> The act therefore represents the most significant attempt by the government to translate the right to have access to health care especially in the public sphere. The act is a culmination of key health system policies dating as far back as 1994. It further reflects elements of the African National Congress (ANC) Health Plan of 1994 as well as the 1997 White Paper on Health Systems Transformation including the decentralisation of health care services through district systems, the need to improve on the quality and standard of health care in both the private and the public sectors and the need for efficient human resource planning and development and increasing access to health care for everyone.<sup>453</sup> The Act was passed by Parliament in 2003 and was assented by the President in July 2004 and a further promulgation notice was issued in April 2005, which brought most of the Act into effect as from 2 May 2005.<sup>454</sup>

The objective of the Act is to regulate national health and to provide uniformity in respect of health care services. Furthermore, the Act aims at establishing a national health system which encompasses both public and private health care providers of health care services. Again the Act aims at protecting, respecting, promoting and fulfilling the right of the people of South Africa to the

<sup>451</sup> General Comment No14 on the right to health adopted by the Committee on *Economic, Social and Cultural Rights* para 12.

<sup>452</sup> Hassim A, Heywood M and Honermann B *The National Health Act 61 of 2003: A Guide* (1<sup>st</sup> ed Siber Ink 2008) 11.

<sup>453</sup> Hassim A, Heywood M and Honermann B (2008)11.

<sup>454</sup> National Health Act, Act 61 of 2003 [http://www.hst.org.za/uploads/files/chap2\\_03.pdf](http://www.hst.org.za/uploads/files/chap2_03.pdf) (Date of use: 15 August 2015).

progressive realisation of the constitutional right to have access to health care services including reproductive health care.<sup>455</sup> Apart from the above, the Act also aims at resolving socio-economic imbalances and inequalities of health care services created by the Apartheid regime and finally the Act aims at putting vulnerable peoples such as women, children, older persons and persons with disabilities at the centre stage of the provision of health care services.<sup>456</sup> The rationale of the Act is to fulfil the transformative goal of the Constitution by improving the quality of life of all citizens as the right to have access to health care services is a fundamental human right vital to the attainment of other fundamental human rights.

In order to achieve these objectives, the Act has set out some important provisions that have a direct link with the constitutional obligation set out in section 27 of the Constitution. Section 3 of the Act states that, the Minister must within available resources, “ensure the provision of such essential health care services, which must at least include primary health services, to the population of the Republic as may be prescribed after consultation with the National Health Council.<sup>457</sup> Section 4 of the Act, further sets out in general terms the ways in which people are to be able to gain access to health care services. This provision prescribes the Minister to provide more details about which categories of people are eligible for certain free health care services, some of whom are already listed under the Act. Section 4 of the NHA states that:

“(1) The Minister, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health care services at public health establishments as may be prescribed.

(2) In prescribing any condition contemplated in subsection (1), the Minister must have regard to-

- (a) the range of free health services currently available;
- (b) the categories of persons already receiving free health care services;
- (c) the impact of any such condition on access to health care services; and
- (d) the needs of vulnerable groups such as women, children, older persons and persons with disabilities.

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<sup>455</sup> Section 2 of the National Health Act (a)-(c).

<sup>456</sup> Section 2 of the National Health Act (a)-(c).

<sup>457</sup> Section 3 of the National Health Act.



(3) Subject to any condition prescribed by the Minister [of Health], the State and clinics and community health centres funded by the State must provide-

- (a) pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services;
- (b) all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free primary health care services; and
- (c) women, subject to Choice on Termination of Pregnancy Act, 1996..., free termination of pregnancy services”.<sup>458</sup>

Furthermore, section 5 of the NHA reaffirms the constitutional provision of section 27(3) that no one may be refused emergency medical treatment by any health care provider, health care professional or health care establishment.<sup>459</sup> According to Gray *et al.*, this provision has a direct implication for the private sector, where the ability to pay is an important barrier to access of health care services.<sup>460</sup> However, no definition is provided for the term emergency medical treatment and no further regulations have been provided in the Act that gives clarity to this provision. In this regard, some private hospitals have refused to abide by the aforesaid provision and insist on charging for any treatment they render to any patient even if it appears to be an emergency case. Accordingly, individual health care facilities are able to provide their own interpretation on what emergency medical treatment.<sup>461</sup>

Notwithstanding the above, the regulation of the Medical Scheme Act 131 of 1998, furnishes us with a definition of the term emergency medical condition. In the Medical Scheme Act, “‘emergency medical condition’ means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s life in serious jeopardy”.<sup>462</sup> This definition can be extended by analogy to cover the gap created in the National Health Act in respect of emergency medical treatment. In *Soobramoney*, the Constitutional Court also provided a definition of the term

<sup>458</sup> Section 4 of the National Health Act.

<sup>459</sup> Section 5 of the National Health Act.

<sup>460</sup> Gray A et al “Health Legislation” in Ijumba P and Barron P (eds) *South African Health Review* (Health Trust Systems 2005) 18.

<sup>461</sup> Hassim A, Heywood M and Honermann B (2008) 15.

<sup>462</sup> Reg 7 of GNR 1262 OF 20 Oct 1999.

emergency medical treatment in which, access to dialysis services was held not to constitute emergency medical treatment.<sup>463</sup> The definition provided by the Court in the aforesaid case can also be extended to apply in the context of the National Health Act.

Section 5 is embodied in Chapter 2 of the National Health Act, which deals with the rights and duties of users and health care practitioners or personnel. Apart from the right to emergency medical treatment, the Act further awards patients a range of other concrete and claimable entitlements to receive relating to health care services. Some of the entitlements outlined here include the right to have full knowledge of one's condition,<sup>464</sup> the right to exercise informed consent to the kind of treatment which are available as well as the benefits and the risk associated with each treatment,<sup>465</sup> the right to participate in decisions relating to the treatment desired,<sup>466</sup> the right to be informed when one is participating in research, the right to confidentiality and access to health records<sup>467</sup> and finally the right of health workers to be treated with respect.<sup>468</sup>

The National Health Act also empowers patients to hold health care establishments accountable when they are not satisfied with a particular health care delivery. It provides an avenue to lodge complaints relating to how they have been treated by a health care facility.<sup>469</sup> It further states that the procedure to follow in order lodge a formal complaint and that this procedure must be clearly displayed in all health care facilities and furnished to a patient if he or she wishes to lodge a complaint.<sup>470</sup>

Another important aspect of the National Health Act that seeks to promote access to health care services is the provisions of the Act that relates to licensing systems.<sup>471</sup> Some scholarly writers have argued that licensing mechanisms under the Act promotes access to health care services in different number of ways. According to Pearmain, the licensing mechanisms under the Act promotes a rational distribution of health care services in accordance with the needs of local population and are further a means of ensuring that the quality of health care delivered at health establishments are up to standard in order to avoid certain risks associated with poor quality treatment.<sup>472</sup>

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<sup>463</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)* para 13.

<sup>464</sup> Section 6 of the National Health Act.

<sup>465</sup> Section 7 of the National Health Act.

<sup>466</sup> Section 8 of the National Health Act.

<sup>467</sup> Section 14, 15 and 16 of the National Health Act.

<sup>468</sup> Section 20 National Health Act.

<sup>469</sup> Section 18 National Health Act.

<sup>470</sup> Section 18(a) National Health Act.

<sup>471</sup> Section 36 National Health Act.

<sup>472</sup> Pearmain D (2007) 24.

Furthermore the National Health Act is further being backed by the development of policy documents which will significantly advance the translation of the right to have access to health care services. Some of the policies documents developed so far are set out as below:

#### 4.3.1.1 National Health Insurance

In 2011, the South African government unveiled a policy paper which put forward recommendations for the development of a comprehensive National Health Insurance (NHI) that would be developed over a period of fourteen years, beginning with a five year pilot in ten selected districts in 2012.<sup>473</sup> The goal of the National Health Insurance is to bring about reform in the health care system, which remains fragmented between the public health sectors and between the private and the public health care sectors with the resultant effect of health care being beneficial to a privileged minority.<sup>474</sup> The National Health Insurance therefore aims to challenge the aforesaid status quo by providing a non-discriminatory public health care that would be accessible by all South Africans irrespective of their socio-economic status.<sup>475</sup> To the extent that the National Health Insurance will be implemented, it is argued that the policy would dramatically change the landscape of access to health care services both in the public and private health care sectors as it would entail the rationing of health care services. It is further described as a progressive pro-poor policy as an effective implementation of the policy would result to an improvement of the livelihoods of many disadvantaged South Africans who are not able to access quality health care services.<sup>476</sup>

However, the efficacy of the National Health Insurance policy in addressing South Africa's health challenges has often been questioned. Some critics believe that the policy will not resolve South Africa's health challenges and other concerns have revolved around its implementation, especially on issues relating to costs for which the answers for these concerns lie only at the successful implementation of the policy. Before the kick off of the NHI project, it was estimated that during the first fourteen (14) years a big stake of approximately R 240 billion would be needed to roll over the project. It was projected that this money would be used to increase infrastructure and capacity for more health practitioners and support staff.<sup>477</sup> In this regard, critics questioned whether based on

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<sup>473</sup> National Health Act No 61 of 2003: (Policy Paper on National Health Insurance, Government Notice, 657 Pretoria: Government Printers 2011).

<sup>474</sup> Lomahoza K (2013) 7.

<sup>475</sup> Lomahoza K (2013) 7.

<sup>476</sup> Naidoo S "The South African National Health Insurance: A Revolution in Health-Care Delivery" (2012) *J Public Health* 149.

<sup>477</sup> South African Private Practitioner Forum in *National Health Insurance in South Africa* (SAPPF submissions on Green Paper on National Health Insurance, 2011-12-06) 19 para 11.2.

these financial challenges, the government would be able to administer the system efficiently given its poor record in governing the public health system in existent before the implementation of the NHI pilot project with particular reference to the governance of the Compensation for Occupational Injury and Diseases Fund and the Road Accident Fund.<sup>478</sup>

In spite of the above, the NHI pilot project kicked off in April 2012. To give effect to its implementation, the 2012 budget was accorded a special condition grant to kick start the pilot project.<sup>479</sup> The then Minister of Finance, Pravin Gordhan announced on 25 October 2011, that about R 500 million had been set aside in the 2012 budget to fund pilot sites identified in the NHI system.<sup>480</sup> The first phase of the National Health Insurance project was therefore rolled out with its primary focus being areas with little or no access to health care services.<sup>481</sup> In this regard, 13 NHI pilot districts were identified within South Africa. Even with the commencement of the NHI project, some critics have argued that patients in these 13 NHI pilot districts have not experienced any tangible difference in health care delivery when compared with patients in non-NHI pilot districts.<sup>482</sup>

Notwithstanding the above criticism, a number of achievements have been identified in respect of the implementation of the National Health Insurance. It was estimated by 2013 that about 25% of the 40,000 community health workers have been trained in the new, national approach to community-oriented primary health care. It was further reported in the same year that more mobile clinics were established to support school health services and that 43% of the 364 posts created for district clinical specialist teams have been filled.<sup>483</sup> The National Department of Health has further attempted to reduce the fragmentation between the public and the private health sector by contracting about 600 private general practitioners to provide sessional services within its primary health care clinics in the pilot NHI districts.

In spite of the above achievements, Ogunbanjo, have asserted that the pace of achievement since the roll out of the National Health Insurance is still very slow and will take some time before an average patient will be able to experience the full impact of the project.<sup>484</sup> Some serious challenges such as inadequate health personnel identified in some of the districts still remains to be

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<sup>478</sup> Brendah MM *Critical Discussion of the Right of Access to Health Care Services and the National Health Insurance Scheme* (LLM Thesis School of Law University of Limpopo 2013) 45-6.

<sup>479</sup> Ogunbanjo G "What is the Status-quo of South Africa's National Health Insurance Pilot Project?" (2013) *S Afr Fam Pract* 301.

<sup>480</sup> Brendah MM (2013) 45.

<sup>481</sup> Matsoso MP and Fryatt R "National Health Insurance: The First 18 Months" (2013) *S Afr Fam Pract* 156.

<sup>482</sup> Ogunbanjo G (2013) 301.

<sup>483</sup> Ogunbanjo G (2013) 301.

<sup>484</sup> Ogunbanjo G "South Africa's National Health Insurance revisited: "Quo vadis"? ("Whither goest thou?)" (2014) *S Afr Fam Pract* 84.

addressed. For this reason, it has been suggested that ongoing monitoring of the implementation of the National Health Insurance is required to ensure that the goals put forward by the aforesaid policy are achieved since this will mean better health care systems and processes of health care provision and improved access to health care services by all South Africans.<sup>485</sup>

#### **4.3.1.2 Patients Right Charter**

Another policy document which significantly advances the right to have access to health care services in South Africa is the Patients Right Charter of 2000. Although this charter predates the National Health Act of 2003, most of the provisions in the NHA are modelled on the provision of the Charter.<sup>486</sup> In section 2.3 of this charter, it is expressly stated that everyone has the right to have access to health care services in South Africa.<sup>487</sup> The right to have access to health care services is expressly set out with clarity under the Act for which reason the Act has been credited for making the aforesaid right more tangible for patients. However, one major challenge identified with the Charter is its limited awareness to the public which has rendered the Charter non-legally enforced.<sup>488</sup>

#### **4.3.1.3 The Charter of the Public and Private Health Sectors of the Republic of South Africa**

Another policy document to significantly translate the right to have access to health care services and reduce the fragmentation between the public and the private sector is the Health Charter drawn up in 2004 and further revised in 2005 and issued in a draft form without finalisation.<sup>489</sup> The Health Charter of South Africa acknowledges that the discrepancies in terms of health care ownership and distribution were disastrous to a majority of South Africans.<sup>490</sup> In this regard, it aims at addressing inequalities within South Africa's health care sector by effecting a transformation of the national health system in respect of equity, quality and access to health care services.<sup>491</sup> The revision of the Health Charter in 2005 also provided targets for black economic empowerment as envisaged in the Black Economic Empowerment Act of 2003 (BEE) and this has resulted to a number of black empowerment deals with three major hospital groups and a number of smaller

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<sup>485</sup> Matsoso MP and Fryatt R (2013) 156-7.

<sup>486</sup> National Parents' Rights Charter 2000.

<sup>487</sup> Section 2.3 of the National Parent Rights Charter.

<sup>488</sup> Pieterse M (2010) 242.

<sup>489</sup> Harrison D "An Overview of Health and Health Care in South Africa 1994-2010: Priorities, Progress and Prospects for New Gains" (A Discussion Document Commissioned by the Henry J Kaiser Family Foundation to Help Inform the National Health Leaders' Retreat Muldersdrift, January 24-26 2010) 25.

<sup>490</sup> Section 1.1 of the Charter of the Public and Private Health Sectors of the Republic of South Africa.

<sup>491</sup> Reynolds L, London L and Sanders D "The Draft Charter of the Private and Public Health Sectors of the Republic of South Africa: health for all, or profits for few?" (2005) *SAMJ* 742-743.

hospitals. However, these deals have so far not addressed the major challenges associated with access, quality and equity in health care service provision.<sup>492</sup>

#### **4.3.1.4 An appraisal of the National Health Act in ensuring Access to Health Care Services**

As can be seen above, the National Health Act therefore provides a framework for structured uniform health system within South Africa taking into account the constitutional requirements relating to the right to have access to health care services. Through this Act and its supporting policies, there has been significant translation of the right to have access to health care services. As highlighted in paragraph 4.2.1.1, the implementation of the National Health Insurance has so far witnessed some significant progress.<sup>493</sup>

However, some significant challenges still lie ahead in respect of the implementation of the National Health Act that will result to a translation of the right to have access to health care services. The Act requires the respective provinces to pass various provincial health legislations and to create provincial consultative bodies that will give effect to some of its provisions. Unfortunately, provinces are yet to fulfil this obligation in order for the population to enjoy the protection and benefits set out by the Act.<sup>494</sup> Furthermore, some supporting policies and regulations to give clarification to some concepts such as emergency medical treatment, which are central to the enjoyment of the right to have access to health care under the Act, are still outstanding.<sup>495</sup> Also, the exact parameters of entitlements to specific services and the obligation of the different types of health care establishments involved in the delivery of health care services and the processes through which patients can access their entitlements and insist on compliance with such obligations are still outstanding.<sup>496</sup> When subordinate legislation is required to give effect to an Act, the result is that the implementation of the Act becomes very slow. For this reason, the implementation of the National Health Act has actually been slow.<sup>497</sup> The failure by the Department of Labour to produce these legislations has resulted to a lot of uncertainty, which has made an overall implementation of the Act subject to a lot of challenges.<sup>498</sup> For this reason some, academic commentators have asserted that the translation of section 27 of the Constitution brought so far by the Act has for most of the part been incomplete especially in relation to access to private

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<sup>492</sup> Harrison D (2009) 25.

<sup>493</sup> Ogunbanjo G (2013) 301.

<sup>494</sup> Hassim A, Heywood M, and Honermann B (2008) 13.

<sup>495</sup> Pieterse M (2010) 240, 244.

<sup>496</sup> Pieterse M (2010) 251.

<sup>497</sup> Gray A and Caron J "Health Policy and Legislation" in Padarath A and English R (eds) *South African Health Review* (Health System Trust 2013) 31.

<sup>498</sup> Gray A and Jack Caron (2013) 32.

medical care. Accordingly, they have advocated that the legislature and the executive must urgently endeavour to correct the challenges associated with the implementation of the NHA should they consider the right to have access to health care services a pipeline dream for the people within South Africa.<sup>499</sup>

### 4.3.2 Medical Schemes Act 131 of 1998

This Act governs the terms of the regulation and registration of medical schemes in South Africa and has been described as one of the most significance attempt by the government to progressively realise the right to have access to health care services.<sup>500</sup> Among its objectives, the Act is designed to protect the interest of members belonging to medical schemes by setting out the terms and conditions for membership of schemes. The Act further prohibits any unfair discrimination on grounds such as sex, race gender, ethnicity, marital status, sexual orientation, pregnancy, disability and past and present state of health.<sup>501</sup> Furthermore, the Medical Scheme Act gives clarity to some major concepts central to the enjoyment of the right to have access to health care services. For instance, the term health service is defined explicitly in the Medical Schemes Act than in any other South African statute or policy document.<sup>502</sup> The Act further empowers members belonging to a medical scheme to insist that their schemes fully cover the costs of diagnosis and treatment of a continuously and updated list of conditions.<sup>503</sup> The Act further designates in a schedule which is attached to the regulations, prescribed benefits which must be made available to all members including their dependants.<sup>504</sup>

The Council for Medical Schemes is created by the Act to oversee that medical schemes comply with the Act and its accompanying regulations.<sup>505</sup> The aim of the council is to create awareness amongst members in respect of their rights under the Act and the Regulation.<sup>506</sup> The council further administers a complaint and efficient mechanism through which members can lodge a complaint to the Council after exhausting internal dispute resolution process.<sup>507</sup> In this regard, the

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<sup>499</sup> Pieterse M (2010) 251.

<sup>500</sup> Pieterse M (2010) 236.

<sup>501</sup> Section 24(2) of the Medical Schemes Act 131 of 1998.

<sup>502</sup> Section 1 of Act 131 of 1998.

<sup>503</sup> Section 29(1)(o) of Act 131 of 1998 read together with section 33(2)(a) and with Regulations 7-9 as well as Annexure A of the General Regulations Made in Terms of the Medical Schemes Act GN R 1262 of 20 October 1999.

<sup>504</sup> Pieterse M (2010) 237.

<sup>505</sup> Section 3 of Act 131 of 1998.

<sup>506</sup> Pieterse M (2010) 238.

