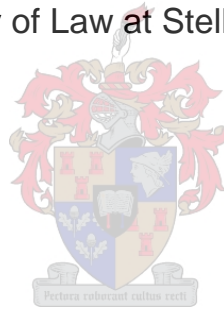


**An evaluation of the National Health Insurance scheme in the light of South Africa's constitutional and international law obligations imposed by the right to health**

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Thesis presented in fulfilment of the requirements for the degree of Master of Laws in the Faculty of Law at Stellenbosch University.



Supervisor: Professor Sandra Liebenberg

December 2017

## **DECLARATION**

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December 2017

## Summary

This study ultimately concerns the right to health care under constitutional law and international law and the National Health Insurance scheme proposed for South Africa. The study begins by contextualising the need for health care system reform. It does so through exposing the historical context of the right to health care in South Africa and how the current context has inherited the inequalities created and manifested by colonialism and apartheid. This is done to motivate the need for reform.

The study examines the constitutional and international law obligations imposed by the right to health. The normative content of the right to health, and the obligations under constitutional and international law, are informed by jurisprudence of the Constitutional Court and General Comments of the United Nations Committee on Economic, Social and Cultural Rights, respectively. The obligations imposed by children's right to basic health care is also examined, as well as the obligations imposed on private entities and in the context of business activities. These obligations provide a framework by which the National Health Insurance scheme can be evaluated to determine compatibility with the right to health and the obligations it imposes.

The National Health Insurance scheme is analysed as a policy. The National Health Insurance scheme is a financing scheme for universal health coverage. It is thus analysed in the framework of financing models for universal health coverage. The analysis further considers issues raised on the National Health Insurance scheme which include implementation costs, quality of health care in the public sector, participation in policy development and the impact which it may have on private rights and interests.

The National Health Insurance scheme is then evaluated for compliance with the constitutional and international law obligations imposed by the right to health. This includes the obligations to respect, protect, promote and fulfil, the obligation to take legislative and other measures, the obligation to progressively realise the right, and to do so within available resources. Fundamental is the obligation that measures taken must be reasonable. Therefore, the reasonableness of the National Health Insurance scheme is evaluated per the framework established.

This study argues that reform is necessary and that the National Health Insurance scheme is a viable means by which to address issues on unequal access to and quality of health care. It argues that the National Health Insurance scheme complies with the

obligations imposed by constitutional and international law and addresses ways in which such compliance can be strengthened.

## Opsomming

Hierdie studie gaan oor die reg op gesondheidsorg kragtens die grondwetlike en internasionale reg en die Nasionale Gesondheidsversekeringskema wat vir Suid-Afrika voorgestel word. Die studie begin deur die behoefte aan hervorming van gesondheidsorgstelsel te kontekstualiseer. Dit doen dit deur die historiese konteks van die reg op gesondheidsorg in Suid-Afrika uiteen te sit en hoe die huidige konteks die ongelykhede wat deur kolonialisme en apartheid geskep is, geërf het. Dit word gedoen om die behoefte aan hervorming te motiveer.

Die studie ondersoek die konstitusionele en internasionale regsverpligtinge wat deur die reg op gesondheid gestel word. Die normatiewe inhoud van die reg op gesondheid en die verpligtinge ingevolge die grondwetlike en internasionale reg word deur die regswetenskap van die Konstitusionele Hof en Algemene Kommentaar van die Verenigde Nasies se Komitee oor Ekonomiese, Sosiale en Kulturele Regte, op die hoogte gebring. Die verpligtinge wat opgelê word deur kinders se reg op basiese gesondheidsorg word ook ondersoek, sowel as die verpligtinge wat aan private entiteite en in die konteks van sakebedrywighede opgelê word. Hierdie verpligtinge voorsien 'n raamwerk waarvolgens die Nasionale Gesondheidsversekeringskema geëvalueer kan word om te bepaal of dit verenigbaar is met die reg op gesondheid en die verpligtinge wat dit oplê.

Die Nasionale Gesondheidsversekeringskema word as 'n beleid ontleed. Die Nasionale Gesondheidsversekeringskema is 'n finansieringskema vir universele gesondheidsdekking. Dit word dus ontleed in die raamwerk van finansieringsmodelle vir universele gesondheidsdekking. Die analise handel ook die implementeringskoste, die gehalte van gesondheidsorg in die openbare sektor, deelname aan beleidsontwikkeling en die impak wat die Nasionale Gesondheidsversekeringskema op private regte en belange het.

Die Nasionale Gesondheidsversekeringskema word dan geëvalueer vir nakoming van die grondwetlike en internasionale regsverpligtinge wat deur die reg op gesondheid gestel word. Dit sluit in die verpligtinge om wetgewende en ander maatreëls te onderneem, te beskerm, te bevorder en te vervul, die verpligting om die reg te besef, en dit binne beskikbare bronne te doen. Fundamenteel is die verpligting dat maatreëls geneem moet redelik wees. Daarom word die redelikheid van die

Nasionale Gesondheidsversekeringskema geëvalueer volgens die vasgestelde raamwerk.

Hierdie studie beweer dat hervorming nodig is en dat die Nasionale Gesondheidsversekeringskema 'n lewensvatbare manier is om kwessies aan te spreek oor ongelyke toegang tot en kwaliteit van gesondheidsorg. Dit beweer dat die Nasionale Gesondheidsversekeringskema voldoen aan die verpligtinge wat deur konstitusionele en internasionale reg opgelê word en spreek maniere aan waarop sodanige nakoming versterk kan word.

## Shwa nkathelo

Olu pho nonongo lujongene nelungelo lokunakekelwa kwezempilo phantsi komthetho-siseko kunye nomthetho wamazwe ngamazwe kunye neNational Health Insurance scheme ephakanyiselwe uMzantsi Afrika. Uphononongo luqala ngokuxhomekeka kweemfuneko zokulungiswa kwempilo kwinkqubo. Ukwenza oko ngokutyhila imeko yembali yelungelo lokunakekelwa kwezempilo eMzantsi Afrika kunye nendlela imeko yangoku izuze ngayo ukungalingani okudalwe kwaye kubonakaliswe yi-colonialism kunye nobandlululo. Oku kwenziwa ukuze kukhuthazwe imfuneko yokuguqulwa.

Uhlolisiso luhlolisisa imigaqo-siseko yomgaqo-siseko kunye namazwe ngamazwe amiselwe ilungelo lempilo. Umxholo osemgangathweni welungelo lempilo, kunye neembopheleleko phantsi komthetho-siseko kunye nomhlaba wonxweme, unolwazi ngecala lolawulo lweNkundla yoMgaqo-siseko kunye neNgxelo Jikelele yeKomiti yeZizwe eziManyeneyo kwizoQoqosho, uLuntu kunye neNkcubeko, ngokulandelelana. Iimbopheleleko ezibekwa lilungelo labantwana kwiinkonzo zempilo ezisisiseko ziyahlolwa kwakhona, kunye nezibophelelo ezibekwe kumashishini abucala kunye nomxholo wemisebenzi yezoshishino. Ezi zibophelelo zibonelela ngesakhelo apho isiCwangciso seNkcazo yezeMpilo kaZwelonke singahlaziywa ukuze kuqinisekise ukuhambelana nelungelo lempilo kunye nezibophelelo ezibekayo.

Inational Health Insurance scheme ihlaziywa njengomgaqo-nkqubo. Inational Health Insurance scheme yinkqubo yokuxhaswa kwempilo kwi-universal health coverage. Ngaloo ndlela ihlalutyiweyo kwisakhelo semimiselo yokuxhaswa kwemali kwi-universal health coverage. Uhlalutyio luqwalasela ngakumbi imiba ephakanyiswe kwiNkqubo ye-Intshumo kaZwelonke yezeMpilo equka iindleko zokuphunyezwa, umgangatho wempilo yoluntu kwicandelo likarhulumente, ukuthabatha inxaxheba ekuphuhliseni komgaqo-nkqubo kunye nefuthe enokuba nayo kumalungelo abucala kunye neminqweno.