<sup>507</sup> Section 47 of Act 131 of 1998.

council may suspend the registration of a particular medical scheme that fails to comply with the provisions of the Act or its regulations.<sup>508</sup>

Thus far, the Medical Scheme Act is one of the most significant pieces of legislation which has been able to translate the right to have access to health care services in the private sphere. For this reason, the Act's provisions and accompanying regulations have been credited for broadening access to health care for members who are registered with medical schemes.<sup>509</sup> In fact, South Africa has a very large private health sector dominated by medical schemes. In 2013, a General Household Survey (GHS) released by Statistics South Africa revealed that South Africa has witnessed an increase in medical aid coverage from 2.5 % in 2002 to 18.4% in 2013.<sup>510</sup>

However, some challenges have still been identified with the Medical Scheme Act, relating to its effectiveness in ensuring that everyone has access to health care services. There has been little or no legislative and executive or judicial action aimed at ensuring accessibility, affordability and the quality of private health care services.<sup>511</sup> In *Afrox Health Care Ltd v Strydom*, an attempt to also control exclusion clauses in admission documents was unsuccessful as the court held that exclusion clauses in themselves do not deny access to care or condone negligence. The court however overlooked the fact that such clauses prevented patients from availing themselves of their only remedy where quality guarantee underlying the right to have access to health care services has been infringed.<sup>512</sup> In *Minister of Health v New Clicks South Africa*, an attempt also by the Department of Health to implement a transparent pricing policy for manufacturers of medicines was held to be unconstitutional.<sup>513</sup> The regulation implemented by the Department of Health aimed at ensuring affordability and accessibility to medicines by regulating the profit margins for pharmaceutical companies and controlling their pricing policy. The regulation was declared invalid and of no force and effect by the Supreme Court of Appeal.<sup>514</sup>

The lack of such relevant regulations makes private health care still very much affordable and accessible in South Africa by the most influential and wealthy segment of the population.<sup>515</sup> Although, the General Household Survey (GHS) released by Statistics South Africa confirmed an increase in the percentage of persons covered by a medical scheme between 2002 and 2013, the

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<sup>508</sup> Pieterse M (2010) 238.

<sup>509</sup> Pieterse M (2010) 238.

<sup>510</sup> Statistics South Africa *General Household Survey* (2013) 28-29,100-103.

<sup>511</sup> Pieterse M (2010) 238.

<sup>512</sup> *Afrox Health Care Ltd v Strydom*.

<sup>513</sup> *Minister of Health v New Clicks South Africa* 2006 (2) SA 311 (CC).

<sup>514</sup> Department of Health *Regulation to a Transparent Pricing System for Medicines and Scheduled Substances* (GN R 553 30 April 2004).

<sup>515</sup> Pieterse M (2010) 238.



overall percentage is very insignificant as a majority of South Africans can only access the public health sector. The General Household Survey in 2013 reveals that 70.2% of South Africans would go to public clinics and hospitals upon any member falling ill or being involved in an accident as compared to 28.9%, who disclosed that they would first consult a private doctor.<sup>516</sup> Accordingly, the majority of South Africans are therefore left to exercise the right to have access to health care services in the public health sector.

#### 4.3.3 Choice of Termination of Pregnancy Act 92 of 1996

Section 27 requires the State to ensure that everyone has access to health care services including reproductive health care and the state must take reasonable legislative and other measures to achieve the realisation of each of these rights.<sup>517</sup> Accordingly, the Choice of Termination of Pregnancy Act is another legislation, which is aimed at translating the right to have access to reproductive health care. Reproductive health implies that people have the ability to engage in safe sexual relationships and that women can safely progress through pregnancy. Therefore access to safe termination services contributes to the right of reproductive health care through the reduction of maternal morbidity and mortality.<sup>518</sup>

The Choice of Termination of Pregnancy Act sets therefore out conditions and procedures to follow when a woman considers terminating a pregnancy.<sup>519</sup> The Act was introduced in response to high number of back street abortions estimated at 44,000 per year.<sup>520</sup> It was reported that as a result of these unsafe abortions using rudimentary methods, about 425 women were thought to die each year, accounting for about 3% of deaths among 20-29% year old women. The Choice of Termination of Pregnancy Act therefore allows for the termination upon request by a woman of a pregnancy which is up to 12 weeks old and at the discretion of a medical practitioner, a pregnancy which is up to 20 weeks of gestation.<sup>521</sup> The passing of this legislation has had the potential of improving maternal health in South Africa. Since 1997, the number of termination of pregnancies has increased and the legalisation of abortion has further decreased morbidity and mortality by 90% associated with unsafe abortions although clinical differences observed in hospitals was not substantial.<sup>522</sup>

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<sup>516</sup> Statistics South Africa *GHS* (2013) 28-29.

<sup>517</sup> Section 27(1) of the Constitution.

<sup>518</sup> Pickles C "Termination of Pregnancy Rights and Foetal Interest in Continued Existence in South Africa: *The Choice on Termination of Pregnancy Act 92 of 199*" (2012) *PELJ* No 5 410. O' Sullivan M "Reproductive Health Rights" in Woolman S *et al* (eds) *Constitutional Law of South Africa* (Juta Cape Town Revised Service 3 2011) 27-34.

<sup>519</sup> Section 2 of Choice on Termination of Pregnancy Act 92 of 1996.

<sup>520</sup> Harrison D (2009) 14.

<sup>521</sup> Harrison D (2009) 14.

<sup>522</sup> Harrison D (2009) 15.

However, even with the above framework in place, in 2011, Human Rights Watch (HRW) released a report showing that women's reproductive health rights are still being undermined in South Africa. The report focused on the public health system in the Eastern Cape Province and highlighted appalling conditions pregnant women had to endure when resorting to public health care facilities.<sup>523</sup> The report described circumstances where women have encountered verbal and physical abuse from attending hospital staff, general neglect, refusal of urgent medical treatment or have been turned away when attending the hospital to access maternal care.<sup>524</sup>

Furthermore, a number of problems and controversies remains as there are moral and religious objections to the idea of abortion.<sup>525</sup> Accordingly, a de facto denial of the right to have access to health care services would occur in situations where a health care professional refuses to terminate a pregnancy out of moral, ethical or religious objections and the requested service cannot be accessible elsewhere within a particular area.<sup>526</sup> The Choice on Termination of Pregnancy Act has failed to indicate how a balance should be struck between the implied rights of the health care professional such as the rights enshrined in section 15 of the Constitution and the express right of the patient to have in order to determine the reasonableness of the refusal by the health care professional.<sup>527</sup> In view of the above controversies, some academic writers have expressed their own opinions on how to strike this balance. According to Charles Ngwena the refusal to perform a termination of pregnancy as a result moral, religious or ethical objections would generally amount to a reasonable limitation on the right to have access to reproductive health care in terms of section 36 of the Constitution unless the termination is required as a matter of medical emergency. In spite of this assertion, he nevertheless regards health care professionals as duty bound to refer the patient to an alternative health care facility where termination services can be accessed.<sup>528</sup> However, the provision in section 6 of the Choice on Termination of Pregnancy Act requires that women who request termination of pregnancy should be informed of their rights in terms of the Act, which imposes limited restriction on the rights to object termination of pregnancy on ethical, moral and religious grounds especially in cases where no alternative facilities are available or accessible.<sup>529</sup> In view of the above, Pieterse has suggested that in circumstances where a conscientious objection amounts to a de facto denial of access to health

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<sup>523</sup> Pickles C (2012) 410. Human Rights Watch 2011 <http://www.hrw.org> (Date of use: 28 August 2015).

<sup>524</sup> Pickles C (2012) 410.

<sup>525</sup> Pieterse M (2014) 40.

<sup>526</sup> Ngwena C "Conscientious Objection and Legal Abortion in South Africa: Delineating the Parameters" 28(1) (2003) *J for Juridical Science* 1, 4.

<sup>527</sup> Ngwena C "Accessing Abortion Services under the Choice on Termination of Pregnancy Act: Realising Substantive Equality" (2000) *J for Juridical Science* 19.

<sup>528</sup> Ngwena C (2000) 19.

<sup>529</sup> Section 6 of Choice on Termination of Pregnancy Act. Pieterse M (2007) 173.

care services, the implied right of the conscientious objection should be over ruled by the express right of access to health care services and that refusal to treat the patient on conscientious objection grounds should be only be justified where alternative services are practically available and accessible to the patient.<sup>530</sup>

#### 4.3.4 The Mental Health Care Act 17 of 2002

The growing awareness of disability, suffering and economic costs associated with mental disorders led to the promulgation of the Mental Health Care Act 17 of 2002, which came into operation on 15 December 2004.<sup>531</sup> The Act is seen as a significant step in addressing mental health as a major public health issue in South Africa and protecting the rights of people with mental illness.<sup>532</sup> The overarching goal of the Act is to improve access and quality of care thereby protecting the human rights of people with mental disorders through compliance with the legislation. It aims at providing care, treatment and rehabilitation of people who are mentally ill and further set out the different procedures to be followed in the admission of such persons and to establish review boards in respect of every health establishment.<sup>533</sup> The Act deals expressly with a range of rights including unfair discrimination and protection against abuse, which are necessary in ensuring that mental health care users access their health care rights.<sup>534</sup> This Act is considered as a significant step towards the translation of the right to have access to health care services to people with mental disabilities. In compliance with section 7 of the Mental Health Act, an active Mental Health Review Board has been established across provinces in South Africa and it is believed that a number of hospitals are also in full compliant with the Act's provisions and provide mentally ill patients with access to trained staff.<sup>535</sup>

However, upholding this right is also subjected to the availability of resources. Some scholarly writers have asserted that the Mental Health Care Act was passed without consideration of the financial implications of its implementation.<sup>536</sup> In this regard, the health care system continues to be dictated by inadequate and inappropriate facilities especially in the public health sectors which

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<sup>530</sup> Pieterse M (2007) 173.

<sup>531</sup> Lund C et al "Challenges faced by South African health services in implementing the Mental Health Act" (2007) *SAMJ* 352.

<sup>532</sup> Lund C et al (2007) 352.

<sup>533</sup> Van Rensburg ABJ "A Framework for Current Mental Health Care Practice in South Africa" (2007) *Afr J Psychiatry* 205.

<sup>534</sup> Section 10 and 11 of the Mental Health Care Act 17 of 2002.

<sup>535</sup> Van Der Merwe M "*Psychiatry in distress: How far has South Africa progressed in supporting mental health?*" <http://www.dailymaverick.co.za/article/2015-07-15> (Date of use: 28 August 2015).

<sup>536</sup> Van Rensburg ABJ (2007) 205-206.

are used by majority of South Africans.<sup>537</sup> The challenges identified with the implementation of the Act poses a serious threat to the realisation of the objective it aims to achieve. Accordingly, the State is called upon to developed mechanisms to narrow the gap between policy and implementation. In doing so, ongoing communication between researchers, policy makers and service providers are recommended in recognition of the fact that integration of mental health in the country's wider health economy is an ongoing process.<sup>538</sup>

Already great strides have been made in respect of the above recommendation. In July 2013, the National Health Council (NHC) adopted the Mental Health Policy Framework for South Africa and the Strategic Plan 2013-2020. This plan has eight key objectives including district based mental health services and primary health care re-engineering; building institutional capacity; surveillance, research and innovation; building infrastructures and capacity facilities; mental health technology equipment and medicines; inter-sectoral collaboration; human resource for mental health, advocacy, mental health promotion and promotion of mental illness.<sup>539</sup> Some writers have asserted that the aforesaid plan calls for jubilation as it will address a gap in public health and offer hopes for millions of people suffering from mental illness, thereby upholding the right in section 27 of the Constitution.<sup>540</sup>

#### **4.3.5 Medicine and Related Substance Control and Amendment Act 90 of 1997**

In order to translate the right to have access to health care services and upheld the value of section 27 of the Constitution, the government of South Africa has also taken efforts to make medicine more affordable to the people. In doing so, they have promulgated the Medicine and Related Substance Control and Amendment Act 90 of 1997. The aforesaid legislation includes provisions for the parallel importation of medicines, the establishment of a medicine committee and the introduction of a transparent, non-discriminatory pricing system of medicines.<sup>541</sup> Under this legislation, South Africa has experienced the introduction of a single exit price for every pharmaceutical product in 2005, which is thought to have reduced prices for medicines by about 20%.<sup>542</sup> However, it is projected that an increase in market competitiveness through expanded use of generic drugs may also account for changes in pricing structures.<sup>543</sup>

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<sup>537</sup> Mkhize N and Kometsi M J "Community Access to Mental Health Services: Lessons and Recommendations" In Barron P (ed) *South African Health Review* (Health System Trust 2008) 106.

<sup>538</sup> Mkhize N and Kometsi M J (2008) 106-107.

<sup>539</sup> Van Rensburg ABJ "Contributions from the South African Society of Psychiatrists (SASOP) to the National Mental Health Action" (2013) *South Afr Journal of Psychiatrist* 205.

<sup>540</sup> Stein DJ "A new mental health policy for South Africa" (2014) *SAMJ* 115.

<sup>541</sup> Section 2 of the Medicines and Related Substances Act 101 1965. See *the entire Act*.

<sup>542</sup> Harrison D (2009) 14.

<sup>543</sup> Harrison D (2009) 14.

#### 4.3.6 The Traditional Health Practitioner Act No. 22 of 2007

The Traditional Health Practitioner Act No. 22 of 2007 was legislated in 2007 and was considered as an important development in the health sector of South Africa as in the past the non regulation of the traditional health practice posed a lot of problems as traditional practitioners could not be held accountable for their wrongful acts.<sup>544</sup> The Act enjoins the creation of a juristic person known as the Traditional Health Practitioners Council of South Africa (THPCSA), through which the quality, safety and efficacy of the services of traditional health practitioner are regulated and maintained through control of management, training and registration of traditional health practitioners.<sup>545</sup> The Act is therefore a positive development in South Africa in respect of the realisation of the right to have access to health care services. However, the aforesaid Council instituted by the Act does not seem capacitated to deliver satisfactorily on its mandate as it faces the difficulty in selecting credible practitioners from bogus ones for purposes of registration.<sup>546</sup>

#### 4.4 Framework for Monitoring the Progressive Realisation of Socio-Economic Rights

Monitoring socio-economic rights involves assessing whether government policies and programmes comply with socio-economic rights obligations and whether adequate money is being spent to realise these rights.<sup>547</sup> It further involves whether money spent to realise socio-economic rights actually leads to appropriate outcomes.<sup>548</sup> In this regard, South Africa has a vibrant civil society and a wide range of organisations and social movements, which are involved in monitoring the progressive realisation of socio-economic rights. This includes institutions such as the South African Human Rights Commission, which has the constitutional mandate to monitor the observance of human rights principles enshrined in the Constitution.<sup>549</sup> Other institutions include the Studies in Poverty and Inequality Institute (SPII), the Public Protector, Centre of Applied Legal Studies (CALs), Treatment Action Campaign (TAC), Budget and Expenditure Monitoring Forum (BEMF) among others. These organisations work hard to support transformational policies and hold the government accountable in the delivery of socio-economic rights enshrined in the Constitution. In doing so, they have utilised various tools and approaches ranging from litigation, research and campaign and picketing to monitor initiatives employed by state organs and non-

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<sup>544</sup> Tshela B "Traditional Health Practitioners and the Authority to Issue Medical Certificates" (2015) *SAMJ* 279.

<sup>545</sup> Section 4 of the Traditional Health Practitioners Act, Act 22 of 2007.

<sup>546</sup> Tshela B (2015) 280.

<sup>547</sup> Dawson H and McLaren D (2015) 7.

<sup>548</sup> Dawson H and McLaren D (2015) 7.

<sup>549</sup> Dawson H and McLaren D (2015) 8.

state entities to promote, fulfil and respect socio-economic rights.<sup>550</sup> In this enquiring, we shall examine the internal reporting mechanisms of the South African Human Rights Commission, which has a constitutional mandate to monitor the progressive realisation of socio-economic rights in the country. Throughout this examination, we will also highlight some of the shortcomings of internal reporting mechanisms of the Commission and will thereafter point towards the need of a comprehensive socio-economic rights monitoring tool in South Africa as highlighted by the aforesaid Commission.

#### **4.4.1 The South African Human Rights Commission**

The South African Human Rights Commission has the constitutional mandate to monitor and assess the observance of socio-economic rights by State organs, including the right to have access to health care services. In contrast with the courts, decisions by the South African Human Rights Commission are not legally binding and the activity of the Commission has been referred to by some academic writers as a soft enforcement mechanism.<sup>551</sup> In terms of section 184(3) of the Constitution, the Human Right Commission is authorised to request relevant organs of the State to provide the Commission with information on the measures which they have developed towards the realisation of the socio-economic rights listed in the Bill of Rights.<sup>552</sup> The objective of the Human Right Commission is therefore, to ascertain the extent to which organs of the State have complied with the provisions to respect, protect, promote and fulfil human rights. Secondly, the Commission also has the mandate to determine the reasonableness of measures adopted by the State including policies, legislations and other programmes to realise human rights in the country. Finally, the Commission is enjoined to make recommendations to ensure the protection, development and attainment of the rights listed in the Bill of Rights.<sup>553</sup>

Section 184(3) therefore creates an internal reporting mechanism on the realisation of socio-economic rights. This reporting mechanism aligns with international reporting mechanisms created by conventions such as the International Convention on Economic and Social and Cultural Rights, which requires state parties to submit reports regularly to international monitoring bodies who then access compliance with the norms articulated in the Convention. Under this reporting mechanism, State organs submit reports to the Human Right Commission concerning a particular human right and the Commission prepares an independent and objective evaluation, which is then presented to

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<sup>550</sup> Dawson H and McLaren D (2015) 8.

<sup>551</sup> Heyns C and Brand D "Introduction to Socio-Economic Rights in the South African Constitution" (1998) *Law, Democracy and Development* 165.

<sup>552</sup> Section 184(3) of the Constitution.

<sup>553</sup> Dawson H and McLaren D (2015) 8.

the parliament.<sup>554</sup> The Commission's monitoring has largely involved a methodology whereby questionnaires are sent to various government departments for completion and return, research field work, public hearings and consultation with affected communities and civil society organisations.<sup>555</sup> This approach has largely focused on documenting human rights violations rather than measuring positive realisation of socio-economic rights. Another major challenge in respect of the approach employed by the South African Human Rights Commission has been the low response from various government departments who have failed to complete and return questionnaires timeously or even failed to provide substantial information beyond what is obtained in departmental annual reports.<sup>556</sup> In view of these challenges, the Commission has highlighted the need for a comprehensive monitoring tool which is linked to indicators and reliable data to compliment what has largely been a qualitative process and to enable it verify administrative data submitted by the state.<sup>557</sup> The Commission has therefore proceeded to endorse a monitoring tool developed by the Studies in Poverty and Inequality Institute (SPII) as this tool builds on international best practice and combines various approaches to monitor socio-economic rights including the right to have access to health care services.

#### **4.4.2 The Studies in Poverty and Inequality Institute (SPII) Socio-Economic Rights Monitoring Tool**

With the support of Ford Foundation the Studies in Poverty and Inequality Institute (SPII) has developed a monitoring tool based on a combination of policy and budget analysis and statistical indicators to monitor and evaluate the progressive realisation of socio-economic rights in South Africa.<sup>558</sup> This monitoring tool developed by SPII aims to build up empirical information to allow the South African Human Rights Commission and civil society organisations to access progress made in respect of socio-economic rights as well as provide government with information on the effectiveness of their policy programmes.<sup>559</sup> The tool uses a methodology for monitoring and evaluating the performance of the government and the realisation of socio-economic rights. This

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<sup>554</sup> Heyns C and Brand D (1998) 165-166.

<sup>555</sup> Dawson H and McLaren D (2015) 8.

<sup>556</sup> Dawson H and McLaren D (2015) 8.

<sup>557</sup> South African Human Rights Commission "*The 8<sup>th</sup> Economic and Social Rights Report: Transforming society, securing rights, restoring dignity*" [http://www.sahrc.org.za/home/21/files/Section%20184\(3\)%20Report.pdf](http://www.sahrc.org.za/home/21/files/Section%20184(3)%20Report.pdf) (Date of use: 16 August 2015).

<sup>558</sup> Brockerhoff S "Socio-Economic rights in South Africa: How to monitor the (progressive) realisation of socio-economic rights in South Africa in a manner that speaks to our historical legacies and spatial inequalities" (2011) *Studies in Poverty and Inequality Institute Working Paper* 1-3.

<sup>559</sup> Dawson H "Monitoring the right to Social Security in South Africa. An analysis of the policy gaps, resource allocation and enjoyment of the right" (2013) *Studies in Poverty and Inequality Institute Working Paper* 3-4.

involves unpacking the content of these rights and the obligation they impose on government, evaluating the extent to which government policies and budget allocations adequately address these obligations and measuring the enjoyment of rights by people on the ground.<sup>560</sup> It is hoped that this tool will guide policies makers into making appropriate decisions around the extension of policies as well as in adjudicating competing priorities. It is further hoped that the tool will assist to link up and coordinate organisations efforts to hold the state accountable.

The monitoring tool's objective goes beyond holding the state accountable and aims to clarify and unpack the content of socio-economic rights and the obligation of the state to ensure access to and enjoyment of socio-economic rights is continuously broadened.<sup>561</sup> Furthermore, it is aimed at determining the extent to which organs of the state have fulfilled their obligations which involves identifying achievements, detecting failures, gaps and regressions and finally by indentifying discriminatory laws, policies, programmes and practices.<sup>562</sup> The tool is therefore a guiding policy on socio-economic rights moving all actors to develop a frame work on how and when to achieve universal access for all people living in South Africa, as guaranteed in the Constitution.<sup>563</sup>

The SPII has so far developed a set of indicators in respect of the right to have access to health care services. In 2012, the institute conducted an in depth analysis on the budget allocation and spending pattern of the Department of Health.<sup>564</sup> The process of developing these indicators was largely informed by background research on the right to have access to health care services. Factors such as medical personnel shortages in hospitals and clinics and the quality of health care in the public sector were identified as being deterrent to the attainment of the right in section 27 of the Constitution. Accordingly, indicators such as medical practitioners per 100,000 persons and the percentage of public health services users highly satisfied with the service received were selected and utilised.<sup>565</sup> Furthermore, extensive consultation with the South African Human Rights Commission and other experts were useful in refining the list of indicators. Since indicators are only reliable as the data that are available, the selected indicators were later scoped against a range of available data obtained from both national surveys such as General Housing Survey published annually and administrative data from the annual reports of the Department of Health.

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<sup>560</sup> Lomahoza K (2013) 1-3.

<sup>561</sup> Studies in Poverty and Inequality Institute "How to make sense of Progressive Realisation of Socio-Economic Rights and Evaluate Progress made over time" in *Measuring, Monitoring & Evaluating Socio-Economic Rights* ( Updated Methodology Paper of a project made possible with funding from Ford Foundation October 2013) 2.

<sup>562</sup> Lomahoza K (2013) 3.

<sup>563</sup> Studies in Poverty and Inequality Institute *Towards Transformation- Measuring, Monitoring & Evaluating Socio-Economic Rights in South Africa* (Policy Brief June 2013) 1.

<sup>564</sup> Studies in Poverty and Inequality Institute (2013) 2.

<sup>565</sup> Lomahoza K (2013) 11.



Thereafter, a final set of indicators were developed and endorsed under three dimensions including access, adequacy and quality.<sup>566</sup> The access indicators measured physical access and affordability. Adequacy measured the provision of service at health facilities and quality measured the health outcome and satisfaction with service offered.<sup>567</sup>

The application of the aforesaid monitoring tool based on policy and budget analysis and statistical indicator to the health care sector of South Africa reveals that there has been a major transformation in the health care sector.<sup>568</sup> The health sector has witnessed an improvement in the level of access to public health facilities.<sup>569</sup> It has further revealed the state's commitment to fight against unequal access to health care services and improve the country's health outcome as financial resource is allocated to the Department of Health have been on the rise with the department receiving the second largest share of the state's budget.<sup>570</sup> Despite the above, some serious challenges continue to affect the country's health care sector. The health care sector remains fragmented within the public sector and between the public and the private sector despite legislation and policies to ensure equality in access to health care services.<sup>571</sup> Shortage of medical personnel also presents a threat to the countries potentials in realising the right to have access to adequate health care.<sup>572</sup> In view of the above challenges, clear priorities needs to be established in respect of health programmes. The need to strengthen cooperative governance across the various spheres of government dealing in health and between the private and public sectors will also assist the agenda for further reform and transformation and guarantee the constitutional right to have access to health care services.<sup>573</sup>

#### **4.5 An Appraisal of Government Measures to Progressively Realise the right to have Access to Health Care Services.**

The adoption of legislation and policies to enhance the realisation of socio-economic rights is an important component of the government's obligation to undertake legislative, policy and other necessary measures to progressively realise socio-economic rights including the right to have

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<sup>566</sup> Studies in Poverty and Inequality Institute (2013) 2.

<sup>567</sup> Lomahoza K (2013) 12.

<sup>568</sup> Lomahoza K (2013) 16.

<sup>569</sup> Lomahoza K (2013) 16.

<sup>570</sup> Lomahoza K (2013) 16.

<sup>571</sup> Kautzky K and Tollman MS "A Perspective on Primary Health Care in South Africa" in Barron P (ed) *South Africa Health Review* ( Health System Trust 2008) 17-18.

<sup>572</sup> Lomahoza K (2013) 16.

<sup>573</sup> Schaay N, Sanders D and Kruger V "Overview of Health Sector Reforms in South Africa" (2011) *Human Development Resource Centre* 21, 31.

access to health care services.<sup>574</sup> This view is recognised even by the CESC who affirms the indispensability of legislation in combating discrimination in realising the right to health.<sup>575</sup> The adoption of a comprehensive and financially-backed legislative, policy and programmatic framework is therefore indispensable in laying a proper foundation for the full and progressive realisation of the right to have access to health care services.

However, the adoption of legislative framework on its own has not been sufficient to enhance the realisation of the right to have access to health care services in South Africa.<sup>576</sup> Some serious challenges lie ahead of the implementation of most of the legislative measures put in place by the government to overcome the challenges relating to adequate and quality health care services. Subordinate legislations and regulations to give effect to the implementation of some of the provisions of these legislations or regulations are still outstanding. The overall effect is that the implementation of some of the laws and policies adopted by the government has been very slow and consequently resulting to very little translation of the right to have access to health care services in the lives of the people in South Africa. In this regard, some scholarly writers such as Alston and Quinn have also contended that the adoption of legislation on its own will not adequately discharge relevant State's obligations.<sup>577</sup> Speaking in connection with the ICESCR, they have stated that what is required to enforce socio-economic rights is to make the Convention's provisions effective in law and in fact.<sup>578</sup> As mentioned above Pieterse, have also contended that the legislature and the executive must urgently endeavour to correct the challenges associated with the implementation of legislation put in place in South Africa, should they consider the right to have access to health care services a pipeline dream for all South Africans.<sup>579</sup>

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<sup>574</sup> Alston P and Quinn G "The nature and scope of state parties obligations under the International Covenant on Economic, Social and Cultural Rights" (1987) *Human Rights Quarterly* 156.

<sup>575</sup> CESC General Comment No 20 para 11, 37,39 and 40, where the Committee emphasises that the adoption of specific legislation is an indispensable measure for eliminating and prohibiting both formal and informal discrimination, be it in public or private sphere. See also General Comment No 16 para 41, where CESC reiterates that the failure by the State to implement and monitor effects of laws, policies and programmes aimed at the prohibition of discrimination in access to socio-economic rights is a violation of the Covenant.

<sup>576</sup> In principle 78, the Limburg principle concurs with this view by stating that States should not only report on relevant legislative measures put in place to realise rights under the ICESCR, but must also specify judicial, administrative procedures and other measures they have adopted for enforcing these rights and the practices under those remedies and procedures.

<sup>577</sup> Alston P and Quinn G (1987) 169.

<sup>578</sup> Alston P and Quinn G (1987) 169.

<sup>579</sup> Pieterse M (2010) 251.

Affirming the inadequacy relating to legislative measures, the representative of France, Mr Cassin, at the drafting of the ICESCR stated that “[l]egislative texts might prove inadequate when it comes to reforms, or indeed, upheavals that [are] sometimes necessary to implement certain [SERs], which had not yet been recognised for reason that a number of diverse measures had to be adopted involving changes in the country’s economic and social equilibrium. It would be deceiving the peoples of the world to let them think that a legal provision was all that was required to implement certain promises, when in fact an entire social structure had to be transformed by a series of legislative and other measures.”<sup>580</sup> To concur with this argument, Dowell- Jones has also decried the continued over reliance on legislative measures to enforce positive obligations in respect of socio-economic rights.<sup>581</sup> In her opinion, a realistic understanding of the obligations entrenched in article 2(1) of the ICESCR must as a necessity, involve a discussion of the macro-economic measures that states must put in place to enhance the realisation of socio-economic rights, a tasks which has so far not been undertaken due to lack of technical, administrative or financial means.<sup>582</sup> Although she made this assertion in the context of the ICESCR, her opinion is also relevant to South Africa, as the Convention has on 12 January 2015, been ratified by South Africa.<sup>583</sup>

Accordingly, other measures are necessary to supplement the adoption of legislation and policies to enforce socio-economic rights. Those other measures which are considered suitable to compliment the adoption of legislation and policies include the provision of adequate remedies. Currie and De Waal contend that the appropriate remedy for the infringement of socio-economic rights is in most cases the declaration of the infringing law and conduct as invalid.<sup>584</sup> In their opinion, where access to an existing socio-economic right is being threatened or has been affected, an interdict can be granted by the Court to prohibit the threatened conduct or restore access to that particular socio-economic right.<sup>585</sup> In South Africa, courts have been vested with the power to apply appropriate remedies by virtue of section 38 and section 172 of the Constitution, which permit the issuing of an order which identifies the violation of a constitutional right and then define reforms that must be implemented while affording the responsible state agency or organ the

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<sup>580</sup> See U.N. Doc. E/CN.4/SR.232 (1951). Alston P and Quinn G (1987) 168.

<sup>581</sup> Mary Dowell-Jones (2004) 40-43.

<sup>582</sup> Mary Dowell-Jones (2004) 40-43.

<sup>583</sup> South Africa has on 18 January 2015 ratified the ICESCR and was due to enter into force on 12 April 2015. See the United Nations Depository Notification Reference CN 232015 TREATIES-IV3 [http:// www.seri-sa.org/images /ICESCRp\\_CN\\_23\\_2015-Eng.pdf](http://www.seri-sa.org/images/ICESCRp_CN_23_2015-Eng.pdf). (Date of use: 22 October 2015).

<sup>584</sup> Currie and De Waal (2013) 594.

<sup>585</sup> Currie and De Waal (2013) 594.

opportunity to choose the means of compliance with the said order.<sup>586</sup> Section 38 in particular avail judicial remedies to individual, groups or public interest organisations in the instances of denial, infringements or violations of the any of the human rights entrenched in the Bill of Rights.<sup>587</sup> Available remedies will normally include, a declaration of rights as expressly mentioned in section 38 of the Constitution, an injunction, a conservatory order, a declaration of invalidity of the infringing law also expressly mentioned in the Constitution,<sup>588</sup> an order for compensation and or judicial review. On this basis, the Court has proceeded to enforce positive obligations relating to socio-economic rights in certain cases. As mentioned above, one of the first cases to which a structural remedy was employed to enforce a positive obligation was the case of *Grootboom v Oostenburg Municipality* in which, the High Court granted an order declaring that the children of the applicant were entitled to be provided with shelter in terms of section 28 of the Constitution.<sup>589</sup> Although on appeal to the Constitutional Court, the court rejected the interpretation of the High Court's judgment as incorrect, the court proceeded to hold that in the circumstances, it was necessary and appropriate to award a declaratory order setting out the shortcomings of the state's housing policy and declaring that reasonable steps must be taken to remedy the shortcomings.<sup>590</sup> Also as mentioned above South African courts have moved further to develop innovative remedies such as a structural interdict to enforce positive obligations in respect of socio-economic rights and have applied these remedies to rectify a violation of socio-economic rights in a few cases.<sup>591</sup>

However, even with the adoption of these measures to compliment the use of legislation, judicial remedies must be made effective to parties who seek judicial enforcement of their socio-economic rights in South Africa through the creation of appropriate implementation and monitoring institutions and the adoption of administrative, financial, educational and social measures. In this regard, the South African Human Rights Commission has the mandate to monitor and assess the observance of the progressive realisation of socio-economic rights as mandated by the Constitution.<sup>592</sup>

Notwithstanding the above, Dowell-Jones has also decried the over reliance of both legal and judicial remedies to enforce socio-economic rights.<sup>593</sup> The main point raised in her argument is that

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<sup>586</sup> Section 38 & 172 of the Constitution.

<sup>587</sup> Section 38 of the Constitution. Currie and De Waal (2013) 595.

<sup>588</sup> Section 38 of the Constitution.

<sup>589</sup> *Grootboom v Oostenberg Municipality* 2000 (3) BCLR 277(C).

<sup>590</sup> *Government of the Republic of South Africa v Grootboom* para 99. Currie and De Waal (2013) 596.

<sup>591</sup> Currie and De Waal (2013) 594.

<sup>592</sup> Section 184 of the Constitution.

<sup>593</sup> Mary Dowell-Jones (2004) 40-43.

resources are critical in the realisation of any particular socio-economic rights and unless measures are put in place to generate the necessary resources, the full realisation of socio-economic rights will remain a pipeline dream. Therefore, her opinion is that measures have to be put in place by the state to enhance macro-economic stability which would lead to a generation of the resources required to achieve realisation of socio-economic rights. The macro-economic measures mentioned by her include creating a sustainable, non-inflationary growth path capable of generating resources to implement positive obligations relating to socio-economic rights.<sup>594</sup> The United Nations Post-2015 Development Agenda also acknowledges this fact as it states that continuous and sustainable economic growth is not only a prerequisite for employment generation but also provide countries with the fiscal pace to address critical social issues such as access to health care services sanitation and the right to safe drinking water.<sup>595</sup> To this end, the South African government therefore needs to adopt strong macro-economic policies to achieve a strong and inclusive economic growth in order to progressively realise socio-economic rights including the right to have access to health care services.

#### 4.6 Conclusion

It can be deduced from this chapter that since 1994, various policies and laws have been put in place in order to progressively realise the right to have access to health care services in South Africa. Arguably, these measures could be said to conform to international best practice and demonstrates the government's commitment to fight unequal access to health care services and improve the country's health outcome.<sup>596</sup> In assessing the various legislative frameworks put in place by the government, it can be said that the government has an ambitious plan to achieve universal health care within the country. Significant progress has so far been made through the ambitious legal and policy frameworks to improve access to health care services and bring health care services to previously under-serviced population or disadvantaged areas.<sup>597</sup> Some experts believe that pilot projects such as the National Health Insurance Scheme will further address inequities presented by the current private and public health system and change the face of the South African health care system over the years in which the project is being implemented.<sup>598</sup> The constitutional mandate of the South African Human Rights Commission to monitor and access the

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<sup>594</sup> Mary Dowell-Jones (2004) 40-43.

<sup>595</sup> UN System Task Team on the Post-2015 UN Development Agenda *Macroeconomic stability and inclusive growth and employment* (May 2012) 3-5 [http://www.un.org/millenniumgoals/pdf/think%20pieces/12\\_macroecnomics.pdf](http://www.un.org/millenniumgoals/pdf/think%20pieces/12_macroecnomics.pdf) (Date of use: 10 January 2016).

<sup>596</sup> Lomahoza K (2013) 16.

<sup>597</sup> Harrison D (2009) 2.

<sup>598</sup> Naidoo S (2012) 149.

progress made in realising socio-economic rights has further enhance the enjoyment of the right to adequate health care. It is imperative to monitor government's policies and programmes to guarantee the enjoyment of a particular socio-economic rights as well as their outcome. By monitoring and evaluating progress made with the realisation of these rights, specific challenges are identified. For instance, the application of the SPII monitoring tool has indentified certain threats to the country's health sector which enables policy makers in the evaluation and development of future programmes as well as policies that align with their obligations under the Constitution.<sup>599</sup>

Despite the above, some serious challenges continue to affect government's efforts in attaining a fulfilment of section 27 of the Constitution. The inadequate implementation of legislative and policy measures developed by the government present a threat to South Africa's potential in realising the right to have access to health care services. Accordingly, the impressive legislative and policy frame work has failed to translate the right to have access to health care services to claimable individual entitlements.<sup>600</sup> There are reports of deplorable health facilities in certain areas across the country which results to an unequal enjoyment of the right to have access to health care services.<sup>601</sup> There is therefore an urgent call for the executive and the judiciary to correct the failures identified in the legislative and policy framework to ensure that the inequities existing in the country's current health care system can be ameliorated. In addition to this the government must strengthen and sustain an inclusive economic growth by putting in place strong macro-economic policies that will address the concerns relating to the access to health care services. In adhering to the above recommendations, the government is finally called upon to ensure that the legal and policies framework put in place to increase access to health care services pass the test of reasonableness both in their conception and implementation as a reasonable measure, which is not reasonably implemented will amount to non-compliance with the state's obligation provided in section 27 of the Constitution.<sup>602</sup>

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<sup>599</sup> Lomahoza K (2013) 16.

<sup>600</sup> Pieterse M (2010) 251

<sup>601</sup> Pickles C (2012) 410.

<sup>602</sup> *Government of the Republic of South Africa and Others v Grootboom* para 39.

## **CHAPTER 5: THE RIGHT TO HAVE ACCESS TO HEALTH CARE SERVICES: A COMPARATIVE ANALYSIS WITH CANADIAN JURISPRUDENCE**

### **5.1 Introduction**

In the previous chapters, I have evaluated the right to have access to health care services entrenched in the South African Constitution. I have further demonstrated how the Bill of Right has been applied in the health care context of South Africa and the measures put in place by the State to progressively realise the right to have access to health care services. In this chapter, I will discuss Canadian jurisprudence in relation to the right to have access to health care services. The reason for contrasting South Africa's on the right to have access to health care services with that of Canada in this study is to establish whether in arrogating health care reforms to improve access to health care services in South Africa, Canada should be considered a notable option by South Africa. Canada has been used in this study to contrast South Africa because both countries share an explicit commitment to equity for all citizens including the poor and most vulnerable in their societies. For this reason both countries have developed statutory framework with socio-economic dimensions to guarantee the protection of socio-economic rights. This chapter shall therefore examine the constitutional framework dealing with the right to have access to health care services as well as other legislative and policy framework put in place in Canada to improve access to health care services from which a determination will be made on whether Canada has been more proactive in upholding the right to have access to health care services than South Africa and whether South Africa should consider Canada's approach in formulating policies to improve access to health care services by all South Africans.