Inational Health Insurance scheme ihlolwe ukuba ihambelane nemimiselo yomgaqo-siseko kunye namazwe ngamazwe amiselwe ilungelo lempilo. Oku kubandakanya iimbopheleleko zokuhlonipha, ukukhusela, ukukhuthaza nokuzalisekisa, uxanduva lokuthatha umthetho kunye nezinye iindlela, umbopheleleko wokuqhubeka nokuqonda ilungelo, nokwenza njalo ngaphakathi

kwezibonelelo ezikhoyo. Okubalulekileyo kuyimfuneko yokuba amanyathelo athatyathwe kufuneka abe nengqiqo. Ngoko ke, neNational Health Insurance scheme yezeMpilo kuhlolwa ngesikhokelo esisungulwe.

Olu phofu luchaza ukuba ukuguqulwa kuyimfuneko kwaye kwaye neNational Health Insurance scheme yindlela efanelekileyo yokujongana nemibandela yokungena ngokungalinganiyo kunye nomgangatho wokunakekelwa kwezempilo. Ichaza ukuba iNkqubo ye-inshurensi yezeMpilo kaZwelonke iyavumelana nezibophelelo ezibekwa ngumgaqo-siseko kunye nomhlaba jikelele kwaye idibanisa iindlela zokuthotyelwa kwaloo nto.



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## LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
COSATU	Congress of South African Trade Unions
CRC	Convention on the Rights of the Child
NHI	National Health Insurance
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
ISHP	Integrated School Health Programme
MTCT	Mother-to-child-transmission
NGO	Non-Governmental Organisation
PHC	Primary Health Care
RAF	Road Accident Fund
SAPPF	South African Private Practitioners Forum
SCA	Supreme Court of Appeal
UDHR	Universal Declaration of Human Rights
UN	United Nations
UPFS	Uniform Patient Fee Schedule
VAT	Value-Added Tax
WHO	World Health Organisation

## CHAPTER 1: INTRODUCTION

### 1 1 Introduction to the research problem

#### 1 1 1 Introduction

Health care inevitably involves tragedies. South Africa's Minister of Health, Dr Aaron Motsoaledi, has expressed that "health is the ultimate dividend of freedom and democracy",<sup>1</sup> in that the promises of our constitutional democracy are meaningless to those who are dead or dying.<sup>2</sup> This echoes a statement by the late former Chief Justice Langa:

"Human rights and the rule of law are foundational values of most democratic states. However, they remain shallow platitudes without a solid foundation of basic healthcare, saleable skills, education and security of the person, in combination with a total dedication from government to the equitable application and interpretation of human rights."<sup>3</sup>

Speaking to this issue, the Minister of Health recently relayed a tragic story of a domestic worker who suffered a heart attack. She was rushed to the nearest hospital, a private hospital in Pretoria. Upon arrival, she was turned away as she had no medical aid and could not afford the alternative deposit. She then had to be transferred to the Steve Biko Hospital where a cardiologist, when contacted to notify him of the transfer, begged the staff of the private hospital to stabilise the patient before transfer. This was refused based on the patient's indigence. She was then transferred without any

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<sup>1</sup> A Motsoaledi "NHI – Our New Centre of Gravity" *Cape Times* 26-06-2017 <[http://www.nhisa.co.za/C\\_NewsReports.asp](http://www.nhisa.co.za/C_NewsReports.asp)> (accessed 30 June 2017).

<sup>2</sup> A Motsoaledi "NHI – Our New Centre of Gravity" *Cape Times* 26-06-2017 <[http://www.nhisa.co.za/C\\_NewsReports.asp](http://www.nhisa.co.za/C_NewsReports.asp)> (accessed 30 June 2017). See also A E Yamin "Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage" (2017) 39 *Human Rights Quarterly* 341 351 where Yamin holds that the recognition of health as a right "implies that the process for defining the priorities and inclusions must be democratically legitimate".

<sup>3</sup> P N Langa "The Role of the Constitution in the Struggle Against Poverty" (2011) 3 *Stell LR* 446 448.

emergency treatment. The woman was declared dead on arrival at Steve Biko Hospital.<sup>4</sup>

Albeit in the context of emergency medical treatment, this story encapsulates the reality of how access to health care in South Africa is predominantly determined by a person's ability to pay. Ensuring that the constitutional recognition of health care as a human right does not remain an empty gesture,<sup>5</sup> the inequalities in access to and quality of health care need to be addressed.

The National Health Insurance ("NHI") scheme seeks to address the problems of inadequate and unequal enjoyment of the right of access to health care<sup>6</sup> in South Africa and the consequential need for reform. This research project seeks to evaluate the NHI scheme in the light of the constitutional and international law obligations imposed by the right to health care. The NHI scheme aims to give effect to section 27(1)(a) read with section 27(2) and section 28(1)(c) of the Constitution of Republic of South Africa, 1996 ("the Constitution"). Constitutional and international law obligations imposed by the right to health care provide a framework against which to evaluate the NHI scheme as a type of universal health coverage.

## 1 1 2 The historical and current context of the right of access to health care in South Africa

Socio-economic inequalities, such as in health care, were engineered by the legal system during colonialism and apartheid.<sup>7</sup> Health care services were segregated, and spending was unequal between races.<sup>8</sup> There was differential treatment between races that depicted the disenfranchisement of the black African population and the

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<sup>4</sup> A Motsoaledi "NHI – Our New Centre of Gravity" *Cape Times* 26-06-2017 <[http://www.nhisa.co.za/C\\_NewsReports.asp](http://www.nhisa.co.za/C_NewsReports.asp)> (accessed 30 June 2017).

<sup>5</sup> *Soobramoney v Minister of Health (Kwa-Zulu Natal)* 1998 1 SA 865 (CC) para 8.

<sup>6</sup> S27(1)(a) read with (2) of the Constitution.

<sup>7</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 2.

<sup>8</sup> For example, in 1987 government health expenditure per white person was R597, and only R137 for each black South African, A Hassim et al *Health and Democracy* (2007) 11-13.

consequent deprivation of access to services, such as health care.<sup>9</sup> Inequalities were further manifested by apartheid in that the social conditions which caused ill health, such as poor working conditions, harsh living conditions, and a lack of socio-economic resources, were also contrived against the disenfranchised black African population.<sup>10</sup>

Inequalities in access to and quality of health care still exist today. A goal of the Constitution is the redistribution of socio-economic resources in seeking to dismantle inherited inequalities.<sup>11</sup> As has been pointed out by the World Health Organisation (“WHO”), the inadequate and unequal enjoyment of the right of access to health care is not a natural phenomenon, but a consequence of social engineering inherited from the legacy of apartheid.<sup>12</sup> It is thus within the context of transformative constitutionalism<sup>13</sup> that attempts to reform the health care system need to be understood to ensure that the purpose of the right is realised.<sup>14</sup>

### 1 1 3 Constitutional and international law framework

The Constitution<sup>15</sup> and international law<sup>16</sup> recognise the right to health care. The right imposes obligations on the State domestically and on the international plane. The nature of the constitutional obligations imposed on the State is informed by the cases of *Soobramoney v Minister of Health (Kwa-Zulu Natal)*<sup>17</sup> (“Soobramoney”), *Government of the Republic of South Africa v Grootboom*<sup>18</sup> (“Grootboom”), *Minister of Health v Treatment Action Campaign*<sup>19</sup> (“TAC”), *Khosa v The Minister of Social*

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<sup>9</sup> A Hassim et al *Health and Democracy* (2007) 68; S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 2.

<sup>10</sup> A Hassim et al *Health and Democracy* (2007) 11-13.

<sup>11</sup> S Liebenberg “Social Rights and Transformation in South Africa: Three Frames” (2015) 31 *SAJHR* 446 446.