### **5.2 Constitutional Framework Regulating the Right of Access to Health Care Services**

#### **5.2.1 The Canadian Charter of Right and Freedom 1982**

The Charter of Rights and Freedoms (CRF) is a Bill of Right and forms part of the Canadian Constitutional Act of 1982.<sup>603</sup> This Charter forms the constitutional frame work regulating the right to have access to health care services in Canada. The Charter which is usually seen as drawing upon a nineteenth century liberal tradition is designed primarily to protect citizens from state actions

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<sup>603</sup> Consolidation of the Constitution Acts 1867 to 1982 published by the Department of Justice in Canada [http://www.laws-lois.justice.gc.ca/PDF/CONST\\_E.pdf](http://www.laws-lois.justice.gc.ca/PDF/CONST_E.pdf) (Date of use 10 January 2016). See also the Canadian Charter of Rights and Freedoms Part 1 of the Constitutional Act 1982 being Schedule B to the Canadian Act 1982 (UK) 1982 c.11(CHARTER).

that infringe their individual liberty and autonomy.<sup>604</sup> The Charter was proclaimed in 1982 as part of the patriation of the British North American Act (BNA), 1867.<sup>605</sup> In this year and for the first time in history, Canadians had codified rights which were guaranteed in the Constitution. This is because until 1982, Canada was governed by a constitution composed of British laws that could only be changed by acts of the British parliament, albeit only with the consent of the Canadian government.<sup>606</sup> The Charter of Rights and Freedoms was preceded in Canada by the Canadian Bill of Rights which had been enacted by Parliament in 1960. This Bill of Rights contained many of the rights and values which have later been incorporated in the Charter with one notable difference, being that the Bill of Rights was quasi-constitutional in nature and was not entrenched in Canada's Constitution.<sup>607</sup> It was therefore a piece of federal legislation that could be amended or repealed by another parliament and did not apply to the actions of the provinces. Parliament could pass subsequent laws notwithstanding the Bill of Rights.<sup>608</sup> Given this status of the Bill of Rights, it was seldom used.<sup>609</sup>

Given the shortcomings of the Bill of Rights, Pierre Trudeau was determined to overcome the hurdles when the BNA Act, 1867 was patriated in 1982. He wanted a charter of rights embedded in the Constitution that would have paramouncy over federal, provincial and territorial laws.<sup>610</sup> This goal was ultimately achieved when the Parliament of Canada and nine of the provinces agreed to Pierre Trudeau's proposals in November 1981.<sup>611</sup> Thus in 1982, the Charter was proclaimed and incorporated in the Canadian Constitution and entrenches the fundamental rights of Canadians in the same vein as the Bill of Right is incorporated in the 1996 Constitution of South Africa and regarded as the corner stone of South Africa's constitutional democracy.<sup>612</sup>

In view of the above, no question therefore arises as to the constitutional legitimacy of courts in Canada in reviewing fundamental human rights although socio-economic rights are not given

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<sup>604</sup> Jackman M "The Application of the Canadian Charter in the Health Care Context" (2001) *Health Law Review* 22.

<sup>605</sup> Rafoss B "The Application of the Canadian Charter of Rights and Freedoms to First Nations' Jurisdiction: An Analysis of the Debate" (MA Thesis University of Saskatchewan Saskatoon Canada 2005) 13.

<sup>606</sup> Sabetti F "The Historical Context of Constitutional Change in Canada" (1983) *Law and Contemporary Problems* 11-13.

<sup>607</sup> Rafoss B (2005) 13.

<sup>608</sup> Hogg P in *Constitutional Law in Canada* (Toronto: Carswell Company Limited 1977) 433.

<sup>609</sup> Hogg P (2005) 431-441.

<sup>610</sup> Hogg P (2005) 433.

<sup>611</sup> Rafoss B (2005) 14.

<sup>612</sup> Section 1 of Constitution of the Republic of South Africa.



express protection under the Charter as Dickson puts it.<sup>613</sup> In fact, Canadian Courts have also developed a two stage approach as their South African counterparts in deciding whether the Charter of Rights and Freedoms has been violated. Under this approach, the court first determines whether the right that is violated is a right protected under the Charter and if so, the court moves to establish whether the violation can be justified under the limitation clause in section 1 of the Charter of Rights and Freedoms.<sup>614</sup>

## 5.2.2 The Protection of Socio-economic Rights under the Charter of Rights and Freedoms

Unlike the South African Constitution of 1996 that includes socio-economic rights as justiciable rights, the Canadian Charter of Rights and Freedoms has no express provisions relating to the protection of socio-economic rights. However, in the light of the Charter's wording and historical context, Canadian High Commissioner has suggested that there is significant opportunity for Canadian Courts to interpret the substantive charter obligations, particularly those under section 7 and section 15 to incorporate almost all the socio-economic rights contained in the ICESCR. In this regard, during the tenure of the Charter of Rights and Freedoms, the equality provision and the right to life, liberty and security of the person provision under sections 15 and 7 of the Charter respectively has been invoked sometimes to secure the protection of socio-economic rights.<sup>615</sup>

Canada ratified the ICESCR in 1976 and in view of the aforesaid ratification, a Special Joint Committee of the Senate and House of Commons on the Constitution of Canada considered to include an explicit reference of the rights contained in the ICESCR under section 36 of the Constitution Act of 1982.<sup>616</sup> However, rather than advocating for an express inclusion of socio-economic rights under section 36 of the Charter, most advocacy groups and human rights experts emphasised the importance of framing rights such as the right to equality as expansively as possible. In doing so, they argued that the Charter could then be applied to require the government to take positive action to address the needs of vulnerable groups in order to remedy inequality and

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<sup>613</sup> Dickson B "The Canadian Charter of Rights and Freedoms: Context and Evolution" in G Beaudoin and E Mendes (eds) *The Canadian Charter of Rights and Freedoms* (1996) 1-1 to 1-12.

<sup>614</sup> McLean K (2009) 27.

<sup>615</sup> Jackman M and Potter B "Socio-Economic Rights under the Canadian Charter" in Langford M (ed) *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (New York: Cambridge University Press 2008) *Faculty of Law University of Ottawa* 209-10. Section 7 and section 15 of the Charter of Rights and Freedoms Part 1 of the Constitutional Act 1982 being Schedule B to the Canadian Act 1982 (UK) 1982 c 11(CHARTER).

<sup>616</sup> Jackman M and Potter B (2008) 210. See also Canada, Special Joint Committee of the Senate and the House of Commons on the Constitution of Canada, Minutes of Proceedings and Evidence, 32<sup>nd</sup> Parl. No 49 (30 January 1981) 65-71. Section 36 is set out in Part III of the Constitutional Act 1982.

to maintain and improve social programs, which form the basis of the enjoyment of equality rights and other rights under the Charter of Rights and Freedom.<sup>617</sup>

Accordingly, section 15 of the Charter of Rights and Freedoms was renamed from its original entitlement as 'non-discrimination rights' to 'equality rights' and reworded to guarantee both equality 'before and under the law' and the equal 'protection and benefit' of the law.<sup>618</sup> The provision was significantly expanded after an unprecedented lobbying campaign by civil society groups such as women as disability groups which signalled the importation into Canadian Constitutional Law an equality provision that had already been accepted under provincial human rights legislation.<sup>619</sup> Section 15 was reworded to ensure that the equality right applies to social benefit programmes such as welfare and unemployment insurance and that the positive obligations of the government towards disadvantaged and vulnerable groups in Canada are constitutionally recognised.<sup>620</sup>

Section 7 also reflects Canadian historical values linked with socio-economic rights. In drafting the provision under this section, the legislature rejected a proposal to include the right to property for fears that property rights would conflict with Canada's commitments to social programs and give rise to challenges on the regulation of the private sector by the government.<sup>621</sup> The proposal to include property rights in the charter was faced with opposition by provincial governments in Canada on grounds that the entrenchment of such rights in the constitution could give rise to challenges to government's regulation of corporate interests and control of natural resources.<sup>622</sup> Also an inclusion of the phrase 'fundamental justice' in section 7 of the Charter was preferred over any reference to 'due process in law' for concerns that the phrase 'due process' was utilised in the United States during the era of *Lochner* as a means of propertied interests to challenge the regulation of private enterprises and the promotion of social rights.<sup>623</sup>

Section 7 and 15 in the charter are therefore remedial in focus in their construction and framing and may be construed to require the government to take necessary steps to accommodate the

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<sup>617</sup> Porter B "Expectation of Equality" (2006) *Supreme Court Law Review* 23.

<sup>618</sup> Jackman M and Potter B (2008) 210.

<sup>619</sup> Jackman M and Potter B (2008) 210.

<sup>620</sup> Porter B (2006) 23.

<sup>621</sup> Choudhry S "The Lochner Era and Comparative Constitutionalism" (2004) *International Journal of Constitutional Law* 17-24.

<sup>622</sup> Choudhry S (2004) 17-24.

<sup>623</sup> Choudhry S (2004) 17-24.

needs of disadvantaged or marginalised groups of people in Canada.<sup>624</sup> As observed in this study, they can be considered to have socio-economic rights dimensions, even though these rights are not expressly mentioned in the Charter of Rights and Freedoms. For instance, section 7 of the Charter have been considered to have positive dimensions of socio-economic rights in the case of *Gosselin v Quebec (AG)*,<sup>625</sup> where in an important dissenting judgment by the Supreme Court, Justice Arbour found that the right enshrined in section 7 places a positive obligation on the government to provide to those in need of an amount of social assistance to cover their basic needs.<sup>626</sup> On the other hand, section 7 has been considered to have negative dimensions by imposing a duty on the government to refrain from interfering with individual physical and psychological security and integrity as illustrated in the case of *R v Morgentaler*,<sup>627</sup> in which a provision of the Federal Criminal Code requiring that abortions performed in hospitals be approved by 'Therapeutic Abortion Committees' was found the Supreme Court to be unlawful state interference with psychological and bodily integrity which violated pregnant women's section 7 right to life, liberty and security of the person in accordance with the principle of fundamental justice.<sup>628</sup>

### **5.2.3 Judicial Approach to the Protection of Socio-Economic Rights under the Charter of Rights and Freedoms.**

Until recently, courts in Canada did not move to recognise socio-economic rights under the Charter of Rights and Freedoms. The approach of courts in respect of section 7 of the Charter of Rights and Freedoms has been very inconclusive. Some Canadian Courts called upon to adjudicate claims on socio-economic rights on the basis of section 7 of the Charter rejected such claims on grounds that economic rights were beyond the scope of this provision and the legislative purview of the courts.<sup>629</sup> The Supreme Court has also been very careful to leave open the possibility that section 7 of the Charter protects a wide range of socio-economic rights. In *Irwin Toy Ltd v Quebec (AG)*,<sup>630</sup> the Court rejected attempts by corporate interest to base their economic claims on section 7 of the Charter and held that private property rights were expressly excluded from the Charter of

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<sup>624</sup> Jackman M & Potter B (2008) 210

<sup>625</sup> *Gosselin v Quebec (AG)* [2002] 4 SCR 429.

<sup>626</sup> *Gosselin v Quebec (AG)* [2002] 4 SCR 429, at para 82-83

<sup>627</sup> *R v Morgentaler* [1988] 1 SCR 30.

<sup>628</sup> *R v Morgentaler* [1988] 1 SCR 30. See also Jackman M "Section 7 of the Charter and Health Care Spending" in Machildon GP, McIntosh T and Forest PG (eds) *The Fiscal Sustainability of Health Care in Canada* (Toronto: University of Toronto Press 2004) 111-114.

<sup>629</sup> *Irwin Toy Ltd v. Quebec (AG)* [1989] 1 SCR 1003-4. See also Jackman M & Potter B (2008) 213.

<sup>630</sup> *Irwin Toy Ltd v. Quebec (AG)* 1003-4.

Rights and Freedoms.<sup>631</sup> However, in this finding, the Court was careful to distinguish what it characterised as ‘corporate commercial economic rights’ from rights entrenched in international conventions such as the rights to clothing, shelter, food, social security and the right to equal pay for equal work. Therefore, the Court found that it would be dangerous to consider that these rights were excluded at so early a moment in the Charter’s interpretation.<sup>632</sup>

In *Gosselin v Quebec (AG)*, although the Court found that there was insufficient evidence in this case to make such findings that the present case warrant a novel application of section 7 of the Charter as the basis for positive state obligation to guarantee adequate living standards, the Court left open the possibility for adopting a novel interpretation of the right to security of the person in future cases.<sup>633</sup>

Unlike section 7 of the Charter, where the courts have been very much inconclusive in their approach to the provision on the protection of socio-economic rights, section 15 of the Charter has been relied upon by the courts to enforce positive obligations in some cases. In *Scharter v Canada*,<sup>634</sup> the Supreme Court justified positive remedies to under-inclusive benefit programmes when it recognised that programmes such as social assistance programmes are encouraged by section 15 of the Charter.<sup>635</sup> In subsequent cases such as in *Eldridge v British Columbia (AG)*,<sup>636</sup> the Supreme Court has also relied on section 15 of the Charter to determine the provision of sign language for deaf patients, as part of a publicly funded scheme for medical care.<sup>637</sup> In several other cases, the Supreme Court has further rely on section 15 of the Charter and issue positive remedies granting an increase or extension of parental, social assistance, pension benefits and legislative protection.<sup>638</sup>

### 5.3 The Right to Health Care Services under the Canadian Charter of Rights and Freedoms

As the Canadian Charter of Rights and Freedom does not explicitly provide for the protection of socio-economic rights, there exists also no explicit provision on the right to have access to health

<sup>631</sup> *Irwin Toy Ltd v. Quebec (AG)* 1003-4.

<sup>632</sup> *Irwin Toy Ltd v. Quebec (AG)* 1003-4.

<sup>633</sup> *Gosselin v Quebec (AG)* para 82.

<sup>634</sup> *Scharter v Canada* [1992] 2 SCR 679.

<sup>635</sup> *Scharter v Canada* [1992] para 41.

<sup>636</sup> *Eldrige v British Columbia (Attorney General)* [1997] 3 SCR 624.

<sup>637</sup> *Eldrige v British Columbia (Attorney General)* para 40.

<sup>638</sup> Buckley M “*Law v Meiorin*: Exploring the Governmental Responsibility to Promote Equality under Section 15 of the Charter” in Faraday F, Denike M and Stephenson MK (eds) *Making Equality Rights Real: Securing Substantive Equality Under the Charter* (Toronto: Irwin Law 2006) 179-206.

care services, contrary to what is obtained under the South African Constitution. In view of the lack of constitutional clarity regarding the right to have access to health care services under the Charter, there is an ongoing debate on whether the Charter guarantees access to health care services. A strong claim is made among scholarly writers and in some judicial decisions linking the right to have access to health care as an element of the right to equal protection and equal benefit of the law under section 15(1) of the Charter.<sup>639</sup> Section 15 (1) of the Charter provides that “every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”<sup>640</sup> This provision offers firm grounds for the recognition of the right to have access to health care as any inequitable access to health care as well as all forms of discrimination that infringes access to health care services would be inconsistent with it. For this reason, the provision has been upheld to provide protection of health care entitlements by some prominent legal organisations in Canada. For instance, the Canadian Bar Association (CBA) health care task Force concluded at 59 that, although there was no right to health care under the Charter, it does provide procedural protection for the equitable distribution of health care services.<sup>641</sup>

There is also a strong claim among some scholarly writers that section 7 of the Charter of Rights and Freedom protects individuals health related interests and guarantees access to basic and medically necessary care.<sup>642</sup> Those who uphold this opinion have argued that from an interpretive perspective, some of the provisions of the charter embody individual health related interests and guarantees access to basic and medically necessary care.<sup>643</sup> For instance, Martha Jackman has argued that the right to life and to security of the person would be meaningless without access to care necessary for sustaining reasonable health to responding to acute illness.<sup>644</sup> The Law Reform Commission of Canada (LRCC) has upheld this argument as in its Working Paper on Medical Treatment and Criminal Law, it has suggested that the right to security of the person does not only mean the protection of one’s physical integrity but also the provision of necessities for its support.<sup>645</sup>

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<sup>639</sup> Jackman M “The Right to Participate in Health Care and Health Resources Allocation Decisions Under Section 7 of the *Canadian Charter*” (1995/96) *Health Law Review* 3.

<sup>640</sup> Section 15 of the Charter of Rights and Freedoms.

<sup>641</sup> Canadian Bar Association Task Force on Health Care *What Law Got To Do With It? Health Care Reform in Canada* (Ottawa Canadian Bar Association 1994).

<sup>642</sup> Jackman M (1995/96) 3.

<sup>643</sup> Jackman M (1995/96) 3.

<sup>644</sup> Jackman M (1995/96) 3.

<sup>645</sup> Law Reform Commission of Canada *Medical Treatment and Criminal Law* (Law Reform of Canada 1980) 6.

In view of the lack of constitutional clarity in respect of the right to have access to health care under the Charter of Rights and Freedoms, judicial review under the Charter serves as an alternative avenue for health care accountability and particularly in cases affecting access to health care. In this regard, this study will survey a number of decided cases to examine how the judiciary has approached the right to health care as an entitlement under the Charter especially in relation to the right to equality under section 15(1) and the right to “life, liberty and security of the person” enshrined in section 7 of the Charter.

### **5.3.1 Judicial Approach to the Right to have Access to Health Care under the Canadian Charter of Rights and Freedoms**

In the context where access to health care has been perceived as a fundamental human right in Canada, the inability to access medically necessary services have constituted the bulk of Canadian case law in health care related litigation under the Charter of Rights and Freedom. In most of these cases, the courts have invoked sections 15(1) and 7 of the Charter of Rights and Freedoms to determine whether health care is an entitlement under the right to equality under section and the right to “life, liberty and security of the person” respectively.

For example, in *Eldridge v British Columbia (AG)*, the Supreme Court of Canada held that a failure to provide sign language interpretation where it was necessary to ensure equal access to health care was in breach of the equality provision in section 15(1) of the Charter of Rights and Freedoms.<sup>646</sup> In this case the appellants, Robin Eldridge and John and Linda Warren were deaf residents of British Columbia. They had experience problems within the provincial health care system because of their inability to communicate with health care providers in the absence of sign language interpretation services. In an application commenced by the appellants in the British Columbia Supreme Court, the appellants claimed that the failure to provide sign language interpretation services under the province’s Medical and Health Services Act and Hospital Insurance Act violated their rights to equality based on disability under section 15 of the Charter of Rights and Freedom.<sup>647</sup> Deciding on this application, the equality rights claim, which had been rejected at trial by the British Columbia Court of Appeal, was granted in a unanimous decision by the Supreme Court of Canada.<sup>648</sup> The Supreme Court therefore held that failure to provide the appellants with sign language interpretation where this was necessary to ensure equal access to

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<sup>646</sup> *Eldridge v British Columbia (AG)* [1997] 3 SCR 624.

<sup>647</sup> Jackman M (2001) 23.

<sup>648</sup> Cornish M and Faraday F “*Eldridge v British Columbia*: Defining the Equality Rights of the Disabled Under the Charter” (Paper presented to the Osgoode Hall Law School Conference “1997 Constitutional Cases Analysis of the 1997 Constitutional Decisions of the Supreme Court of Canada”, Toronto April, 1998) 1-5.

health care was in breach of the equality provisions in section 15 (1) of the Charter of Rights and Freedom.<sup>649</sup>

However, in the subsequent case of *Auton v British Columbia (AG)*<sup>650</sup>, the Court narrowly circumscribed the limits of the approach in *Eldridge* and held that the failure to provide a particular treatment for autistic children of certain ages was not an infringement of the equality rights.<sup>651</sup> In this case, the Court introduced a requirement in the section 15 analysis and stated that the benefit claimed should be provided by the law. The Court therefore held that the benefit claimed, being the treatment for autistic children, was not specifically provided by the legislative scheme.<sup>652</sup>

The decision of the Court in *Auton* aligns with Justice La Forest argument in *Eldridge*. In dealing with the section 15(1) analysis in *Eldridge*, Justice La Forest had to consider the applicability of the Charter of Rights and Freedoms in the health care context of Canada and the specific issue whether the failure to provide sign language interpretation services for the Deaf was subject to scrutiny under the Charter of Rights and Freedoms.<sup>653</sup> Upon reviewing the terms of the of the British Columbia Medical and Health Care Service Act and the Hospital Insurance Act, the judge found that the above two statutes were drafted permissively and except in cases of certain specialised services, the two statutes did not specify what specific health services were to be provided under the provincial medical and hospital insurance regime.<sup>654</sup> The judge therefore found that without such specificity, failure to provide interpretation services could not be said to amount to a violation of section 15(1) of the Charter of Rights and Freedoms. The judge held that it was the actions of the entities rather than the legislation that gave rise to the appellant's equality claim as the power to decide what services would be funded was delegated by the Medical and Health Care Service Act to the province's Medical Service Commission, and by the Hospital Insurance Act to individual hospitals.<sup>655</sup>

In *Cameron v Nova Scotia (AG)*,<sup>656</sup> the Plaintiffs, being a childless couple argued that the lack of health insurance coverage for Intra Cytoplasmic Sperm Injection (ICSI), a form of *in vitro*

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<sup>649</sup> Cornish M and Faraday F (1998) 1-5.

<sup>650</sup> *Auton v British Columbia (AG)* 2004 SCC 78 [2004] 3 SCR 657 245 DLR (4<sup>th</sup>) 1.

<sup>651</sup> Cousins M "Health Care & Human Rights after *Auton* & *Chaoulli*" (2009) *McGill Law Journal* 719.

<sup>652</sup> *Auton v British Columbia (AG)*, para 35.

<sup>653</sup> Jackman M (2001) 23.

<sup>654</sup> Jackman M (2001) 23. *Eldridge v British Columbia* 649-54.

<sup>655</sup> *Eldridge v British Columbia* 650-651,654.

<sup>656</sup> *Cameron v Nova Scotia* (1999) 204 NSR (2d) 1 177 DLR (4<sup>th</sup>) 611 (CA).

fertilisation treatment, discriminated against those who were infertile and thus violated section 15 of the Charter of Rights and Freedoms as they sought benefit under the Health Services Act to cover the cost of vitro fertilisation.<sup>657</sup> The Court however, rejected the plaintiffs' claim on grounds that there was no discrimination against the plaintiffs as it stated that the fact that the procedure is accessible by only the infertile was not the reason why the procedure was not covered as it was not covered due to reasonable government policies made in compliance with provincial law.<sup>658</sup> Not being satisfied with this decision, the claimant decided to appeal against the judgment. On appeal, the majority in the Nova Scotia Court of Appeal agreed with the appellants that the exclusion of IVF and ICSI from the province's health insurance plan constituted a discrimination against the infertile.<sup>659</sup> However, the judges concurred that while the exclusion of these procedures was based on a physical disability contrary to section 15(1) of the Charter of Rights and Freedoms, the exclusion was justified under section 1 of the Charter as the objective of the policy was to provide the best possible health care in the midst of limited financial resources.<sup>660</sup>

Section 7 of the Charter of Rights and Freedom states that, "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."<sup>661</sup> In view of an ongoing debate on whether this provision also should be interpreted to guarantee access to health care, many scholarly writers have expressed their opinion that there is no positive entitlement to the right to have access to health care under section 7 of the Charter. For instance, some scholarly writers have asserted that the right to security would be infringed only if government measures prevented a person from choosing a service the person would have chosen and the cost of which the person would have assumed.<sup>662</sup> In contrast to the above assertion, Martha Jackman believes that section 7 of the Charter of Rights and Freedoms guarantees a constitutional right to publicly funded health care.<sup>663</sup>

In the midst of this controversy, the issue of whether the right to life, liberty and security to the person should be interpreted to include the right to health care was first considered in the landmark decision of the Supreme Court in the case of *Chaoulli v Quebec (Attorney General)*.<sup>664</sup> In this

<sup>657</sup> Jackman M "Charter Review as a Health Care Accountability Mechanism in Canada" (2010) *Health Law Journal* 4-5.

<sup>658</sup> *Cameron v Nova Scotia* (1999) para 102, 154-158.

<sup>659</sup> *Cameron v Nova Scotia* (1999) para 122.

<sup>660</sup> *Cameron v Nova Scotia* (1999) para 122. See section 1 of the Charter of Rights and Freedoms.

<sup>661</sup> Section 7 of the Charter of Rights and Freedoms.

<sup>662</sup> Kouri RP "Achieving Reproductive Rights: Access to Emergency Oral Contraception and Abortion in Quebec" in Flood C M (ed) *Just Medicare: What's In, What's Out, How We Decide* (University of Toronto Press 2006) 175.

<sup>663</sup> Jackman M "The Regulation of Private Health Care under the *Canadian Health Act* and the Canadian Charter" (1995) *Constitutional Forum* 56.

<sup>664</sup> *Chaoulli v Quebec (Attorney General)* [2005] SCC 35.



case, the appellants being Jacques, a self-represented doctor and long time campaigner against public health care in Canada and his patient, Mr George Zeliotis objected to the waiting times they had endured in the health care system in Quebec. They further challenged the legislation prohibiting private health care insurance for services that were covered by public health care insurance. This legislation did not prohibit access to health care for those who could afford and wanted to pay for it. Rather, it prevented large health care firms, from creating a parallel system of health care in Canada, that could be accessed by the most affluent in the society and invariably benefit from public financing of health care research, training and prevention in Canada and drain the public system of key personnel and resources.<sup>665</sup>

The appellants asked the Court to find that, in the face of waiting times for health services in Quebec's public health system, legislation prohibiting private health insurance schemes, which would allow those who can pay for them to access faster services, violates the right to "life, liberty and security of the person" under section 7 of the Charter of Rights and Freedom and the right to "life, and to personal security, inviolability and freedom" under the Quebec Charter of Rights.<sup>666</sup>

The appellant's first brought their case before the Superior Court of Quebec and the Appeal Court of Quebec. The application of the appellants was dismissed by the Superior Court of Quebec upon finding that the appellant had demonstrated a deprivation of the right to life, liberty and security of the person within the meaning of section 7 of the Canadian Charter of Rights and Freedom.<sup>667</sup> The Court proceeded to hold that the legislative prohibition was justified because it was in accordance with principles of fundamental justice and did not conflict with the values expressed in the Canadian Charter of Rights and Freedom as well as the Quebec Charter of Rights.<sup>668</sup> In the findings of the Superior Court, allowing private health insurance would result to considerable harm on the Canadian public health care system upon which a majority of Canadians rely.<sup>669</sup>

On a similar note the Court of Appeal in Quebec also dismissed the appeal, with the three judges putting forward different reasons on which the rejection was based. Delise JA, found that access to publicly funded health care was a fundamental right under section 7 of the Charter of Rights and Freedom but the right to obtain private health insurance was an economic claim not protected under the above provision.<sup>670</sup> Justice Forget on his part agreed with the trial judge, finding that the

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<sup>665</sup> Porter B "A Right to Health Care in Canada: Only If You Can Pay For It" (2005) *ESR Review* 8.

<sup>666</sup> Porter B (2005) 8.

<sup>667</sup> *Chaoulli v Quebec (Attorney General)* [2000] JQ No 479 (CSQ) para 263.

<sup>668</sup> *Chaoulli v Quebec (Attorney General)* [2000] para 263.

<sup>669</sup> *Chaoulli v Quebec (Attorney General)* [2000] para 263.

<sup>670</sup> *Chaoulli v Quebec (Attorney General)* [2002] JQ No 759 (CAQ) (117-18).

right to health care was threatened, but that the province's decision to favour the broader collective interest was in accordance with the principles of fundamental justice.<sup>671</sup> Finally, Justice Brossard found that the evidence presented by the appellant failed to show that the restrictions on private health insurance violated the plaintiff's right to life or health.<sup>672</sup>

In view of the above, the appellants filed an appeal to the Supreme Court of Canada in a panel constituted of seven judges. The Supreme Court of Canada allowed the appeal in a 4-3 split decision.<sup>673</sup> Three of the seven judges including the Chief Justice found the legislative prohibition of private health insurance to be inconsistent with section 7 of the Charter of Rights and Freedom.<sup>674</sup> These judges found that in circumstances where a lack of timely health care can result in death, the section 7 right to life exist and in circumstances where a lack of timely health care can result to serious psychological and physical suffering, the section 7 right to protection of security of person exist.<sup>675</sup> Furthermore, these judges stated that where a law negatively affects an individual's life and liberty or security of the person, such a law must conform to the principles of fundamental justice. On this basis the judges concluded that the legislative prohibition on private insurance violated section 7 of the Canadian Charter of Rights and Freedoms.<sup>676</sup>

Three other judges found the prohibition of private health insurance not to be inconsistent with section 7 of the Charter and one of the judges was neutral and did not rule on the Charter of Rights and Freedom.<sup>677</sup>

The Supreme Court considered the matter and based its ruling under the Quebec Charter of Rights and the Canadian Charter of Rights and Freedoms. The Quebec Charter of Rights distinguishes itself as the only human rights legislation in North America to incorporate a section on socio-economic rights although it does not expressly make mention of the right to health care.<sup>678</sup> The Charter however expressly prohibits discrimination on the ground of a social condition.<sup>679</sup> On this basis the court had also based its ruling under the Quebec Charter. Four of the seven judges sitting in the panel found that in the context of unreasonable wait times of

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<sup>671</sup> *Chaoulli v Quebec (Attorney General)* [2002] para 63.

<sup>672</sup> *Chaoulli v Quebec (Attorney General)* [2002] para 63.

<sup>673</sup> Porter B (2005) 9.

<sup>674</sup> Porter B (2005) 9.

<sup>675</sup> *Chaoulli v Quebec (Attorney General)* [2005] para 123-124.

<sup>676</sup> *Chaoulli v Quebec (Attorney General)* [2005] para 123-124.

<sup>677</sup> Porter B (2005) 9.

<sup>678</sup> Quebec Charter of Human Rights and Freedoms [www2.publicationduquebec.gouv.qc.ca](http://www2.publicationduquebec.gouv.qc.ca) (Date of use: 15 March 2016). Porter B (2005) 9.

<sup>679</sup> Section 10 of Quebec Charter of Human Rights and Freedoms.

service, Quebec's prohibition of private health insurance violated the right to life and personal security under the Quebec Charter.<sup>680</sup>

The Court further considered whether the breach of section 7 of the Charter of Rights and Freedoms could be justified under section 1 of the Charter as a reasonable limit demonstrably justified in a free and democratic society.<sup>681</sup> The court found that there was no rational connection between the government's objectives and the prohibitions in the two statutes. The court recognised that the government had an undeniable interest in protecting the public health regime of Canada and had intended to this through the prohibition of private health insurance. However, the evidence did not show that a prohibition on private health insurance actually protected the public health system. The court found that the prohibition went further than necessary to protect the public health system and was not minimally impairing.<sup>682</sup> The prohibition against purchasing private health insurance was therefore not shown to be justified as a reasonable limit under section 1 of the Charter of Rights and Freedoms.<sup>683</sup>

Justice Deschamps agreed with the above decision and also considered the matter under the Quebec Charter of Rights. In doing so, she found that the patients on waiting list were in pain and could not fully enjoy any real quality of life. Accordingly, she agreed that section 1 of the Quebec Charter of Rights on the rights to life and to personal security, inviolability and freedom was violated by the statutes prohibiting against the contracting of private insurance and that the prohibition could not be justified under section 9.1 of the Quebec Charter of Rights which is a corresponding provision under section 1 of the Canadian Charter of Rights and Freedom.<sup>684</sup> Using the Canadian Charter of Rights and Freedoms analysis, Justice Deschamps found that there was a rational connection between the government's objective of preserving the integrity of an accessible public health insurance scheme for the people in Quebec and the prohibition on private insurance, but that the complete prohibition on private insurance went further than was necessary and was not a measure that minimally impaired the protective rights.<sup>685</sup> She concluded that there

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<sup>680</sup> *Chaoulli v Quebec (Attorney General)* [2005] para 26-33, para 49-58, para 68, para 83-84.

<sup>681</sup> *Chaoulli v Quebec (Attorney General)* [2005] para 154-157.

<sup>682</sup> *Chaoulli v Quebec (Attorney General)* [2005] para 154-157.

<sup>683</sup> *Chaoulli v Quebec (Attorney General)* [2005] para 154-157.

<sup>684</sup> *Chaoulli v Quebec (Attorney General)* [2005] para 26-33, para 38-43, para 49-58, para 68, para 83-84, para 87-89, para 97.

<sup>685</sup> *Chaoulli v Quebec (Attorney General)* [2005] para 26-33, para 38-43, para 49-58, para 68, para 83-84, para 87-89, para 97.

was evidence that a range of less dramatic measures could have been applied instead of an outright prohibition against private health insurance.<sup>686</sup>

The *Chaoulli* case has been considered as the most notorious decision in the context of Charter litigation relating to access to health care. The case has been relied upon by patients across Canada in litigation in which they sought relief under the Charter in respect of their rights to have access to health care. In *Nell Toussaint v Canada (AG)*,<sup>687</sup> for instance, an undocumented Grenadian woman living in Ontario challenged the rejection of her application for medical coverage under the Interim Federal Health Program (IFHP). This program provided access to federally funded health services for refugees and certain categories of immigrants who are not eligible for medical coverage under provincial health insurance plans. Relying on the decision of the majority in *Chaoulli*, the applicant claimed that her exclusion from the IFH Program violated her rights under section 7 of the Charter of Rights and Freedom, in particular the right to life and to security of the person and also in violation of Canada's obligation under international human rights law.<sup>688</sup> She further claimed that her exclusion from the above programme was contrary to section 15 of the Charter as her rights to equal access to health without discrimination was violated on grounds of disability and non-citizenship.<sup>689</sup> On trial, the Federal Court found that, the exposure of the applicant to a risk to her life and to long and a potential irreversible negative health circumstances through the exclusion from the IFH Program constituted a violation of the section 7 right to life, liberty and security of the person under the Charter.<sup>690</sup> However, the Court concluded that the exclusion was not contrary to the principles of fundamental justice as the applicant's exclusion from the IFH programme was due to her immigration status rather than on a prohibited ground such as disability or citizenship.<sup>691</sup> On this basis, her claim the applicant's claim alleging the violation of section 15 of the Charter of Rights and Freedom was rejected.

The applicant then proceeded to file an appeal to the Federal Court of Appeal submitting that the Federal Court had erred in its interpretation and application of the Charter of Rights and Freedoms as well as international human rights law. Upon reviewing the decision of the Federal Court, the Appeal Court upheld the decision of the Federal Court that the appellant was exposed to significant risk to her life and health that was sufficient to trigger a violation of section 7 of the

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<sup>686</sup> *Chaoulli v Quebec (Attorney General)* [2005] para 26-33, para 38-43, para 49-58, para 68, para 83-84, para 87-89, para 97.

<sup>687</sup> *Nell Toussaint v Attorney General of Canada* 2010 FC 810.

<sup>688</sup> *Nell Toussaint v Attorney General of Canada* 2010 FC para 20, para 63-70.

<sup>689</sup> *Nell Toussaint v Attorney General of Canada* 2010 FC para 20, para 71-83.

<sup>690</sup> *Nell Toussaint v Attorney General of Canada* 2010 FC para 20, para 84-94.

<sup>691</sup> *Nell Toussaint v Attorney General of Canada* 2010 FC para 94.

Charter.<sup>692</sup> However, the Appeal Court further held that the operative cause of the risk of her life was due to her decision to remain in Canada without legal status and therefore agreed with the Federal Court that her exclusion from the IFP Programme was not contrary to the principles of fundamental justice.<sup>693</sup> The Court stated that discrimination on grounds of immigration or citizenship status did not qualify as analogous of discrimination under the Charter of Rights and Freedom.<sup>694</sup> Aggrieved by this decision, the applicant sought leave to file an appeal at the Supreme Court of Canada. Her application for leave to appeal was denied in a decision released on 5 April 2012.<sup>695</sup>

In certain cases the Charter was invoked without any reliance on *Chaoulli*. For example, In *Flora v Ontario (Health Insurance Plan, General Manager)*,<sup>696</sup> the Plaintiff was declared non suitable for a liver transplant after consulting several specialists in Ontario and he was further informed that he had only six months to live. In this regard, the Plaintiff decided to seek medical treatment elsewhere and subsequently, he underwent a liver transplant at a private hospital in England. Thereafter, he filed a claim for the reimbursement of the cost of his treatment at the private hospital in England, amounting to \$450,000.00, from the Ontario Health Insurance Plan (OHIP), which turned down his request.<sup>697</sup> The Plaintiff proceeded to apply to the provincial Health Service Appeal and Review Board, which confirmed that the treatment did not fulfil the regulatory requirement that it had to be generally accepted in Ontario as appropriate for a person in the same medical circumstances as the Plaintiff.<sup>698</sup> In this regard, the Plaintiff appealed for a review of the above decision in the Ontario Divisional Court. The Court concluded that his section 7 Charter Rights had not been violated since he was free to seek alternative treatment outside the province.<sup>699</sup> On further appeal to the Ontario Court of Appeal, the Appeal Court upheld the trial court's conclusion that lack of OHIP funding for medical treatment sought out of the country was not in violation of section 7 of the Charter of Rights and Freedoms.<sup>700</sup>

In some cases, section 7 of the Charter of Rights and Freedom has been invoked by patients who are unable to access necessary medical care in a timely manner. For instance, in *Cilinger v*

<sup>692</sup> *Nell Toussaint v Attorney General of Canada* 2011 FCA 213.

<sup>693</sup> *Nell Toussaint v Attorney General of Canada* 2011 FCA 213 paras 70 to 73.

<sup>694</sup> *Nell Toussaint v Attorney General of Canada* 2011 FCA 213 paras 83 and 99.

<sup>695</sup> *Nell Toussaint v Attorney General of Canada* 2012 CanLII 17813 (SCC).

<sup>696</sup> *Flora v Ontario (Health Insurance Plan, General Manager)* 2008 ONCA 538 (2008) 91 OR (3d) 412 [*Flora* (CA)] aff'g (2007) 83 OR (3d) 721 278 DLR (4<sup>th</sup>) 45 (Sup.Ct.Div.Ct) [*Flora* (Div.Ct) cited to OR].

<sup>697</sup> *Flora v Ontario* (Div Ct) at para 2-6.

<sup>698</sup> *Flora v Ontario* (Div Ct) at para 43. Jackman M (2010) 5.

<sup>699</sup> *Flora v Ontario* (Div Ct) at para 168.

<sup>700</sup> *Flora v Ontario* (CA) at para 102.

*Quebec (AG)*,<sup>701</sup> the applicant sought to bring a class action against the government of Quebec due to delay in breast cancer patients' access to radiation treatment. According to the applicant, the failure by breast cancer patients to obtain radiation treatment interfered with their physical and psychological integrity and thereby infringed their rights under section 7 of the Charter of Rights and Freedoms. The Superior Court of Quebec held that the applicant could proceed with its class action against the 12 publicly funded hospitals providing radiation services in the province of Quebec but further stated that the class action could not be brought against the provincial government of Quebec as the Court concluded that province's health budget decisions were political in nature and not subjected to review under the Charter of Rights and Freedom.<sup>702</sup>

### **5.3.2 A Review of Judicial Application of the Charter of Rights and Freedoms in the Context of Health Care.**

There is call for a broad perspective in approaching the Charter of Rights and Freedoms and the need to take into consideration the Charter's special character into account in fashioning principles for its interpretation.<sup>703</sup> However, the cases illustrated above demonstrates Canadian courts unwillingness to engage with the Charter of Rights as a mechanism to enforce claims relating to the right to have access to health care as most of case law demonstrates.<sup>704</sup> This is because, apart from *Chaoulli*, patients and those advocating for their rights to have access to adequate health care have achieved limited success invoking the Charter to enforce this right.<sup>705</sup>

Some scholarly writers have identified the reluctance of imposing positive obligations on the government, the difficulties of challenging ameliorative programmes, the limit to the remedies that will be ordered and the deference to government allocation of scarce resources to be the main obstacles of enforcing socio-economic rights claims in Canada.<sup>706</sup> Notably, judicial deference

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<sup>701</sup> *Cilinger v Quebec (AG)* [2004] RJQ 2943 (CA) [*Cilinger (CA)*] aff'g *Cilinger c. Centre hospitalier de Chicoutimi* [2004] RJQ 3083 (CS) [*Cilinger (CS)*] leave to appeal to SCC refused 30703 (July 14 2005).

<sup>702</sup> *Cilinger v Quebec (AG)* (CA) aff'g *Cilinger c. Centre hospitalier de Chicoutimi* [2004] at para 17. Hardcastle L "Case Comment: *Cilinger c. Centre hospitalier de Chicoutimi*" (2006) 14:3 *Health Law Review* 44.

<sup>703</sup> See MacKay WA's affidavit cited as Exhibit A: *The Nature and Scope of the Charter Rights and Values of Freedom of Association: A Complex and Evolving Legal Saga* In the matter of an Arbitration pursuant to the *Health Authorities Act* SNA 2014 C 32 between *Canadian Union of Public Employees & Anor, South Shore District Health Authority & Anor and Attorney General of Nova Scotia* 3-5 [www.nsgeu.ca/filemanager/pdf/WayneMacKayAffidavit.pdf](http://www.nsgeu.ca/filemanager/pdf/WayneMacKayAffidavit.pdf). (Date of use: 13 March 2016).