<sup>12</sup> World Health Organisation *Closing the Gap in Generation* (2008) 165.

<sup>13</sup> K Klare “Legal Culture and Transformative Constitutionalism” (1998) 14 *SAJHR* 146 150.

<sup>14</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 27.

<sup>15</sup> S27(1)(a) of the Constitution.

<sup>16</sup> See chapter four part 3.

<sup>17</sup> 1998 1 SA 865 (CC).

<sup>18</sup> 2001 1 SA 46 (CC).

<sup>19</sup> 2002 5 SA 721 (CC).

*Development*<sup>20</sup> (“Khosa”), *Mazibuko v City of Johannesburg*<sup>21</sup> (“Mazibuko”), *Minister of Health v New Clicks South Africa (Pty) Ltd*<sup>22</sup> (“New Clicks”) and *Law Society of South Africa v Minister of Transport*<sup>23</sup> (“Law Society”).

The key instrument with regard to the international obligations imposed by the right to health care is the International Covenant on Economic, Social and Cultural Rights (“ICESCR”).<sup>24</sup> South Africa became a signatory to the ICESCR in 1995 and ratified the treaty in January 2015.<sup>25</sup> The ICESCR influenced the drafting of section 27 of the Constitution, and both recognise the principles of progressive realisation, available resources and legislative measures to be taken.<sup>26</sup> The right to health is elaborated on in the United Nations Committee on Economic, Social and Cultural Rights’ (“the Committee”) General Comment 14 on the right to the Highest Attainable Standard of Health<sup>27</sup> (“General Comment 14”). Additionally, General Comment 3 on the Nature of States Parties’ Obligations<sup>28</sup> (“General Comment 3”) elaborates on article 2(1) and emphasises the desirability of legislative measures as a primary mechanism for realising the rights provided for in the ICESCR.<sup>29</sup>

Regarding children’s health care rights, section 28(1)(c) of the Constitution provides children with an unqualified right to basic health care. As section 28(1)(c) is not subject to a qualification like section 27(1), the State arguably has an obligation to effectively

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<sup>20</sup> 2004 6 SA 505 (CC).

<sup>21</sup> 2010 4 SA 1 (CC).

<sup>22</sup> 2006 2 SA 311 (CC).

<sup>23</sup> 2011 1 SA 400 (CC).

<sup>24</sup> International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3. South Africa signed the ICESCR in 1995 and ratified it in 2015.

<sup>25</sup> ICESCR Depository Notification C.N.23.2015-TREATIES-IV.3.

<sup>26</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 107; see chapter four part 2 regarding the role and status of international law in South Africa.

<sup>27</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 14: *The Right to the Highest Attainable Standard of Health (art 12 of the Covenant)* UN Doc E/C.12/2000/4.

<sup>28</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 3: *The Nature of State Parties’ Obligations (art 2(1) of the Covenant)* UN Doc E/C.14/12/90.

<sup>29</sup> Para 3.

and immediately realise these rights of children.<sup>30</sup> International law also recognises the right to health regarding children's rights specifically, and the Convention on the Rights of the Child<sup>31</sup> recognises children's right to "the highest attainable standard of health".<sup>32</sup>

The Committee's General Comment No 24 on State Obligations in the Context of Business Activities<sup>33</sup> ("General Comment 24") contributes to the framework of obligations imposed by the right to health care regarding business activities. Socio-economic rights also impose obligations on private entities horizontally under the Constitution.<sup>34</sup> The NHI scheme will also be evaluated for its impact on private entities and business activities in the light of the obligations imposed by the right of access to health care.

The international framework also provides a means by which to realise the right to health care: universal health coverage. WHO has referred to universal health coverage as the "practical expression" of the right to health.<sup>35</sup> The Sustainable Development Goals of 2015<sup>36</sup> expressed universal health coverage as a goal to be achieved, "including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."<sup>37</sup>

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<sup>30</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 234.

<sup>31</sup> United Nations Convention on Rights of the Child (adopted 20 November 1989 and entered into force 2 September 1990) 1577 UNTS 3. South Africa signed the Convention on the Rights of the Child in 1993 and ratified it in 1995.

<sup>32</sup> Art 24(1).

<sup>33</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 24: *State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities* UN Doc E/C.12/GC/24.

<sup>34</sup> S8 of the Constitution.

<sup>35</sup> World Health Organisation Discussion Paper *Positioning Health in the Post-2015 Development Agenda* (2012) <[http://www.int.topics/millennium\\_development\\_goals/post2015/WHOdiscussionpaper\\_October2012.pdf](http://www.int.topics/millennium_development_goals/post2015/WHOdiscussionpaper_October2012.pdf)> (accessed 13 May 2016).

<sup>36</sup> United Nations Sustainable Development Goals para 54 of United Nations Resolution A/RES/70/1 of 25 September 2015.

<sup>37</sup> Goal 3. See also United Nations Sustainable Development Goals <<http://www.un.org/sustainabledevelopment/health/>> (accessed 11 August 2017).

## 1 1 4 The National Health Insurance scheme

The NHI scheme is a financing system for achieving universal health coverage in South Africa. It seeks to ensure access to quality and affordable health care to all South Africans, based on their needs and financed through a redistribution of resources. The NHI scheme seeks to realise the right to health care progressively. It purports to address the inequities inherited from the past and the unequal and inadequate enjoyment currently being experienced.<sup>38</sup> The NHI scheme seeks to address the major underlying problems implicating the right to health care: the social determinants of health; the structural issues of the health system; and the burden of disease.<sup>39</sup>

The NHI scheme purports to regulate a variety of facets, especially regarding access, human resources and quality of health care. In evaluating the NHI scheme's compliance with the obligations imposed by the right to health, various issues raised by the NHI scheme are considered. A fundamental issue is the impact that the NHI scheme will have on the private sector. While the exorbitant prices in the private sector is concerning, so is the current state of the public sector. The public sector has repeatedly been criticised for its inadequate provision of health care services.<sup>40</sup> A problem with the current two-tier system is that the private sector is unaffordable to the majority of the population while the standard in the public sector is deteriorating. The NHI scheme seeks to address both of these facets through structural changes and its approach to the burden of disease.

## 1 2 Research question

The primary research question which this study seeks to answer is to what extent the National Health Insurance scheme fulfils South Africa's constitutional and international law obligations imposed by the right to health.

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<sup>38</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 2; see chapter five part 2 1.

<sup>39</sup> See chapter five part 2 2.

<sup>40</sup> See chapter two part 4 2.

### 1 3 Research aims and hypotheses

This research seeks to determine to what extent the NHI scheme fulfils South Africa's constitutional and international law obligations imposed by the right to health. To answer the research question posed above, this thesis aims to, firstly, provide an exposition of the historical and current context of the right of access to health care in South Africa. Secondly, the research aims to analyse the constitutional obligations imposed by section 27(1)(a) read with (2) and section 28(1)(c) of the Constitution. Similarly, the third aim is to analyse the international law framework regarding the right to health and the international law obligations imposed on the State. Fourthly, this thesis seeks to analyse the NHI scheme and lay the foundation for applying the relevant constitutional and international law principles. Lastly, the research aims to evaluate to what extent the NHI scheme complies with the constitutional and international law obligations imposed by the right to health care.

The research question and aims are based on certain hypotheses. Firstly, the study assumes that there is inadequate and unequal enjoyment of the right to health care in South Africa and thus a need for reform. The circumstances of the past have resulted in the unequal and inadequate enjoyment of the right to health care currently experiences in South Africa. Post-democratic efforts of reform have been unsuccessful in realising the constitutional right to health.

The second hypothesis is that the constitutional obligations imposed by sections 28(1)(c) and 27 provide an important normative framework for evaluating the NHI scheme, particularly if it may be subject to constitutional challenges. Similarly, the third hypothesis is that international law provides a set of normative principles and obligations regarding the right to health care. These constitutional and international law principles and obligations provide a normative framework for evaluating the extent to which the NHI scheme fulfils and protects the right to health.

Fourthly, the NHI scheme seeks to realise the right to health care but may be subject to challenges as it will regulate stakeholders in the health sector. Lastly, the study assumes that the NHI scheme may be defended against possible challenges in so far that it fulfils the constitutional and international law obligations regarding the right to health care. Therefore, the purpose of this study is to determine the extent to which these obligations are fulfilled.



## 1 4 Scope and methodology

### 1 4 1 Scope

This thesis will examine the right to health as per sections 27(1)(a) and (2) of the Constitution as well as section 28(1)(c). Reproductive health rights are included in section 27(1)(a) and the NHI scheme's provisions made for pregnant and nursing women, *inter alia*, is relevant.<sup>41</sup> The right to health is also provided for in section 35(2)(e) of the Constitution, regarding the right to medical care of prisoners. While recognising the importance of this right, the focus of this study will be confined to sections 27(1)(a), read with 27(2) and 28(1)(c). The vast amount of international law, comparative law and South African jurisprudence regarding the health rights of prisoners and detained persons would require a focused study to address the relevant issues in that regard thoroughly.

The right to emergency medical care under section 27(3) is relevant to this study in that the NHI scheme makes provision for emergency medical treatment. The obligations imposed by section 27(3) differ from those imposed by section 27(1)(a) read with (2). Section 27(3) will be considered as necessary for the evaluation of the NHI scheme. Although the NHI scheme also implicates the right to social security in the event of sickness, this study will only consider the right to social security regarding it being a measure through which to realise access to the right to health care. Furthermore, this research project will only consider the right to equality<sup>42</sup> and non-discrimination to the extent that it plays a role in the interpretation of the right of access to health care.

### 1 4 2 Methodology

This research project seeks to contribute to the field of socio-economic rights, particularly the right of everyone to have access to health care services. This study

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<sup>41</sup> For more on reproductive health rights specifically see C Ngwena & E Durojaye (eds) *Strengthening the Protection of Sexual and Reproductive Health Rights in the African Region through Human Rights* (2014).

<sup>42</sup> S9 of the Constitution.

will rely on primary and secondary sources. The main primary sources will include the latest National Health Insurance Policy Document<sup>43</sup> (“Policy Document”), the White Paper on a National Health Insurance<sup>44</sup> (“White Paper”), the Green Paper, the Constitution, South African jurisprudence, international law documents, and statistics. The secondary sources consist of literature, such as journal articles and books, regarding the right to health, the history of health care in South Africa, the current context of health care in South Africa and the NHI scheme. The historical and current contexts need to be discussed to depict any previous attempts at reform and the reasons behind the unequal and inadequate enjoyment.

The constitutional obligations stem from section 7(2), section 27(1)(a) read with (2) and section 28(1)(c) of the Constitution. An analysis of these obligations and the manner in which courts and international bodies have interpreted them will provide a normative framework for evaluating the NHI scheme. Constitutional jurisprudence on socio-economic rights as well as academic literature will thus be relied on.

The international law framework includes treaties, conventions, customary international law and soft law. The use of international law is governed by sections 231 and 39(2) of the Constitution. The ICESCR, which South Africa has ratified, imposes international law obligations regarding the right to health. The General Comments of the Committee will be relied on for interpretation of the right to health in international law. While the ICESCR remains the focal source, the international law framework of the right to health care is also informed by, *inter alia*, the Convention on the Rights of the Child,<sup>45</sup> the African Charter on Human and Peoples’ Rights,<sup>46</sup> the

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<sup>43</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017.

<sup>44</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15.

<sup>45</sup> United Nations Convention on the Rights of the Child (adopted 20 November 1989, entered into force 21 October 1986) 1577 UNTS 3.

<sup>46</sup> African (Banjul) Charter on Human and Peoples’ Rights (adopted 28 June 1981, entered into force 21 October 1986) 1520 UNTS 217. South Africa signed and ratified the African Charter in 1996.

African Charter on the Rights and Welfare of the Child,<sup>47</sup> the WHO Constitution,<sup>48</sup> and other WHO documents.<sup>49</sup> These instruments depict the international obligations regarding the right to health and guide policy and legislative development.<sup>50</sup> The NHI will be analysed as per the Policy Document of June 2017 as it is the latest policy document in this regard. The submissions made in response to the White Paper of 2015, especially those by civil society organisations,<sup>51</sup> will also be considered.

## 1 5 Overview of chapters

In chapter two the historical and current context of the right to health care in South Africa is examined. This chapter exposes the past events that led to the current circumstances regarding the inadequate and unequal enjoyment of the right to health care in South Africa.

Chapter three analyses the constitutional law obligations imposed by sections 27(1)(a) read with (2) and 28(1)(c) of the Constitution. The socio-economic rights jurisprudence of the Constitutional Court elaborates on the nature of obligations imposed by the right of access to health care. This chapter also considers the obligations imposed on the private sector.

Chapter four will examine the role and status of international law in South Africa. On this basis, the international law obligations imposed by the right to health care will be analysed. The primary source is the ICESCR, informed by the Committee's General Comments. The work of WHO on primary health care ("PHC") and universal health coverage is used to examine the nature of the international law obligations imposed by the right to health care.

The NHI scheme will be analysed as a financing system for achieving universal health coverage in chapter five. The Policy Document is the primary source of this

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<sup>47</sup> African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1991) OAU Doc. CAB/LEG/24.9/49. South Africa signed and ratified the African Children's Charter in 1997 and ratified it in 2000.

<sup>48</sup> World Health Organisation Constitution (adopted June 1946, entered into force 7 April 1948) 14 UNTS 185.

<sup>49</sup> Such as World Health Reports by the World Health Organisation.

<sup>50</sup> See chapter four part 2.

<sup>51</sup> See chapter five part 5.

analysis as it is the most recent policy paper on the NHI scheme. The aims, principles, features, funding and functioning of the NHI scheme will be analysed. The competing interests raised in submissions on the White Paper and commentary on the NHI scheme will be examined.

Chapter six evaluates to what extent the NHI scheme fulfils its constitutional and international law obligations imposed by the right to health care. The NHI scheme is evaluated through the obligations analysed in chapters three and four. The obligations include the overarching obligations to protect, respect, promote and fulfil the right. Section 27(2) obliges the state to take reasonable legislative and other measures, seeking the progressive realisation of the right, within available resources. The obligations imposed by children's right to health care are also used to evaluate the NHI scheme. Lastly, the obligations imposed on the private sector are considered in the light of the issues raised on the NHI scheme, in addition to the State's obligations regarding the private sector.

## **1 6 Conclusion**

The NHI scheme explicitly seeks to realise the right of access to health care. Universal health coverage has been expressed as the practical expression of the right to health care.<sup>52</sup> The NHI scheme is a means to provide universal health coverage in South Africa. This study seeks to evaluate to what extent the NHI scheme complies with the constitutional and international law obligations imposed by the right to health. Compliance with these obligations may provide a strong argument for the implementation of the NHI scheme as a financing system to provide universal health coverage in South Africa. The following chapter will analyse the historical and current context of the right to health care in South Africa to provide the contextual background for reforming the South African health care system.

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<sup>52</sup> World Health Organisation Discussion Paper *Positioning Health in the Post-2015 Development Agenda* (2012) <[http://www.int.topics/millennium\\_development\\_goals/post2015/WHOdiscussionpaper\\_October2012.pdf](http://www.int.topics/millennium_development_goals/post2015/WHOdiscussionpaper_October2012.pdf)> (accessed 13 May 2016).