<sup>704</sup> Jackman M (2010) 15.

<sup>705</sup> Jackman M (2010) 14-15.

<sup>706</sup> Gary Z M Wilkie C Baker D "The Law as it affects People with Disabilities: A Case Study Paper on Rights to Supports Prepared for the Law Commission of Ontario" (2010) *Baker Law Accessible Justice* 6-22.

towards decisions of the executive is often identified as the main obstacle in the enforcement of socio-economic rights claims as it is often based on the principle of separation of powers.<sup>707</sup>

In the context of the right to health care in Canada, Martha Jackman has upheld the latter view and has asserted that the limited success achieved in enforcing claims relating to access to health care under the Charter of Rights and Freedoms is due to the high level of judicial deference observed in most of the cases in that the government is called upon by patients to defend their spending choices and also as a result of the adoption negative right based approach towards the Charter which in her opinion is very narrow.<sup>708</sup> In her view, Canadian courts, particularly at the trial and appellate level have avoided the key issue underlying most access to health care claims, which is whether health care rationing decisions undertaken by most provincial governments in Canada comply with the substantive and procedural requirements of the Charter of Rights and Freedoms.<sup>709</sup> In doing so, she argues that the courts have appeared to endorse with minimal degree of scrutiny in most of those cases where patients have resorted to the Charter of Rights and Freedoms for suitable remedies against decisions and decision-making processes that they find inconsistent with their health care rights.<sup>710</sup>

To support these assertions, Jackman has made reference to cases where the courts have utilised the strategy of deference by diverting complex matters on health care for a unilateral decision by some other branch of government. In *Cameron v Nova Scotia*, for instance, she has demonstrated the appellate court's unwillingness to deal with Cameron and Smith's charter claim by deferring to the government to defend its health care funding choice.<sup>711</sup> In particular in this case, Kennedy CJ held that "[c]ourts should take care before interfering with an elected government's allocation of limited public funds for social programs or medical profession's determination of health priorities."<sup>712</sup> In making this assertion, the Court tended to regard its role in the enforcement of the patient's right to health care as secondary to the provincial government which is similar to the court's position *Government of the Republic of South Africa v Grootboom* in which the Court utilised the administrative law concept of reasonableness to assess the measures taken by the

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<sup>707</sup> Gary Z M Wilkie C Baker D (2010) 22-24.

<sup>708</sup> Jackman M (2010) 15.

<sup>709</sup> Jackman M (2010) 19-20.

<sup>710</sup> Jackman M (2010) 18. Campbell S "Pathways to and from the Supreme Court of Canada for Health Litigants" in Downie J and Gibson E (eds) *Health Law at the Supreme Court of Canada* ( Toronto: Irwin Law 2007) 365.

<sup>711</sup> *Cameron v Nova Scotia* at para 234, 236-37. Jackman M (2010) 16-17.

<sup>712</sup> *Cameron v Nova Scotia* at para 52.

government to give effect to the economic rights enshrined in the South African Constitution.<sup>713</sup> Similarly, Jackman has made reference to the case of *Cilinger v Quebec (AG)*, and has demonstrated how the Appeal Court deferred to the choices of government's health funding to the extent that it regarded these choices to be non-justiciable.<sup>714</sup>

However, the opinion of other scholarly writers contradicts Jackman's view that undue judicial deference has made it impossible to enforce health care claims under the Charter of Rights and Freedoms. On the contrary, these scholarly writers have upheld the court's approach of deferring complex issues regarding health care to the government choice of health care spending. Kate Dewhirst, have concluded that Kenneth C.J.'s judgments in *Cameron* was correct as the Nova Scotia government was not in breach of the Charter of Rights and Freedoms by noting paying for IVF and ICSI procedures. She has further justified the Supreme Court's restraint in using the Charter to affect government's budgetary allocation. In her opinion, there was a rational connection between the government's decision not to fund the IVS and ICSI procedures and the objective of the legislation, the *Health Service Insurance Act*, which was to allocate resources to the most appropriate health services.<sup>715</sup> In the case of the IVS and ICSI procedures, she argues that the Nova Scotia government did not determine these procedures to be medically necessary or priority medical services and had therefore not included them in the province's health care insurance scheme.<sup>716</sup>

Notwithstanding the above, Canadian courts have generally demonstrated their unwillingness to enforce socio-economic rights claims for which Jackman is attributing same to judicial deference by the courts to the government to defend its policies. Judicial deference reinforces the doctrine of separation of powers and in South Africa, it is argued that the court's excessive refuge under this doctrine has contributed to the South African court's failure to develop the substantive content of socio-economic rights which have limited the adjudication of these rights.<sup>717</sup> Similarly, Jackman believes that the court's excessive use of judicial deference in access to health care cases in

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<sup>713</sup> *Government of the Republic of South Africa v Grootboom*. Davis DM "The Relationship Between Courts and the Other Arms of Government in Promoting and Protecting Socio-Economic Rights in South Africa: What about Separation of Powers?" (2012) *PELJ* 7.

<sup>714</sup> Jackman M (2010) 17.

<sup>715</sup> Dewhirst K "An (In) Conceivable Question: Do Provincial Governments Discriminate against the Infertile by not Paying for IVF and ICSI Services? A Comment on *Cameron and Smith v. Nova Scotia (AG), The Minister of Health, The Department of Health and the Administrator, Insured Professional Services.*" (1999) *Dalhousie Journal of Legal Studies* 177.

<sup>716</sup> Dewhirst K (1999) 177.

<sup>717</sup> McLean K (2009) 105-107.



Canada reinforces the perception that the Charter of Rights and Health Care is not a health care accountability mechanism.<sup>718</sup>

Jackman has further averred that another way Canadian courts have been reluctant to enforce claims relating to the right to have access to health care is by adopting a negative right based approach to the Charter of Rights and Freedoms. In making this assertion, she has pointed to certain judgments where the negative rights based approach was used by the courts to support her arguments. For instance she has been so critical about the view of Chief Justice MacLachlin in *Chaoulli* as in her opinion, the view of the Chief Justice suggest that section 7 of the Charter does not require the government to take affirmative measures to ensure universal access to health care as the Judge stated that the Charter does not confer a freestanding constitutional right to health care even as she agreed that Quebec's ban on private insurance was objectionable under section 7 of the Charter because it prevented ordinary Quebec residents from securing private insurance that would enable them to obtain alternative health care from the private sector and enable them avoid the delays in the public health care system.<sup>719</sup>

Similarly, in *Auton*, Jackman has pointed out that the Supreme Court repeatedly declared that the legislature is not under an obligation to create a particular benefit as it was free to target the social programmes it intended to fund as a matter of public policy, provided the benefit is not conferred in a discriminatory way.<sup>720</sup> To this end, Jackman has argued that the conception of the right to health care put forward by the courts especially in *Chaoulli* is clearly a negative right rather than a positive right, which falls short of Canada's obligations under ICESCR to guarantee, 'to the maximum of its available resources' the right of everyone to the highest attainable standard of health, including access to medical service without discrimination based on 'social origin, poverty, birth or other status'.<sup>721</sup> To conclude, she has stated that the excessive use of judicial deference and the adoption of negative right based approach on the interpretation of the Charter of Rights and Freedoms by Canadian Courts have doomed the claims of most patients relating to the right to have access to health care.<sup>722</sup> Accordingly, she has suggested that there is need for courts in Canada to subject health rationing decisions to careful Charter scrutiny to ensure that these decisions constitute a reasonable and justifiable limit within the meaning of section 1 of the Charter of Rights and Freedoms as they have a great role to play in this regard.<sup>723</sup> Until the above

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<sup>718</sup> Jackman M (2010) 18.

<sup>719</sup> Jackman M (2010) 18. See *Chaoulli v Quebec (AG)* (SCC) para 104.

<sup>720</sup> Jackman M (2010) 18. See *Auton v British Columbia* (SCC) para 41.

<sup>721</sup> Article 2(1) of the International Convention on Economic, Social and Cultural Rights (ICESCR).

<sup>722</sup> Jackman M (2010) 19-25.

<sup>723</sup> Jackman M (2010) 25.

recommendation is taken into consideration, she has indicated that health care claims in Canada will continue to generate unprincipled judicial rulings.

#### **5.4 The Horizontal Application of the Charter of Rights and Freedom in the Context of Health Care Services**

The South African Constitution is parallel to the Canadian Charter of Rights and Freedoms in that the former makes provision for its application to horizontal relationships involving non- state entities whereas the latter makes no provision for the application of the Charter to such relationships.<sup>724</sup> Section 32(1) of the Charter in principle makes non-governmental entities immune from the provisions of the Charter. It states that the Charter applies only to the federal parliament and provincial legislatures and to the actions and decisions of the federal and provincial governments.<sup>725</sup> The scope and meaning of section 32(1) was first considered in the case of *R.W.D.S.U., Local 580 v Dolphin Delivery Ltd*,<sup>726</sup> in which, the Supreme Court held that the Charter of Rights and Freedoms applied only to the government. By implication, the Court meant that while decisions and actions of the legislative and executive branch of government, whether in the form of laws, regulations, policies or practices, were subject to scrutiny under the Charter, the actions and practices of private entities were not.<sup>727</sup>

In the health care context, it was observed in the case of *Stoffman v Vancouver General Hospital*<sup>728</sup> that the Vancouver General hospital did not form part of 'government' within the meaning of section 32(1) and were not subjected to Charter scrutiny.<sup>729</sup> In this case, the appellant claimed that the mandatory retirement policy for physicians of the Vancouver General Hospital violated the prohibition against age discrimination under section 15 (1) of the Charter. In the decision of the majority, Justice La Forest found that while the provincial government of British Columbia retained control over the Vancouver General Hospital, the provincial hospital's legislation did not subject the hospital's management to government control and as a consequence, the Judge held that the hospital did not form part of government within the meaning of section 32(1) of the Charter making the appellant's claim not subjected to scrutiny under the Charter.<sup>730</sup> As a horizontal application is not within the purview of the Charter, the question arises whether patients

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<sup>724</sup> Section 8 of the South African Constitution.

<sup>725</sup> Section 32(1) of the Canadian Charter of Rights and Freedom.

<sup>726</sup> *R.W.D.S.U., Local 580 v Dolphin Delivery Ltd* [1986] 2 SCR 573.

<sup>727</sup> *R.W.D.S.U., Local 580 v Dolphin Delivery Ltd* 598.

<sup>728</sup> *Stoffman v Vancouver General Hospital* [1990] 3 SCR 483.

<sup>729</sup> *Stoffman v Vancouver General Hospital* [1990] 3 SCR 516.

<sup>730</sup> *Stoffman v Vancouver General Hospital* [1990] 3 SCR 516.

whose health care rights are infringed by non-state entities can rely upon the provisions of the ICESCR to enforce these rights. As mentioned above, Canada has been a State party to the ICESCR since 1976. There remains a lot of controversy as to whether non-state entities are subjects of international law.<sup>731</sup> Some scholarly writers are of the opinion that obligations under international human right instruments like the ICESCR are addressed to State parties only, which make the State the only entity with all embracing responsibility for socio-economic rights protection.<sup>732</sup> In this regard, it is difficult to impose direct binding obligations under the ICESCR upon non-state entities following the construction of its article 2(1).<sup>733</sup> However, the General Comment No 14 makes it clear that non-state actors have responsibilities to fulfil in respect of health care and failure to fulfil these responsibilities will amount to a violation of the right to health under the ICESCR.<sup>734</sup> On this basis, it can be said that the provisions of the ICESCR can be relied upon to enforce the right to health care in Canadian as well as other socio-economic rights. For instance, article 11 of the ICESCR has been invoked in Canada to challenge the practice of screening prospective tenants based on their income level and credit history by landlords.<sup>735</sup>

Furthermore, other statutory means exist in Canada as alternatives where these socio-economic rights can be enforced against non-state entities. Human rights legislations exist in all provinces and at the federal level that protects the right to equality at the federal sector and the courts' approach under these legislations have been similar to their approach to the substantive equality under section 15 of the Charter of Rights and Freedoms.<sup>736</sup> In Quebec for instance, socio-economic rights are explicitly recognised under the Quebec Charter of Rights and Freedoms and extend to non-state entities in some cases.<sup>737</sup>

Again, the Supreme Court has emphasised that the government cannot contract out of their constitutional obligations.<sup>738</sup> In other words, where private actors are given the responsibility to implement specific government policies or programs, these entities will be subjected to Charter scrutiny in respect of those activities. This principle was first observed in *Eldridge* in which the Court found that the hospital's failure to provide medical interpretation services to deaf patients to ensure

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<sup>731</sup> Weissbrodt D "Non- State Entities and Human Rights within the Context of the Nation State in the 21<sup>st</sup> Century" in M Castermans F van Hoof and Smith J (eds) *The Role of the Nation State in the 21<sup>st</sup> Century* (Dordrecht: Kluwer 1998) 194.

<sup>732</sup> Weissbrodt D (1998)195.

<sup>733</sup> See Article 2(1) of the ICESCR.

<sup>734</sup> CESCR General Comment No. 14 E/C 12/2000/4 para 42.

<sup>735</sup> Jackman M and Porter B (2008) 7.

<sup>736</sup> Jackman M and Porter B (2008) 7.

<sup>737</sup> Sections 1-20 of the Quebec Charter of Rights and Freedoms.

<sup>738</sup> *Eldridge v British Columbia (Attorney General)* para 40. Jackman M and Porter B (2008) 6.

that they enjoyed equal benefits of health care services was contrary to section 15 of the Charter. The basis on which the Supreme Court upheld and applied the Charter to this case was that although hospitals were non-governmental entities and fell out of the scope of application of the Charter, they were however subjected to the Charter when acting as a vehicle chosen by the government to deliver its comprehensive health care programmes.<sup>739</sup> Another important dimension of horizontal application of the Charter is found in government's obligation to protect vulnerable groups from violation of their rights by others in so far as this obligation can be grounded in a requirement that the legislation is not under-inclusive.<sup>740</sup>

### 5.5 Remedies.

In terms of section 24(1) of the Charter, courts can provide a wide range of remedies for violation of the Charter's rights and Canadian Courts have made use of this remedial flexibility in dealing with socio-economic rights claims.<sup>741</sup> The wide category of remedies available for anyone whose constitutional rights have been violated in relation to the Charter include, the issue of an immediate declaration of invalidity or the suspension of the declaration for a period of time to enable the government to put in place necessary measures to give into effect socio-economic rights.<sup>742</sup> The courts may award damages and order the government to take positive remedial action and may even order supervisory orders and maintain ongoing jurisdiction over the implementation over remedies that take time to be put in place.<sup>743</sup> Again the courts may also enforce orders against the government through contempt of court proceedings.<sup>744</sup> The courts may also issue a constitutional exemption to protect the interest of a party who has succeeded in having a legislative provision declared unconditional, where the declaration of the invalidity has been suspended.<sup>745</sup>

In spite of the powers granted the courts to issue appropriate remedies in respect of Charter's violation and in particular, the right to health care which is in context in this study, some scholarly writers have argued judicial adherence to a positive and negative rights framework in access to health care cases, has had adverse effects at a remedial level and undermine the values and purposes of the Charter of Rights and Freedoms and also falls short of Canada's obligation under ICESCR to guarantee, "to the maximum of its available resources" the right of everyone to the highest attainable standard of health, including access to medical service without discrimination

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<sup>739</sup> *Eldridge v British Columbia (Attorney General)* para 40-52.

<sup>740</sup> Jackman M and Porter B (2008) 7. *Vriend v Alberta* [1998] 1 SCR 493 para 64.

<sup>741</sup> Section 24 of the Charter of Rights and Freedom.

<sup>742</sup> Jackman M and Porter B (2008) 22.

<sup>743</sup> Jackman M and Porter B (2008) 22.

<sup>744</sup> *Doucet- Boudreau v Nova Scotia (Minister of Education)* [2003] 3 SCR 3.

<sup>745</sup> Roach K "Remedial Consensus and Dialogue under the Charter: General Declarations of Invalidity" (2002) *University of British Columbia Law Review* 715-717.

based on social origin, poverty, birth or other status.<sup>746</sup> In the opinion of these scholarly writers, the conception of the right to health care put forward by majority in cases like *Chaoulli* clearly depicts the right to health care as a negative right rather than a positive one as they agreed that the prohibition on private insurance was unconstitutional.<sup>747</sup> This view depicts a negative right in that it does not require the government to take affirmative action to ensure universal access to health care by all Canadians. Rather it requires government's inaction and the appellants must just be free to purchase at their own expense health care without any interference from the government. By implication, this means the result of the decision in *Chaoulli* is a constitutional remedy available only for those who can buy their way out of the public health care system.<sup>748</sup>

The use of judicial deference in most socio-economic rights cases has also had adverse effects on the issue of remedies and undermines the purpose and values of the Charter of Rights and Freedoms. The application of deference has led to a judicial preference for suspended declaration of invalidity as a remedy for situations where positive remedial action would be an appropriate remedy and in which the government have various other policy options available to comply with the Charter of Rights and Freedoms as envisaged in *Eldridge*.<sup>749</sup> In this case, the Supreme Court insisted that section 15 of the Charter of Rights and Freedoms was applicable to a failure to fund interpretation services and the failure could not be justified under section 1 of the Charter while the trial and appellate courses had initially concluded that section 15 ought not to be invoked to government choices in the allocation of scarce resources among health care priorities.<sup>750</sup> However, at the remedial stage, the Supreme Court found deference to legislative policy choices to be appropriate as Justice La Forest stated that a declaration was more appropriate than an injunction relief and that it was further appropriate for the effectiveness of the declaration to be suspended for a period of six months to enable the government to explore other options to formulate an appropriate response to correct the unconstitutionality of its scheme.<sup>751</sup>

To justify the use of judicial deference, the court has held that it is aimed at determining the appropriate remedy for a breach of the Charter and in deciding whether a limit is justified under section 1 of the Charter.<sup>752</sup> The Supreme Court has further emphasised in the case of *Symes v*

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<sup>746</sup> Jackman M "Charter Remedies for Socio-economic Rights Violations: Sleeping under a Box?" in Roach K (ed) *Taking Remedies Seriously* (Montreal: Les Editions Yvon Blais 2010) 4.

<sup>747</sup> Jackman M and Porter B (2008) 15-16.

<sup>748</sup> Jackman M in Roach K (2010) 6-8.

<sup>749</sup> Jackman M and Porter B (2008) 22-23.

<sup>750</sup> *Eldridge v British Columbia (Attorney General)* para 85.

<sup>751</sup> *Eldridge v British Columbia (Attorney General)* para 96.

<sup>752</sup> Jackman M and Porter B (2008) 22.

*Canada*,<sup>753</sup> that the exercise of judicial deference alongside the role of the legislature in exercising socio-economic policy choices should not be construed as rendering the Charter rights as invalid or immunising the government's authority from constitutional scrutiny.<sup>754</sup> Notwithstanding this argument, it is recorded in some scholarly writings that in Canada, the actions of governments continue to escape from judicial review as a result of judicial deference and the continuous reliance by Canadian courts to the traditional distinction on socio-economic rights as positive and negative rights.<sup>755</sup> In this regard, some scholarly writers have suggested that it is time for Canada to wake up from under the box and address its long standing failure relating to the protection of the rights of marginalised groups under the Charter of Rights and Freedom.<sup>756</sup>

## **5.6 Other Policy Framework Regulating the Right to Have Access to Health Care in Canada**

Despite the shortcoming envisaged under judicial review which has affected the potential of the Charter of Rights and Freedom to provide adequate protection to marginalised people in respect of their socio-economic rights entitlements under the charter, it is important to note that the constitutional framework is not standing alone in the protection of socio-economic entitlements. Canada has also adopted other legislative and policy frameworks to guarantee the protection of socio-economic rights. As far as the right to have access to health care services is concerned, a good piece of legislation enacted in Canada to enforce this right is the Canadian Health Care Act of 1984 which shall be examined in the next paragraph to determine its potential in realising the right to have access to health care services in Canada.