## **CHAPTER 2: HISTORICAL AND CURRENT CONTEXT OF HEALTH CARE IN SOUTH AFRICA**

### **2 1 Introduction**

Unequal access to health care and disparities in the quality of health care are prevalent in South Africa. This chapter engages with the historical development of the existing inequalities in health care. South Africa's health care system has been subject to the social engineering of both colonialism and apartheid.<sup>1</sup> Vast disparities still exist between the lived realities of the people and the promise of the Constitution of the Republic of South Africa, 1996 ("the Constitution").<sup>2</sup>

This chapter also engages with the constitutional and legislative framework of the right of access to health care. Legislation such as the National Health Act 61 of 2003 contextualises the post-1994 efforts to realise the right of access to health care. The National Health Insurance ("NHI") scheme introduces a new legislative framework seeking to create a health care system which facilitates equal access to quality primary health care ("PHC") for all. To evaluate the extent to which the NHI scheme fulfils its constitutional and international law obligations in this regard, an examination of the historical and current context of health care legislation, policy and programmes are necessary to understand the problems which the NHI seeks to address.

### **2 2 Historical context of the right to health care in South Africa**

#### **2 2 1 Introduction**

The series of events which influenced the current health care system of South Africa are vast and intricate. This section will accordingly focus specifically on those most pertinent to current inequalities in the health care system, and the evolution of the idea of a national health insurance system in South Africa.

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<sup>1</sup> A J Christopher *The Atlas of Changing South Africa* (2001) 1; N Protasia & K Torkington *Community Health Needs in South Africa* (2000) xii.

<sup>2</sup> M Pieterse "Legislative and Executive Translation of the Right to Have Access to Health Care Services" (2014) *Law, Democracy & Development* 231 231.

## 2 2 2 The colonial period: 1651-1948

The current disparities in access to and quality of health care in South Africa trace back to the colonial period. The colonial era of Dutch rule over South Africa from 1652 facilitated a military-centred health care system focusing primarily on curative care and disease treatment, and paying very little attention to preventative care and the underlying determinants of health.<sup>3</sup> Traditional medicine was practised alongside the newly emerging Western health care system, and so differential treatment between races began to emerge.<sup>4</sup>

The period of British occupation from 1795 onwards produced many policy developments, new organisation, and regulation of the health care system.<sup>5</sup> During this time the Supreme Medical Committee was established to control the health care system, and they required the licensing of medical practitioners.<sup>6</sup> To obtain a license a practitioner needed to state their case and submit themselves for examination before the Supreme Medical Committee if they did not possess a European qualification.<sup>7</sup> In 1807 the Supreme Medical Committee released a list of approved practitioners, consisting of just 22 names. The requirement of needing a European qualification institutionalised white supremacy within the health care system.

Racial fragmentation was further institutionalised by legislation such as the Public Health Act 4 of 1883, the Medical and Pharmacy Act 34 of 1891<sup>8</sup> and the Public Health Amendment Act 23 of 1897. Both the Public Health Act and the Public Health Amendment Act were concerned with containing the spread of disease. Diseases (such as the bubonic plague at the time) were associated with the black African

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<sup>3</sup> The underlying determinants of health comprise of the socio-economic conditions which influence people's health such as living conditions, working conditions, access to water and sanitation and food, H C J Van Rensburg *Health and Healthcare in South Africa* (2004) 55.

<sup>4</sup> 86-89.

<sup>5</sup> 56-57.

<sup>6</sup> 56.

<sup>7</sup> Report of the Supreme Medical Committee Cape Town Gazette 2 No 86 15-8-1807.

<sup>8</sup> S18 of the Medical and Pharmacy Act 34 of 1891 established the Colonial Medical Council of the Cape Province.

population, even though it was mostly the white population contracting this disease.<sup>9</sup> The legislation authorised the removal of the Cape's black African population upon the outbreak of disease.<sup>10</sup>

In 1910 the Union of South Africa was established.<sup>11</sup> The health care policies and regulations of the provinces occupied by the British and Dutch were integrated into one, resulting in a nationwide dominance of Western health care practices.<sup>12</sup> Consequentially this resulted in more intense racial fragmentation and the entrenchment of rural-urban discrepancies.<sup>13</sup> The Public Health Act 36 of 1919 legitimised the racial fragmentation in the public sector while allowing the private sector to develop without restrictions.<sup>14</sup> The Native (Urban Areas) Act 21 of 1923 provided only curative services for the rural black African areas. The Group Areas Act 41 of 1950 divided urban spaces into racially segregated zones, preventing black African patients from seeking care in designated white areas, and white doctors from practising in designated black African areas.<sup>15</sup>

The socio-economic circumstances imposed on the black African population through their disenfranchisement implicated access to health care. Legislation neglected to address the underlying determinants of health such as housing, safe working conditions, education and information for most of the population. Subsequently, racially differential treatment became entrenched beyond just the provision of health care services. The Black Administration Act 38 of 1927 became, as described by the late former Chief Justice Langa, "a cornerstone of racial oppression,

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<sup>9</sup> M W Swanson "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909" (1977) 18 *The Journal of African History* 387 392.

<sup>10</sup> S15 of the Public Health Amendment Act 23 of 1897 authorised officials to control the outbreak of diseases.

<sup>11</sup> South Africa Act 1909.

<sup>12</sup> H C J Van Rensburg *Health and Healthcare in South Africa* (2004) 69.

<sup>13</sup> 69.

<sup>14</sup> 73. The Public Health Act 36 of 1919 concerned itself with the control of infectious diseases and at the time people believed that black Africans were the cause of disease, see M W Swanson "The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909" (1977) 18 *The Journal of African History* 387 392.

<sup>15</sup> S3(d) of the Group Areas Act 41 of 1950.

division and conflict in South Africa, the legacy of which will still take years to completely eradicate.”<sup>16</sup>

The Committee of Inquiry into the Training of Natives in Medicine and Public Health (“Loram Committee”)<sup>17</sup> considered the health issues arising in the black African communities.<sup>18</sup> The Loram Committee feared that disease and ill-health would affect the labour of the black African population.<sup>19</sup> To combat the rising state of ill-health, the Loram Committee recommended training more black African doctors.<sup>20</sup> Similarly, the 1939 Committee on Medical Training in South Africa<sup>21</sup> suggested training more black African doctors through the establishment of more training centres for black African doctors.<sup>22</sup> Both committees argued that to remedy the ill-health of the black African population, there should be State-sponsored medical schemes for the black African population and more training of black African doctors.<sup>23</sup> Although more training centres began to emerge, the recommendations were discarded.<sup>24</sup>

The most significant efforts to provide universal health care services emerged in 1942 from the National Health Services Commission<sup>25</sup> (“Gluckman Commission”), known as the Gluckman Commission as it was headed by Dr Henry Gluckman. The

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<sup>16</sup> *Bhe and Others v Khayelitsha Magistrate and Others* 2005 1 SA 500 (CC) para 61. See also S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 4.

<sup>17</sup> C T Loram *Report of the Committee Appointed to Inquire into the Training of Natives in Medicine and Public Health* (1928) UG 35/28 Pretoria: Government Printer.

<sup>18</sup> Para 4.

<sup>19</sup> Paras 4-6.

<sup>20</sup> Para 9.

<sup>21</sup> Committee on Medical Training in South Africa (1939) UG 25-1939 Pretoria: Government Printer.

<sup>22</sup> Botha *Report of the Committee on Medical Training in South Africa* (1939) UG 25-1939 Pretoria: Government Printer.

<sup>23</sup> Para 31; C T Loram *Report of the Committee Appointed to Inquire into the Training of Natives in Medicine and Public Health* (1928) UG 35/28 Pretoria: Government Printer para 5.

<sup>24</sup> A Digby *Diversity and Division in Medicine: Healthcare in South Africa from the 1800s* (2006) 205.

<sup>25</sup> Gluckman Commission *Report of the National Health Services Commission* (1944) UG 30/1944 Pretoria: Government Printer. See also C Ngwena “The Historical Development of the Modern South African Healthcare System: From Privilege to Egalitarianism” (2004) 37 *De Jure* 290 297.