### **5.6.1 Canada Health Act of 1984**

Canada Health Act is a piece of Canadian federal legislation passed into law in 1984.<sup>757</sup> The Act is premised on the objective of accessibility which is clearly stated in its preamble. The preamble of the act states that the objective of Canadian Health Care policy is "that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians." The primary objective of the Act is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to

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<sup>753</sup> *Symes v Canada* [1993] 4SCR 695.

<sup>754</sup> *Symes v Canada* para 753.

<sup>755</sup> Jackman M in Roach K (2010) 4-15.

<sup>756</sup> Jackman M in Roach K (2010) 25-26.

<sup>757</sup> Canadian Health Act of 1984 published by the Department of Justice in Canada <http://laws-lois.justice.gc.ca/PDF/C-6.pdf> (Date of use 14 August 2017).

health services without financial or other barriers."<sup>758</sup> The act therefore establishes a public funded health care scheme whereby patients access health care services on the basis of need and not on the basis of affordability.<sup>759</sup> As prescribed by the act, the federal government establishes national standards for health care and the provinces and territories deliver the services which are required by the people. In order for the provinces and territories to receive federal transfer payments to carry out their function to deliver services, the act prescribes certain criteria and conditions they must meet to be considered for the aforesaid funding. Therefore, territorial and provincial governments that allow direct charges to patients are punished under the act and the federal government does so by reducing their federal transfer payments.<sup>760</sup>

The condition and criteria which the provincial and territorial governments must meet to receive federal transfer payments are set out in brief as follows. Firstly, public administration which implies that the public health insurance plan must be managed in a public, not-for-profit fashion.<sup>761</sup> Secondly comprehensiveness meaning that all residents must be covered for medically necessary health care services.<sup>762</sup> Universality is the third criteria under the act and the goal of this criterion is to ensure that all residents are covered by the public insurance plan on uniform terms and condition.<sup>763</sup> Portability is another condition which provinces and territories must fulfil which requires that all resident be covered by their public plan, wherever they are treated in Canada.<sup>764</sup> Finally, accessibility as a criterion under the act requires that all resident must have access to insured health care services on uniform terms without direct or indirect financial charges, or discrimination based on age, health status or financial circumstances.<sup>765</sup>

### **5.6.2 Access to Health Care Services under Canada Health Act of 1984**

As mentioned above Canada Health Act is premised on the objective of accessibility and this objective is among one of the criteria which provinces and territories must meet in order to receive federal transfer payments. As far as the accessibility to health care services is concerned, The Canadian Health Act has often been viewed by various stakeholders in the health policy arena as

<sup>758</sup> See Preamble of Canadian Health Act of 1984.

<sup>759</sup> Irvine B, Ferguson S and Cackett B "Healthcare Systems: Canada" (2013) *CIVITAS* <http://www.civitas.org.uk/content/files/canada.pdf> 1 (Date of use: 11 August 2017).

<sup>760</sup> The Council of Canadians "Understanding the Canada Health Act" (2010) <https://canadians.org/sites/default/files/publications/CHA%20Feb%202010.pdf> 1 (Date of use: 11 August 2017).

<sup>761</sup> Section 8 of Canada Health Act of 1984.

<sup>762</sup> Section 9 of Canada Health Act of 1984.

<sup>763</sup> Section 10 of Canada Health Act of 1984.

<sup>764</sup> Section 11 of Canada Health Act of 1984.

<sup>765</sup> Section 12 of Canada Health Act of 1984.

an ideal Canadian medical system through which the entitlements to health care services can be achieved.<sup>766</sup> Accordingly, this act serves as an avenue through which individuals can protect their interest through the courts. One of those court cases where the Canada Health Act has been invoked to enforce the right of access to health care services is in *Lexogest v. Manitoba (AG)*,<sup>767</sup> in which the applicant Lexogest Inc. Owned and operated a free standing abortion clinic in Winnipeg which was approved by the College of Physicians as a non hospital surgical facility where therapeutic abortions could be performed. Pursuant to the *Health Insurance Services Act*<sup>768</sup> however, the provincial government adopted a regulation which removed coverage for therapeutic abortions performed outside a hospital. The applicant argued that the regulation did not comply with the intent of the Canada Health Act.<sup>769</sup> Although the majority in this case was of the opinion that the regulation was *ultra vires* parent provincial statute and did not consider the Canada Health Act, Scott C.J.M however in his dissent analyse the compatibility of the regulation with the Canada Health Act whose view was concurred by Lyon J.A.<sup>770</sup>

The cases where this act has been considered has however been few. This is because it's potential as a statutory frame work to achieve social justice has greatly been overlooked in that it has often been recognised as merely a political and not a legal instrument.<sup>771</sup> For this reason, there has been contravention of the act in some provinces due to the proliferation of private clinics which has given rise to reports of overbilling resulting to gross human rights violations. In British Columbia for example, potential human rights violation is being debated in the case of *Cambie Surgeries Corp. v Medical Services Commission of British Columbia*.<sup>772</sup> In this case, the court will have to decide on whether the ban on private medical insurance violates the Canadian Charter of Rights and Freedoms.<sup>773</sup> Although the Charter of Rights and Freedom is being invoked to determine this case, it is also anticipated that the decision reached by the court could have far reaching consequences on Canadians who cannot afford private health insurance.<sup>774</sup> This case also revolves around the argument that Canada should adopt a parallel health care system that will run alongside its current public health care system. Some scholarly writers believe that allowing a private health care system to emerge alongside Canada's current health care system

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<sup>766</sup> Choudhry S "The Enforcement of the Canada Health Act" (1996) *McGill Law Journal* 463.

<sup>767</sup> *Lexogest Inc. v. Manitoba (AG)* (1993), 101 D.L.R. (4th) 523 (Man. C.A.).

<sup>768</sup> Choudhry S (1996) 488.

<sup>769</sup> Choudhry S (1996) 489.

<sup>770</sup> Choudhry S (1996) 489.

<sup>771</sup> Choudhry S (1996) 461.

<sup>772</sup> *Cambie Surgical Centre et al. v. Medical Services Commission et al (Cambie Case)* pending in BC Supreme Court (Unreported).

<sup>773</sup> Sibbald B and Stanbrook MB "Canada Health Act needs bite" (2016) *CMAJ* 1133.

<sup>774</sup> Sibbald B and Stanbrook MB (2016) 1133.



raises grave concerns as a two tier system of health care will have dubious prospects of protecting the right of all Canadians to have access to health care services.<sup>775</sup> In the opinion of these scholarly writers therefore, Canada should rather fix the current public health care system by strengthening its existing framework to ensure that the universality and equitable values of its current public health care system is upheld.<sup>776</sup>

## 5.7 Conclusion

In this chapter, I have examined statutory framework regulating the right to have access to health care services in Canada to contrast with South Africa and determine whether Canada should be considered as an option by South Africa in formulating health care policies to improve on access to health care services. The statutes which have been limited to this enquiry have been the Charter of Rights and Freedom which is Canada's constitutional framework and the Canada Health Act of 1984. Accordingly, this study has been able to establish that although the Charter of Rights and Freedoms is parallel to the South African Constitution in that it does not provide for socio-economic rights, in light of its historical expectation to rights holder and as the High Commissioner Arbour noted, it can be said that the Charter has socio-economic rights dimensions.<sup>777</sup> In the above study, I have illustrated the socio-economic rights dimensions by making reference to some important cases brought before the court in respect of socio-economic rights violation. In the context of health care, which is the subject of this study, claimants whose ability to access necessary medical services have been infringed, have resorted to the Charter and in most of the cases, they have either invoked section 7 right to life, liberty and security of the person or section 15 right of equality to justify their claims.

However, the review of case law as seen in this study demonstrates that claimants in their quest to invoke the Charter and correct any infringement of their right to have access to health care have achieved limited success due to the courts' excessive use of judicial deference and Canadian courts continuous reliance on the traditional distinction of rights as positive rights and negative rights.<sup>778</sup> As I have disclosed above, much criticism have been lodged against these approaches and in particular the excessive use of judicial deference. Notably in South Africa with a modest constitution in which socio-economic rights are explicitly protected, the court has been criticised for regarding its role in the enforcement of socio-economic rights as secondary to the political

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<sup>775</sup> Sibbald B and Stanbrook MB (2016) 1133.

<sup>776</sup> Sibbald B and Stanbrook MB (2016) 1133.

<sup>777</sup> Jackman M and Porter B (2008) 4-5.

<sup>778</sup> Jackman M (2010)13-14.

process.<sup>779</sup> This is because in utilising such an approach, the courts have failed to define and evaluate the interest at stake in socio-economic rights cases brought before them.<sup>780</sup> Similarly in Canada, because of failure by the courts to evaluate the interests of claimants in health care entitlement claims, the claims of many patients under the Charter has been frustrated by the policies of provincial governments. In view of the above, some scholarly writers have suggested that the way forward is to subject health care decisions to Charter scrutiny to avoid excessive deference that undermines the value and purpose of the Charter.<sup>781</sup>

This study has also been able to examine the role played by the Canadian Health Act to improve access to health care services to all Canadians. Accordingly, the finding in this study is that there is limited jurisprudence to demonstrate how the Canada Health Act has been invoked to improve access to health care services. Notwithstanding the above, the public funded health care system in Canada often known as Medicare which this act enforces has largely been upheld to have addressed the problem of inequity in Canada.<sup>782</sup> Although this act has been met with criticism that it prevents the current health care system in Canada to adapt to new requirements and demands, some scholarly writers believe that the Medicare programme implemented by this act can serve as a notable option to improve access to health care services in South Africa.<sup>783</sup> I also concur with this view in that as South Africa is currently rolling the National Health Insurance programme, aspects from Canada's Medicare can be borrowed to successfully implement the aforesaid programme. However, in doing so, components borrowed from Canada's Medicare to implement the NHI should be informed by South Africa's socio-economic indicators before they can be adopted. Therefore, it is conclusive to say that although Canada's approach in upholding the right to have access to health care services might not be a panacea, lessons may yet be found in its fundamental principles and funding structures, which can inform South Africa's quest for a fair, effective and equitable health care system.<sup>784</sup>

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<sup>779</sup> Davis DM (2012) 7.

<sup>780</sup> Davis DM (2012) 7.

<sup>781</sup> Jackman M (2010) 20.

<sup>782</sup> Birn AE and Nixon S "Canada's health care system: A relevant approach for South Africa?" (2010) *South African Medical Journal* 519.

<sup>783</sup> Birn AE and Nixon S (2010) 520.

<sup>784</sup> Birn AE and Nixon S (2010) 520.

## CHAPTER 6: SUMMARY, CONCLUDING REMARKS AND RECOMMENDATIONS

### 6.1 Summary

South Africa in its 1996 Constitution has entrenched justiciable socio-economic rights with the aim of transforming the existing unequal social and economic status quo and with a view of ensuring that the dignity of its people are guaranteed and their well being are being accounted for and protected.<sup>785</sup> Among the socio-economic rights protected by the Constitution is the right to have access to health care services which is the subject of this study. The main objective of this study has been to explore the constitutionality of this right and its application in the context of South Africa. In doing so, it aimed at examining the extent to which the substantive normative content of the right to have access to health care services has been developed including the positive and negative duties imposed by this right. To this end, the study has mainly been based on a literature survey, with secondary and primary literature being analysed and the findings from them applied in order to answer the questions relating to this research. The work of various scholarly writers, civil society documents, South African, international human rights law and foreign case law and international human rights instruments have been examined. The study sets out to enquire how the substantive normative content of the right to have access to health care services has been developed to achieve its constitutional objective and the purpose for which it was entrenched in the Constitution.

In Chapter one, a background to the entire study was considered and the current state of health care in South Africa was discussed. This chapter discussed how the government has committed itself to fight against unequal access to health care services by adopting a constitutional framework that affirms the right to have access to health care services. Furthermore the chapter revealed how the government has abide itself by its constitutional mandate and has initiated reforms to bring about changes that will address inequities inherent in the health sector of South Africa.

However, this chapter revealed that despite the efforts by the government to overcome unequal access to health care services by all South Africans, there remain some fundamental hurdles in the policies and legislative framework developed by the government to enable the population to gain access to health care services as it is established that there are gaps in the implementation of some of government's policies and framework at the national and provincial level which amounts to social exclusion and contrary to a right based approach.<sup>786</sup>

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<sup>785</sup> Coomans F (2005) 169.

<sup>786</sup> SAHRC (2006-2009) 79.

To this effect, this chapter emphasise the importance of the entire corpus of socio-economic rights including the right to have access to health care services entrenched in the Bill of Rights as they are intended to break the country from the shackles of its past grounded by inequality and gross human rights violations and forge a new future for all South Africans.<sup>787</sup> Thus this chapter revealed that this study is motivated by concerns of an ineffective implementation of government policies to realise the right to have access to health care services and thereafter stressed the importance of upholding this right in the social transformation process of South Africa in order to consolidate and deepen democratic values.

In Chapter two, the nature, scope and content of the right to have access to health care services was discussed. Under this chapter, it was found that the right to have access to health care services under section 27 of the Constitution is a socio-economic right and the Constitution imposes a positive obligation on the government to realise this right in terms of section 27(2) of the said Constitution.<sup>788</sup> It was further found that in the context of South Africa the Constitution makes socio-economic rights entrenched in the Bill of Rights justiciable in nature. This means that socio-economic rights including the right to have access to health care services can be enforced through litigation in courts in the same manner as civil and political rights.<sup>789</sup> In entrenching socio-economic rights in the Bill of Rights as justiciable rights, this chapter reveals that the South African Constitution has adopted the principle of indivisibility, interdependence and interrelatedness of rights affirming that all rights are mutually self-supporting and that the realisation of one would depend on the scrupulous implementation of other socio-economic rights or rights embedded in the Constitution.<sup>790</sup>

Thus far, this chapter found out that the courts have been proactive in upholding socio-economic rights including the right to have access to health care services as evident in some cases including, *Grootboom*,<sup>791</sup> *TAC*,<sup>792</sup> and *Soobramoney*.<sup>793</sup> In doing so the chapter revealed that the Constitutional Court has interpreted socio-economic rights in a manner that only entitles the beneficiaries of the rights granted in provisions such as sections 26 and 27 of the Constitution to reasonable state

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<sup>787</sup> Klare K (1998)150.

<sup>788</sup> Section 27 of the Constitution.

<sup>789</sup> Certification of the Constitution of the Republic of South Africa para 49.

<sup>790</sup> *Government of the Republic of South Africa v Grootboom*. Olivier M (2002)135.

<sup>791</sup> *Government of the Republic of South Africa v Grootboom*.

<sup>792</sup> *Minister of Health and Others v Treatment Action Campaign and Others*.

<sup>793</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)*.

action undertaken to progressively realise the rights subject to the available resources.<sup>794</sup> Furthermore, the chapter revealed how Courts have utilised the broad remedial powers vested by section 38 of the Constitution to develop new remedies and apply structural interdicts in order to provide appropriate relief in cases where an infringement or threatened violation of a socio-economic right is established.<sup>795</sup>

However, in spite of judicial commitment of converting socio-economic rights into actual entitlements considering the very nature of their justiciability, this chapter found that judicial enforcement of socio-economic rights is being limited by the doctrine of separation of powers and by the argument of polycentrism.

In analysing the scope of the entrenched socio-economic rights including the right to have access to health care services, this chapter also analysed the right to health under international human rights law as well as the relationship between section 27 of the Constitution and other international instruments and their incorporation into the South African legal system. In doing so the chapter undertook a comparative study between the right to have access to health care services under the South African Constitution and other relevant international human right instruments and it was established that the South African Constitution is more comprehensive in its approach to protect the right to health than its international counterparts. This is because the Constitution places much emphasis on access to health care services whereas the international instruments highlighted in this study only make reference to the right to health care.

The goal of chapter three in this study was to establish whether the Constitution also regulates relationships that bind private parties as the private sector was increasingly involved in the provision of health care services. The chapter therefore reviewed the privatisation of health care services in South Africa to highlight the role private entities play in the provision of health care services in South Africa and emphasised that it is important to discuss the concept of privatisation as it was the process through which these entities engage themselves in the health care sector. In this regard the features of privatisation in South Africa were discussed and the arguments for and against privatisation were also considered. Furthermore, the relationship between privatisation and the right to have access to health care services as well as the impact of privatisation on section 27 of the Constitution was examined and it was established that there is increasing disenchantment with

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<sup>794</sup> Mbazira C (2009) 77.

<sup>795</sup> Section 38 of the Constitution. *Grootboom and Others v Oostenberg Municipality, Occupiers of 51 Olivia Road and Others v City of Johannesburg and Others*.

privatisation as it has not resolved some of the challenges that South Africa's health sector continues to face.<sup>796</sup>

In view of the above, it was therefore established in this chapter that the Constitution acknowledges that rights may sometimes bind private parties and require courts to apply existing common law or develop the common law in accordance with the spirit, purport and object of the rights in the Bill of Rights in order to enforce these rights. To support this assertion, the constitutional framework relating to the horizontal application of socio-economic rights including the right to have access to health care services were discussed to show how the Constitution regulates relationships involving non-state entities. Regrettably, it was established that despite the Constitutional dispensation regulating relationships binding private parties, the judiciary has been very reluctant to undertake any major doctrinal reforms in order to give effect to the values of the constitution as there has only been a few cases where South African Courts have addressed the issue of horizontal application of socio-economic rights.<sup>797</sup> This chapter further examined the horizontal dimensions of the right to have access to health care services but also established that thus far judicial review has been limited in respect of enforcement of the right to have access to health care services against non-state entities. The chapter further revealed that there has been little development in South Africa regarding the development of the common law in order to enforce the right to have access to health care services horizontally.

Despite the above, this chapter remained adamant to the fact that common law development is a viable remedial paradigm for the horizontal enforcement of socio-economic rights given the fact that development of the common law in the course of private litigation is often regarded as an uncontroversial aspect of the judicial function.<sup>798</sup> In this regard, this chapter reviewed the concept of medical negligence and illustrated how there has been attempt to develop the common law standard of care rule in cases where medical negligence is alleged as an avenue through which section 27(1)(a) can be applied horizontally.<sup>799</sup>

In Chapter four, this study found that although socio-economic rights including the right to have access to health care services were justiciable in nature, the South African Constitution has adopted the standard of "progressive realisation" in the implementation of these rights, a standard first entrenched in article 2(1) of the International Convention on Economic, Social and Cultural Rights (ICESCR). The adoption of the standard of progressive realization was due to the perception that

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<sup>796</sup> Rispel L and Setswe G (2007) 5.

<sup>797</sup> Liebenberg (2014) 62.

<sup>798</sup> Pieterse M (2009) 157.

<sup>799</sup> Pieterse M (2007) 173-178.

the implementation of socio-economic rights was highly dependent upon available resources. Therefore availability of resources was perceived to be an internal limitation to a State's obligation to realize socio-economic rights. However, due to the vagueness of the progressive realization standard and the difficulties in designing indicators to monitor its use in the realization of socio-economic rights, it was revealed in this chapter that the standard has come under serious criticism, with several commentators arguing that it is the major reason associated with the endemic neglect in the realization of socio-economic rights nationally and internationally.<sup>800</sup>

Despite the above criticism, this chapter revealed that in the context of South Africa, the importance of the availability of resources in the realization of socio-economic rights was emphasized by the Constitutional Court in the *Soobramoney case*<sup>801</sup> and later adopted in its decisions in the *Grootboom case*.<sup>802</sup> Notwithstanding the Constitutional Court's acknowledgement of the importance of resources in the realization of socio-economic rights, it was also observed in this chapter that the Court also realizes that it is possible for the State to use the progressive realization standard as an excuse not to undertake necessary measures to realize substantive socio-economic rights. In this regard, we observed that the Court has stated in *Grootboom* that progressive realisation means, "accessibility should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and, where possible, lowered over time."<sup>803</sup>

However, chapter four also revealed that despite the Court's qualification of the term "progressive realisation" in *Grootboom*, a lot of ambiguity still revolves on how the concept of progressive realisation should be understood and applied to a particular socio-economic right given the fact that the Court has not engaged the definition it provided for the term in *Grootboom* in subsequent cases. Rather, these cases have attempted several qualification of the term "progressive realisation" which has resulted to more controversies and has undermined efforts to effectively implement and enforce socio-economic rights.<sup>804</sup> In this regard, it is observed in this chapter that certain scholarly writers have arrived a consensus that the progressive realisation would require the state to strive towards

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<sup>800</sup> Dowell-Jones M (2004) 39.