Gluckman Commission found that the health care system was uncoordinated and short of resources, that the private sector resisted regulation, and that the health system disproportionately prioritised curative care over preventive care.<sup>26</sup> To address these concerns, the Gluckman Commission suggested a significant decrease in private care. A needs-based approach to health care was recommended, accompanied by an increase in the number of health personnel being trained. The recommendations of the Gluckman Commission were never implemented.<sup>27</sup> The lack of consideration for these recommendations is attributed to strong resistance from the Government, including the provincial authorities, and the coming into power of the National Party, whose interests favoured the growth of the private sector.<sup>28</sup>

The report of the Gluckman Commission held that:

“[U]nless there were drastic reforms in the sphere of nutrition, housing, health education and recreation, the mere provision of more doctoring would not bring more health to the people of the country.”<sup>29</sup>

The Gluckman Commission’s recommendations envisioned a polycentric approach to addressing ill-health. Access to health care services at the time was determined by race and ability to pay, not by need.<sup>30</sup> The recommendations were, however, not entirely in vain, as they have influenced health care policies seeking to address the disparities in access to health care in South Africa.<sup>31</sup>

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<sup>26</sup> Gluckman Commission *Report of the National Health Services Commission* (1944) UG 30/1944 Pretoria: Government Printer.

<sup>27</sup> The recommendations of the Gluckman Commission were not even tabled in Parliament, H C J Van Rensburg *Health and Healthcare in South Africa* (2004) 76. See also C Ngwena “The Historical Development of the Modern South African Healthcare System: From Privilege to Egalitarianism” (2004) 37 *De Jure* 290 297.

<sup>28</sup> C Ngwena “The Historical Development of the Modern South African Healthcare System: From Privilege to Egalitarianism” (2004) 37 *De Jure* 290 298; H C J Van Rensburg *Health and Healthcare in South Africa* (2004) 76.

<sup>29</sup> Gluckman Commission *Report of the National Health Services Commission* (1944) UG 30/1944 Pretoria: Government Printer.

<sup>30</sup> H C J Van Rensburg *Health and Healthcare in South Africa* (2004) 76.

<sup>31</sup> 76.

### 2 2 3 The apartheid period

The apartheid regime introduced homeland policies, an administrative mechanism which moved the black African population away from the urban areas to designated “homelands”.<sup>32</sup> The disenfranchisement and unequal provision of resources on a racial basis led to significant inequalities in health care services between the white urban areas and the homelands.<sup>33</sup> The apartheid government denied the responsibility of providing health care services to the black African population, blaming the homeland authorities for the poor health of the people.

The Reservation of Separate Amenities Act 49 of 1953 sought to control space on a racial basis by legalising segregation of public spaces and services.<sup>34</sup> The legislation provided access to amenities based on race, deeming white people superior and subsequently entitled to better amenities.<sup>35</sup> Access to health care facilities was available separately but not equally.<sup>36</sup> The Minister of Justice at the time, Mr C R Swart held that:

“In our country we have civilised people, we have semi-civilised people and we have uncivilised people. The government of this country gives each section facilities according to the circumstances of each.”<sup>37</sup>

The effects of the racial segregation and oppression were reflected in the health statistics of South Africa from the 1950s. For white South Africans, life expectancy was high, 65 years for men and 72 years for women.<sup>38</sup> The white population had a low infant mortality rate (less than 15 per 1000 live births),<sup>39</sup> reflecting a very different pattern than that of the disenfranchised black African population. In rural areas, 30-

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<sup>32</sup> H C J Van Rensburg *Health and Healthcare in South Africa* (2004) 84, 300; S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 2.

<sup>33</sup> H C J Van Rensburg *Health and Healthcare in South Africa* (2004) 84.

<sup>34</sup> S3(b).

<sup>35</sup> A J Christopher *The Atlas of Changing South Africa* (2001) 5.

<sup>36</sup> S3(b).

<sup>37</sup> C R Swart *Hansard* 1953: Cols. 1054-5 cited in A J Christopher *The Atlas of Changing South Africa* (2001) 5.

<sup>38</sup> S Horwitz *Health and Health Care under Apartheid* (2009) 1.

<sup>39</sup> 1.

50% of black African live births resulted in death before the age of five.<sup>40</sup> The life expectancy of black African men and women were low at 36 years and 37 years, respectively.<sup>41</sup>

Due to a lack of legislative regulation, private sector prices increased. In 1960 the Snyman Commission investigated the rising costs of medical services and goods.<sup>42</sup> The Snyman Commission found that the legislation governing the patenting of medicines was a cause of the increasing prices.<sup>43</sup> It was recommended that generics be allowed and that the Minister of Health be empowered to regulate the sale of medicines by issuing licenses. These recommendations were not implemented.<sup>44</sup> They did, however, influence the development of the Medical Schemes Act 72 of 1967. This Act sought to regulate the private sector, but it was unsuccessful and resulted in further fragmentation between the public and private sector.<sup>45</sup> The National Health Act 63 of 1977 further negated State responsibility for the provision of health care services by placing the responsibility of obtaining health care on the individual. The National Health Act provided that the burden was on the individual to obtain health care and that they assumed the financial risk in the event of sickness.<sup>46</sup> It facilitated better administration of health care, although it was still racially segregated.

In the 1980s there were many attempts at reforming the health care system, but these failed in addressing the inequalities in resources, access to services, and the

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<sup>40</sup> 1.

<sup>41</sup> 1.

<sup>42</sup> J H Snyman *Commission of Enquiry into the High Costs of Medical Services and Medicines* (1960) K322 Pretoria: Government Printer; H C J Van Rensburg *Health and Healthcare in South Africa* (2004) 80.

<sup>43</sup> J H Snyman *Commission of Enquiry into the High Costs of Medical Services and Medicines* (1960) K322 Pretoria: Government Printer.

<sup>44</sup> H C J Van Rensburg *Health and Healthcare in South Africa* (2004) 80.

<sup>45</sup> 88.

<sup>46</sup> S1A(a)(ii) provided that the Minister may determine the circumstances under which monies are payable and the amounts payable. This allowed for racial discrimination as the Ministers were allowed to set the criteria implicating financial access. See also C Ngwena "The Historical Development of the Modern South African Healthcare System: from Privilege to Egalitarianism" (2004) 37 *De Jure* 290 296.

social conditions causing ill health.<sup>47</sup> These attempts sought to redistribute resources to address the inequalities and racial fragmentation in the provision of health care services. They were however unsuccessful, due to the political dispensation and racial segregation.<sup>48</sup>

The politically authorised racial discrimination affected spending on health care services. For example, in 1982, the entire health budget of KwaZulu-Natal, which was mainly a homeland and had over five million inhabitants, equated to the budget of the Johannesburg General Hospital, which was reserved for whites only.<sup>49</sup> In 1987 the government expenditure on health care per white person was R597 and only R137 per black African person.<sup>50</sup> Apartheid also manifested inequalities in the social determinants of health such as poor working conditions, harsh living conditions and lack of amenities endured by the oppressed black African population.<sup>51</sup>

The apartheid-endorsed ideals of free-markets favoured privatisation.<sup>52</sup> Subsequently, health care was considered a privilege and personal responsibility.<sup>53</sup> The National Health Policy for Health Act 116 of 1990 held that individuals were primarily responsible for their health. Section 2(e)(i) provided:

“That an inhabitant of the Republic, if he is capable of doing so, shall primarily be responsible for his own and his family’s physical, mental and social well-being, but that the State and local authorities shall share responsibility in this regard by providing an efficient and comprehensive health service.”

The racial divide was further perpetuated as the black African population had diminished resources at their disposal to meet their health care needs and were exposed to more health risks due to the living conditions and working conditions

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<sup>47</sup> Attempts at reforming the South African health care system included, *inter alia*, the Browne Commission of 1986, Browne Commission *Final Report of the Commission of Inquiry into Health Services* (1986) RP67/1986 Pretoria: Government Printer; the National Health Facilities Plan of 1980 and the National Health Plan of 1986 as adopted by the Department of National Health and Population Development.

<sup>48</sup> H C J Van Rensburg *Health and Health Care in South Africa* (2004) 92.

<sup>49</sup> A Hassim et al *Health and Democracy* (2007) 13.

<sup>50</sup> 11-13.

<sup>51</sup> 11-13.

<sup>52</sup> H C J Van Rensburg *Health and Health Care in South Africa* (2004) 96.

<sup>53</sup> 96.

manufactured by apartheid.<sup>54</sup> Health care was just one facet of many socio-economic inequalities which had become institutionalised by the racial segregation introduced by colonialism and then manifested under the apartheid regime. The political unrest and movement towards a democratic and equal society brought more focus to socio-economic inequalities, such as in access to health care services. Although parties had been contemplating health care reform,<sup>55</sup> it was only with the demise of apartheid in the 1990s that these ideas received recognition.<sup>56</sup>

## 2 3 Recognition of health care as a right

### 2 3 1 Towards constitutional recognition

The late 1980s and early 1990s were significant in paving the way for the recognition of health as a fundamental human right in South Africa.<sup>57</sup> The right to health was recognised within the liberation struggle as evidenced by the Freedom Charter adopted in 1955 by the Congress of the People.<sup>58</sup> The Constitutional Committee of the African National Congress (“ANC”) included socio-economic rights in its Bill of Rights for a democratic South Africa.<sup>59</sup> It was recognised that the socio-economic circumstances inherited from the apartheid regime needed to be addressed

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<sup>54</sup> 56.

<sup>55</sup> For example, the Freedom Charter adopted by the Congress of the People on 26 June 1955 sought free medical care and transformation.

<sup>56</sup> For example, the National Policy for Health Act 116 of 1990 modifying the health care system to align with the changes in society, such as making special provision for the indigent regarding costs of medical services.

<sup>57</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 16.

<sup>58</sup> 17; Freedom Charter adopted by the Congress of the People on 26 June 1955, Kliptown.

<sup>59</sup> 1991 7 *SAJHR* 110-123 Freedom Charter – vision on health:

“A preventative health scheme shall be run by the state. Free medical care and hospitalisation shall be provided for all, with special care for mothers and young children... the aged, the orphans, the disabled and the sick shall be cared for by the state.”

with positive action through a legal framework facilitating transformation.<sup>60</sup> In 1994 the ANC released a National Health Plan for South Africa,<sup>61</sup> grounded in the right to health and envisaging a national health system based on PHC.

The Constitution of the Republic of South Africa Act 200 of 1993 (“the interim Constitution”) included socio-economic rights. Section 29 provided for the right of every person “to an environment which is not detrimental to his or her well-being”. Section 30(1)(c) provided for children’s rights, including the right to basic health. The limited scope of the socio-economic rights included is attributed to the role of the interim Constitution to facilitate free and fair elections.<sup>62</sup> Their inclusion did, however, provide a basis for socio-economic rights which was significantly expanded in the 1996 Constitution.

### 2 3 2 Constitutional recognition of the right of access to health care

Section 68 of the interim Constitution provided that the final Constitution should be negotiated and adopted by the Constitutional Assembly in compliance with the Principles specified in schedule 4. Principle II provided:

“Everyone shall enjoy all universally accepted fundamental rights, freedoms and civil liberties, which shall be provided for and protected by entrenched and justiciable provisions in the Constitution, which shall be drafted after having given due consideration to *inter alia* the fundamental rights contained in Chapter 3 of this Constitution.”

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<sup>60</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 9. See also D Omar “Enforcement of Social and Economic Rights” in *A Bill of Rights for a Democratic South Africa* (1991) 106 112; A Sachs “Towards a Bill of Rights in a Democratic South Africa” (1990) 6 *SAJHR* 1 4-6; N R Mandela “Address: On the Occasion of the ANC’s Bill of Rights Conference” in *A Bill of Rights for a Democratic South Africa: Papers and Reports of a Conference convened by the ANC Constitutional Committee May 1991* (1991) 9 12.

<sup>61</sup> ANC “A National Health Plan for South Africa” (30-05-1994) <<http://www.anc.org.za/show.php?id=257>> (accessed 2 April 2016).

<sup>62</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 16.

Initially, it was decided that socio-economic rights amounted to universally accepted fundamental human rights norms.<sup>63</sup> Due to concerns and objections, the Constitutional Assembly sought to draft the socio-economic rights in such a way that they did not demand the impossible from the State, but where the State has a duty to remove barriers and provide access, and that the provisions did not impugn on the separation of powers.<sup>64</sup>

In *Ex Parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa 1996*<sup>65</sup> (“*First Certification Judgment*”) the Constitutional Court would not certify the text due to the lack of compliance with Principle II.<sup>66</sup> The *First Certification Judgment* also raised concerns regarding the inclusion of socio-economic rights. Firstly, it was questioned whether they amounted to universally accepted fundamental rights.<sup>67</sup> The Constitutional Court held that the principle allows for the Constitutional Assembly to substitute these rights, the Principle requires *consideration*.<sup>68</sup> The second objection questioned whether their inclusion would be inconsistent with the separation of powers doctrine.<sup>69</sup> In response, it was held that civil and political rights also require positive action from the State and implicate budgets. Lastly, socio-economic rights were argued not to be justiciable.<sup>70</sup> The Constitutional Court held that their budgetary implications do not affect their justiciability.<sup>71</sup> Liebenberg contends that, in deciding that socio-economic rights are justiciable, the Court did not preclude the enforcement of positive obligations imposed by socio-economic rights.<sup>72</sup> The amended text was certified by the

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<sup>63</sup> 17.

<sup>64</sup> Constitutional Assembly, Constitutional Committee Sub-Committee *Draft Bill of Rights, Volume 1, Explanatory Memoranda* 9 October 1995, 1 154.

<sup>65</sup> 1996 4 SA 744 (CC).

<sup>66</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 16.

<sup>67</sup> 1996 4 SA 744 (CC) para 78.

<sup>68</sup> Para 76, emphasis added.

<sup>69</sup> Para 78.

<sup>70</sup> Para 78.

<sup>71</sup> Para 78.

<sup>72</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 21.

Constitutional Court in *Certification of the Amended Text of the Constitution of the Republic of South Africa, 1996*.<sup>73</sup>

The recognition of socio-economic rights in the final Constitution reflected the commitment to social justice and more equitable distribution of social and economic resources and services.<sup>74</sup> The right of access to health care is provided for in section 27(1)(a), read with section 27(2).

Other rights in the Constitution affect the right of access to health care. Section 12(2) provides for the right to “bodily and psychological integrity” which includes autonomy over reproductive decisions. The right to equality, particularly subsections (1) and (2) affect the realisation of the right of access to health care as they provide that everyone is entitled to benefit from the law and entitled to the “full and equal enjoyment of all the rights and freedoms.”<sup>75</sup> The right of everyone “to an environment that is not harmful to their health or well-being”<sup>76</sup> incorporates the environmental influences on health as well as occupational health.<sup>77</sup> The rights of access to adequate housing,<sup>78</sup> social security,<sup>79</sup> food and water<sup>80</sup> and basic education<sup>81</sup> all affect the realisation of the right of access to health care. These non-medicinal determinants influence the realisation of the right not only regarding section 27 but also in terms of children’s right to basic health care as provided for by section 28(1)(c).<sup>82</sup>

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<sup>73</sup> 1997 2 SA 97 (CC).

<sup>74</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 21-22.

<sup>75</sup> S9(2) of the Constitution.

<sup>76</sup> S24(a).

<sup>77</sup> M Pieterse *Can Rights Cure?* (2014) 19.

<sup>78</sup> S26 of the Constitution.

<sup>79</sup> S27(1)(b).

<sup>80</sup> S27(1)(c).

<sup>81</sup> S29(1)(a).