<sup>801</sup> *Soobramoney v Minister of Health* para 11. In this case the President of the Court, Justice Chaskalson, held as follows: "What is apparent from these provisions is that the obligation imposed on the State by sections 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled."

<sup>802</sup> *Government of the Republic of South Africa v Grootboom* para 45.

<sup>803</sup> *Government of the Republic of South Africa v Grootboom* para 45.

<sup>804</sup> Chenwi L (2013) 768-769.

the fulfilment and enjoyment of socio-economic rights to the maximum extent possible, even in the face of scarce resources.<sup>805</sup>

Furthermore in this chapter, it was observed that it is the responsibility of the government to guarantee enjoyment of the entrenched socio-economic rights by taking reasonable legislative and other measures within its available resources to ensure that everyone within the country has access to these rights.<sup>806</sup> In this regard, this chapter acknowledged that Courts have played an enormous role in ensuring the progressive realisation of socio-economic rights through judicial enforcement. Thus, Courts have developed the willingness to enforce positive obligations arising from certain socio-economic rights in a few cases that have been brought before them such as *Grootboom* in which applied a test for reasonableness as a guide to determine whether the government programme were consistent with constitutional requirement.<sup>807</sup>

Apart from the above, in this chapter it was also observed that the government has committed itself in upholding the right to have access to health care services. The chapter disclosed how significant progress has so far been made through the ambitious legal and policy frameworks adopted by the government to improve access to health care and bring health care services to previously underserved population or disadvantaged areas.<sup>808</sup> However, it was further observed in this chapter that the adoption of the ambitious policy and legislative framework has not been sufficient to enhance the realisation of the right to have access to health care services in South Africa as some serious challenges lie ahead of their implementation.<sup>809</sup> In this regard, the study in this chapter undertook to discuss other measures such as judicial remedies which could compliment the use of legislation and policies to realise the right to have access to health care services.

However, it was observed in this chapter that even with the adoption of other measures to compliment the use of legislation, these measures must be made available and effective to parties who seek their relief in order to enforce a particular socio-economic right. In South Africa, it was observed that through the creation of appropriate implementation and monitoring institutions and the adoption of administrative, financial, educational and social measures, these measures could be

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<sup>805</sup> Dawson H and McLaren D "Monitoring and Evaluating the Progressive Realisation of Socio-Economic Rights in South Africa" (2015) *Studies in Poverty and Inequality Institute* 6.

<sup>806</sup> Section 27(2) of the Constitution.

<sup>807</sup> South African Human Rights Commission (7<sup>th</sup> Report on Economic and Social Rights 2006-2009)10.

<sup>808</sup> Harrison D (2009) 2.

<sup>809</sup> In principle 78, the Limburg principle concurs with this view by stating that States should not only report on relevant legislative measures put in place to realise rights under the ICESCR, but must also specify judicial, administrative procedures and other measures they have adopted for enforcing these rights and the practices under those remedies and procedures.



made effective and available to the people. In this regard, we realised that the South African Human Rights Commission is mandated by the Constitution to monitor and assess the observance of the progressive realisation of socio-economic rights.<sup>810</sup> With this mandate, the SAHRC has endorsed a monitoring tool developed by the Studies in Poverty and Inequality Institute (SPII) based on a combination of policy and budget analysis and statistical indicators to monitor and evaluate the progressive realisation of socio-economic rights in South Africa.<sup>811</sup> This tool aims at building up empirical information to allow the South African Human Right Commission and civil society organisations to access progress made in respect of socio-economic rights as well as provide government with information on the effectiveness of their policy programmes.<sup>812</sup>

It was further observed that this tool has so far developed a set of indicators in 2012, through which the right to have access to health care services have been monitored. Based on these indicators, it was revealed in this chapter that there has been a major transformation in the health care sector as the sector has witnessed an improvement in the level of access to public health facilities.<sup>813</sup> However, the tool further revealed some serious challenges that continue to affect the country's health sector and amongst them, the problem of inequity. As a result, this chapter disclosed that there is an urgent call for the executive and the judiciary to resolve the problem of inequity by correcting the loopholes in the legislative and policy framework adopted to uphold the value of section 27 of the Constitution.<sup>814</sup>

In view of these challenges and the inadequacy associated with the measures adopted by the government, this chapter further revealed that some experts believe that the National Health Insurance which is currently being rolled out across some pilot districts will address the problem of inequity inherent in the health sector and change the face of the South African health care system over the years in which the project is being implemented.<sup>815</sup> In addition to this the government is strongly advised in this chapter to strengthen and sustain an inclusive economic growth by putting in place strong macro-economic policies that will address the concerns relating to the access to health care services.<sup>816</sup>

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<sup>810</sup> Section 184 of the Constitution.

<sup>811</sup> Brockerhoff S (2011) 1-3.

<sup>812</sup> Dawson H (2013) 3-4.

<sup>813</sup> Lomahoza K (2013) 16.

<sup>814</sup> Pieterse M (2010) 251.

<sup>815</sup> Naidoo S (2012) 149.

<sup>816</sup> Mary Dowell-Jones (2004) 40-43.

In Chapter five, the right to have access to health care was discussed from a Canadian perspective to make a comparative study with the right to have access to health care services in South Africa. In this chapter, it was observed that just like the South African Constitution, the Canadian Charter of Rights and Freedoms have been very instrumental in the social transformation of Canada as it has socio-economic rights dimensions. However, unlike its South African counterparts, these rights and in particular the right to have access to health care services, which is in context in this study, are not expressly protected by the Charter. In this regard, claimants have relied on the equality provisions of section 15(1) of the Charter and the right of security and liberty provision in section 7 of the Charter to enforce their claims on access to health care. As case law demonstrates, we have observed that health care claims have achieved limited success as a result of the court's unwillingness to subject most of the claims to scrutiny under the Charter for reasons which were discussed in this study. For this reason, I have highlighted how the attitude of the courts have provoked a lot of scholarly debate with some scholarly writers calling upon the courts wake up from under the box and address its long standing failure relating to the protection of socio-economic rights including the right to health care under the Charter of Rights and Freedom.<sup>817</sup> Furthermore, I examined in this chapter the Canada Health Act of 1984 and the role the act has played to improve access to health care services in Canada. The finding in this study revealed that although there is limited jurisprudence to demonstrate how the Canada Health Act has been invoked to improve access to health care services, the public funded health care system in Canada which this act implements known as Medicare has largely been upheld to address the problem of inequity in Canada.<sup>818</sup> Accordingly, some scholarly writers believe that the Medicare programme implemented by this act could serve as a notable option to improve access to health care services in South Africa taking into consideration legal framework of Canada which is also committed to uphold equitable and universality values.<sup>819</sup>

## 6.2 Concluding Remark and Recommendations

As has been elaborated in this thesis, the right to have access to health care services is a fundamental human right and constitutionally guaranteed by the Constitution of the Republic South Africa. The incorporation of this right as one of the justiciable socio-economic rights enshrined in the Bill of Rights and the efforts by the courts to enforce this right as well as the measures currently undertaken by the government in line with its constitutional obligation to protect this right

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<sup>817</sup> Jackman M in Roach K (2010) 25-26.

<sup>818</sup> Birn AE and Nixon S (2010) 519.

<sup>819</sup> Birn AE and Nixon S (2010) 520.

as illustrated in this study, demonstrates the judiciary's and executive's commitment to achieve social solidarity and break the country from the shackles of its past.

The policy and legislative measures introduced by the government over the years are significant steps taken towards the progressive realisation of the right to have access to health care services. Most importantly, the implementation of the National Health Insurance is welcomed as a pilot project by some academic commentators as it provides a framework of legislation binding all stakeholders involved in the provision of health care services.<sup>820</sup> In the same light, the role played by the Courts to enforce socio-economic rights including the right to have access to health care services have also been very instrumental in the realisation of this right. The Constitutional Court's decision in *Soobramoney case* and *TAC case* has had a direct impact on the development and implementation of health policies.<sup>821</sup> The Court's decisions in other socio-economic right cases such as *Grootboom case* and *Khosa case* are also relevant as they are central to any discussion on the state's positive duties in respect of socio-economic rights.

However, implementation difficulties in respect of some of these measures remain a major challenge in upholding the value of section 27 of the Constitution. Furthermore, juridical reasoning and findings in respect of section 27 have been considered in some academic proclamation as being legally absurd to some extent.<sup>822</sup> The legal absurdity is attributed to the judiciary's failure to deal with the content of health rights in their interpretation and the internal limitation that the fulfilment of the right to have access to health care services is conditional upon availability of state's resources among other factors.<sup>823</sup> For instance, the opinion of some legal scholars suggest that the Court's decision in *Soobramoney* did not contribute significantly to the understanding of the rights to have access to health care services.<sup>824</sup> To support this argument, Moellendorf appears to have submitted that Chaskalson P and Madala J's comments on section 27 (1) and section 27(2) of the Constitution 'seem to foreshadow a downgrading of the status of socio-economic rights'.<sup>825</sup> Again, he submits that the Constitutional Court's decision in the aforesaid case

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<sup>820</sup> SAHRC (2000) 134.

<sup>821</sup> Chapter 2 of the Constitution.

<sup>822</sup> Peter LL "The Right of Access to Health Care Services in South Africa: A Critical Analysis of the Realisation of the Right" (Research Report by the Faculty of Health Sciences University of Witwatersrand Johannesburg 2009) 43.

<sup>823</sup> Peter LL (2009) 43.

<sup>824</sup> Peter LL (2009) 38.

<sup>825</sup> Moellendorf D "Reasoning about resources: Soobramoney and the future of socio-economic rights claims" (1998) SAJHR 329.

went beyond what the Court was required to rule on and, even when the Court did so, its conduct 'signals a disturbing possibility for the basis of future decisions about socio-economic claims'.<sup>826</sup>

In the midst of these challenges and the controversies associated with the right to have access to health care services, it can arguably be said that the goal of achieving an equitable access to health care services remains to be realised in South Africa. It is in this context that this study will suggest some modest recommendations to enhance the realisation of the right embodied in section 27 of the Constitution and other socio-economic rights. These recommendations follow from the findings and discussions in this study. Although these recommendations may not be a perfect solution to the challenges associated with the right to have access to health care services, it is hoped they might be useful in eliminating some of the obstacles in realising the right embodied in section 27 of the Constitution and enhance human dignity as well as ensuring social transformation with the aim of achieving social justice for all South Africans.

In some academic literature, the 1996 Constitution of South Africa is described as a transformative Constitution for the fact that it contains certain elements that are essential for transformation such as the entrenchment of justiciable socio-economic rights.<sup>827</sup> In order to fulfil this transformative aspiration, this study has invoked Orago's transformation and integrated approach to the realisation of socio-economic right highlighted in his research on poverty, inequality and socio-economic rights in Kenya.<sup>828</sup> This approach is a strong rights-based approach based on adopting the best of the minimum core and reasonableness approaches to socio-economic rights interpretations with the purpose of ensuring that socio-economic rights entrenched in the Constitution achieve their true potential in transforming the lives of South Africans. Furthermore, the approach is principled, purposive as well as progressive, and is aimed at developing the substantive content of the socio-economic rights embodied in the Constitution.<sup>829</sup>

In this regard, I have recommended in this study that South Africa should adopt the transformative and an integrative approach to socio-economic rights adjudication proposed by Orago since this approach has its basis in the Constitution and in particular, in section 39, which states that in interpreting the Bill of Rights, a court tribunal or forum must not only promote the values underlying an open and democratic society based on human dignity, equality and freedom, but must also promote the spirit, purport and objects of the Bill of Rights.<sup>830</sup>

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<sup>826</sup> Moellendorf D (1998) 329.

<sup>827</sup> Liebenberg S (2010) 2.

<sup>828</sup> Orago NW (2013) 1.

<sup>829</sup> Orago NW (2013) 443,444.

<sup>830</sup> See Section 39 of the Constitution.

Since the transformative and intergraded approach calls for the development of the substantive content of the entrenched socio-economic rights in the Bill of Rights including the basic minimum essentials for a dignified life, through the adoption of progressive aspect of the minimum core approach, developed by the Committee on Economic, Social and Cultural Rights (CESCR),<sup>831</sup> I have in this study suggested that South African courts should adopt the minimum core approach in order to be able to implement the aforesaid approach proposed by Orago. The concept of the 'minimum core' in the realm of socio-economic rights seeks to confer minimum legal content for such rights. The minimum concept is important in that it prevents the government from citing lack of resources for failing to fulfil a particular socio-economic right. Thus it is necessary for the government to address expeditiously a minimum level of the entitlements under a particular socio-economic right while recognising that other elements of the right will be realised over time.<sup>832</sup>

Accordingly, South Africa should adopt the minimum core approach to implement the transformative and intergraded approach and undergo the development of the content of enshrined socio-economic rights including the right to have access to health care services, which is the subject of this study. Under the transformative and integrated approach, Orago has suggested that the development of the content of socio-economic rights can be undertaken by political institutions of the State, with the mandatory and active participation of all sectors of the society, in the design, development and implementation of the State's legislative, policy and programmatic framework for the realisation of socio-economic rights.<sup>833</sup> He submits that the content, as developed by political institutions can then be subjected to improvements by the courts during the adjudication of socio-economic rights. Orago further avers that the advantage of an elaboration of the aforesaid approach by political institutions with the substantive participation of the population in a deliberative process in that it ensures that the meaning, content and scope of socio-economic rights are not permanent but remain contingent and incomplete so as to allow their evolution to meet societal context as well as new forms of injustices.<sup>834</sup>

The second part of the transformative and integrated approach suggest that courts should adopt an expansive reasonableness approach to scrutinise and assess the State's legislative, policy and programmatic frameworks developed to enforced socio-economic rights during their

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<sup>831</sup> Chowdhury J "Judicial Adherence to a Minimum Core Approach to Socio-Economic Rights- A Comparative Perspective" (Paper presented at Cornell Law School Inter-University Student Conference 2009) 2.

<sup>832</sup> Chowdhury J (2009) 6.

<sup>833</sup> Orago NW (2010) 443.

<sup>834</sup> Orago NW (2010) 443.

adjudication.<sup>835</sup> This approach entails that courts should enquire whether implementation framework for socio-economic rights adopted by the State makes provision for basic minimum essential elements to cater for the socio-economic needs of the most vulnerable and marginalised groups of people in the society.<sup>836</sup> It further suggest that if the implementation framework fails to provide these minimum essential elements, then courts should in the absence of any countervailing reasons hold the measure or framework to be unreasonable. But if the courts are satisfied that the implementation framework has sufficiently provide for the minimum content of any entrenched socio-economic right, they should access the framework using the reasonableness benchmarks set out by the Constitutional Court in *Grootboom*.<sup>837</sup>

Furthermore, in this study it is recommended by analogy that Courts can overcome the legal absurdity associated with juridical reasoning on the right to have access to health care services and the failure of the judiciary to deal with the content of health rights in their interpretation by preconceiving the model of reasonableness review in the context of socio-economic rights.<sup>838</sup> The reasonable review model can be linked to a more broad expansion of the substantive content of individual rights and duties, so as to situate the bench mark used to measure compliance to the nature and scope of this right.<sup>839</sup> In doing so, this will give impetus to the prioritisation of the right to have access to health care services and by extension to other socio-economic rights and aligns them to the transformation aspiration of the Constitution.<sup>840</sup>

More so, courts could also develop the substantive content of the right to have access to health care services by enhancing constitutional dialogue between the judiciary, executive and legislative arms of government despite the fact that meaningful engagement, as a component of constitutional dialogue, has already been developed and used by the Constitutional Court in the enforcement of socio-economic rights.<sup>841</sup> The constitutional dialogue theory argues for an intermediate approach to the judicial enforcement of constitutional rights and envisages a greater

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<sup>835</sup> Orago NW (2010) 444.

<sup>836</sup> Orago NW (2010) 444.

<sup>837</sup> *Grootboom* para 87. Liebenberg S (2010) 153. Wilson S "Breaking the tie: Eviction from private land, homelessness and a new normality" (2009) *South African Law Journal* 270, 274-275. Orago NW (2013) 444.

<sup>838</sup> Liebenberg S and Quinot S "Narrowing the band: Reasonableness in administrative justice and socio-economic right jurisprudence in South Africa" (2011) *Stell LR* 639-663.

<sup>839</sup> Pieterse M (2004) 407.

<sup>840</sup> Pieterse M (2004) 407.

<sup>841</sup> *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street Johannesburg v City of Johannesburg and Others* (24/07) [2008] ZACC 1; 2008 (3) SA 208 (CC); 2008 (5) BCLR 475 (CC) (19 February 2008).

co-operation between, the executive, courts and the legislature in achieving the aforesaid goal.<sup>842</sup> The model also allow courts to define rights in relatively broad terms and to adopt strong remedies provided they defer to legislative sequels that evidence clear and considered disagreement with their rulings.<sup>843</sup>

In specific context of a case where the positive dimension to socio-economic rights is concerned, the theory however requires court to adopt weak remedies depending on the circumstances of the particular country and case.<sup>844</sup> The theory further envisage the court not to be the sole, exclusive and ultimate interpreter of the provisions of the Constitution but a forum as well as a facilitator of societal dialogue and deliberation of constitutional meaning that aligns with the vision and values of the society.<sup>845</sup> In doing so, this theory will effectively respond to the challenges associated with the adjudication of socio-economic rights which is the doctrine of separation of powers and the concerns of polycentricity.

As the dialogical constitutionalism theory advocates for the participation of a wide section of the society in the design of framework for the implementation of socio-economic rights as well as in the design of judicial remedies, the theory ensures that societal realities are taken into consideration in the process with the effect that any adverse effect of polycentricity of a judicial remedy is anticipated and dealt with immediately.<sup>846</sup> Also the court have the capacity to respond to previously unforeseen polycentricity challenges as it retains its mandate to review its judgment during implementation.<sup>847</sup> In view of the above, it can arguably be said that the constitutional dialogue theory will create an impetus for change.

Finally, in line with the their mandate in terms of sections 38 and section 172(1) (a) and (b) of the Constitution, the Court could play a proactive role in devising more creative remedies to deal with non-compliance with the positive and negative duties imposed by the right to have access to health care. Applying this wide remedial power also provide the court with an opportunity to nurture and enhance its relationship and dialogue with the other arms of the government.<sup>848</sup> Accordingly, the challenges associated with the adjudication of socio-economic rights will also be avoided

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<sup>842</sup> Dixon R "Creating dialogue about socioeconomic rights: Strong-form versus weak-form judicial review revisited" (2007) *Oxford University Press and New York School of Law* 390.

<sup>843</sup> Dixon R (2007) 390.

<sup>844</sup> Dixon R (2007) 390.

<sup>845</sup> Orago NW (2014) 442.

<sup>846</sup> Fuller L and Winston KI "The forms and limits of adjudication" (1978) *Harvard Law Review* 398.

<sup>847</sup> Fuller L and Winston KI (1978) 398-399.

<sup>848</sup> Pieterse M (2004) 411-412.

following this recommendation as this approach will achieve an appropriate balance between the dictates of the doctrine of separation of power and judicial independence and maintain appropriate checks and balances between the three arms of government.<sup>849</sup>

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<sup>849</sup> Pieterse M (2004) 411-412.



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