<sup>82</sup> See A E Yamin “Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage” (2017) 39 *Human Rights Quarterly* 341 349-250 where Yamin states:

“[P]romoting health justice as a matter of rights will require actions on the part of the state that go well beyond the health sector, to address these economic, social and political determinants, which include eliminating discrimination and protecting other economic and social rights such as education, as well as civil and political rights such as freedom of information, movement and expression.”



The inclusion of socio-economic rights in the Constitution supports the transformative agenda, as was articulated by van der Westhuizen J in *Road Accident Fund v Mdeyide*:<sup>83</sup>

“One of the most important purposes of this transformation is to ensure that, by the realisation of fundamental socio-economic rights, people disadvantaged by their deprived social and economic circumstances become more capable of enjoying a life of dignity, freedom and equality that lies at the heart of our constitutional democracy.”<sup>84</sup>

The Constitution is both forward-looking and backward-looking. The Constitution seeks to right the wrongs of the past through transformation. The preamble of the Constitution articulates this commitment in seeking to “[h]eal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights.” In looking forward, the Constitution seeks to redefine the socio-economic and political order based on the fundamentals of democracy, equality and dignity.<sup>85</sup> The constitutional entrenchment of the right of access to health care imposed obligations to *inter alia* enact legislation to facilitate the realisation of the right.

### 2 3 3 Legislative reforms post-1994

The legislative reforms post-1994 aimed to redress the fragmentation of the health care system, the oppression of the black African majority, the distributional inequalities of resources and the inappropriate neglect of preventative care.<sup>86</sup> In 1998 the Truth and Reconciliation Commission<sup>87</sup> noted that the health sector:

“[T]hrough apathy, acceptance of the *status quo* and acts of omission, allowed the creation of an environment in which the health of millions of South Africans was

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<sup>83</sup> 2011 2 SA 26 (CC).

<sup>84</sup> Para 125.

<sup>85</sup> C Ngwena “Access to Health Care Services as a Justiciable Socio-Economic Rights under the South African Constitution” (2003) 6 *Medical Law International* 13 19-20.

<sup>86</sup> A Hassim et al *Health and Democracy* (2007) 111.

<sup>87</sup> Truth and Reconciliation Commission as established by the Promotion of National Unity and Reconciliation Act 34 of 1995.

neglected, even at times actively compromised, and in which violations of moral and ethical codes of practice were frequent, facilitating violations of human rights.”<sup>88</sup>

The legislative efforts sought to address the inherited fragmentation. The White Paper for the Transformation of the Health System in South Africa 1997<sup>89</sup> (“White Paper for Transformation”) sought to develop a unified health system for all, guided by a PHC approach.<sup>90</sup> Complementing the White Paper for Transformation, the White Paper on Transforming Public Service Delivery 1997<sup>91</sup> aimed to provide a policy framework to transform public service delivery effectively.<sup>92</sup>

The Medical Schemes Act 131 of 1998 was enacted to regulate the private medical insurance business. It is praised for increasing access to health care as it prohibits discrimination and seeks to ensure that the private sector is regulated and therefore more affordable.<sup>93</sup> In recent years, however, it has come to light that the Medical Schemes Act is not all that effective in regulating the private sector and this implicates the right of access to health care. The increase of prices in the private health care sector over the last ten years has far surpassed that of inflation.<sup>94</sup> The Competition Commission is currently busy with an inquiry into the private health care sector due to the growing concern over the high prices. Their goal is to determine how quality health care can be made more affordable and accessible.<sup>95</sup>

In 1999 the Patient Rights Charter was adopted by the Department of Health with the aim of providing a common standard for achieving the realisation of the right to

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<sup>88</sup> Truth and Reconciliation Commission Report *Volume 5: Findings and Conclusions* 250.

<sup>89</sup> Department of Health *White Paper for the Transformation of the Health System in South Africa No. 667* (1997) Notice 667 of 1997.

<sup>90</sup> See chapter four part 3 8 1 for more on PHC.

<sup>91</sup> Department of Public Service and Administration *White Paper on Transforming Public Service Delivery No. 1459* (1997) Government Gazette 18340.

<sup>92</sup> Para 11.2.

<sup>93</sup> Preamble, Medical Schemes Act 131 of 1998.

<sup>94</sup> Competition Commission ‘Market Inquiry into the Private Healthcare Sector’ <<http://www.compcom.co.za/healthcare-inquiry/>> (accessed 20 June 2016). The Inquiry is in terms of Chapter 4A of the Competition Act 89 of 1998.

<sup>95</sup> 27.

health care.<sup>96</sup> This standard of health care recognised by the Patient Rights Charter includes, *inter alia*, a healthy and safe environment, participation in decision-making, knowledge of one's health insurance/medical aid scheme, choice of health services and access to health care including information, emergency care and provision for special needs.<sup>97</sup> The Patient Rights Charter includes both rights and responsibilities, also reflected in post-apartheid legislation such as the National Health Act 61 of 2003.

The National Health Act brought legitimised structure to the ideals of an equal health care system. This effort was arguably too late and insufficient to address the growing disparities between races, the rich and the poor, the public and private, and the urban and rural. The National Health Act aims to "provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution."<sup>98</sup> Its objectives are three-fold in that it seeks to establish a unified health care system consisting of both private and public providers. Secondly, it seeks to articulate the rights and duties regarding health care. Lastly, it purports to protect, respect, promote and fulfil the constitutional right of access to health care.<sup>99</sup>

The National Health Act established the district health care system.<sup>100</sup> The district health care system divides the responsibility of health care per districts and metropolitan municipal boundaries.<sup>101</sup> The National Health Act requires that the districts comply with the obligations imposed by section 27 of the Constitution.<sup>102</sup> This division of responsibility differs from the racial divisions of apartheid. The district

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<sup>96</sup> Department of Health *Patient Rights Charter* (1999) <<http://www.doh.gov.za/docs/legislation/patientrights/charterer.html>> (accessed 4 January 2017).

<sup>97</sup> The Patient Rights Charter states that provision must be made for those with special health care needs such as the disabled, the aged, children, pregnant or nursing women and persons suffering from HIV.

<sup>98</sup> Preamble of the National Health Act 61 of 2003.

<sup>99</sup> S2.

<sup>100</sup> S29(1).

<sup>101</sup> S29(2).

<sup>102</sup> The National Health Act also required that the districts comply with section 19(5) of the Constitution and the criteria provided for in s25 of the Local Government Municipal Demarcation Act 27 of 1998 which includes *inter alia* equity (s30(2)(a)), access (s30(2)(b)), and overcoming fragmentation (s30(2)(d)).

system seeks to provide everyone with equal access to quality health care.<sup>103</sup> The district system is a vehicle for the delivery of PHC services.<sup>104</sup>

The National Health Act provides free health care services to children under the age of six years old and pregnant and nursing women.<sup>105</sup> In the public sector, the cost of health care is determined by a means test.<sup>106</sup> The determination of the amount payable is calculated according to income percentiles as provided for in the Uniform Patient Fee Schedule.<sup>107</sup> The National Health Act is currently the backbone of the South African health care system, guiding service delivery to comply with constitutional obligations. The NHI scheme has the potential to build on the successes of the National Health Act and to rectify its shortcomings.

In 2007 at the ANC Polokwane Conference a resolution was passed to establish a National Health Insurance system.<sup>108</sup> A green paper was published in 2012<sup>109</sup> followed by the White Paper on National Health Insurance<sup>110</sup> (“White Paper”) in 2015. On the 30<sup>th</sup> of June 2017, the latest version of the White Paper was gazetted as an official policy document (“Policy Document”).<sup>111</sup> The NHI scheme proposes an overhaul of the current health care system, transforming the health care sector and addressing the unequal enjoyment of the right to health. The following section considers the current context of access to health care in South Africa. This supports the need for reform as proposed by the NHI scheme.

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<sup>103</sup> H C J Van Rensburg *Health and Health Care in South Africa* (2004) 133.

<sup>104</sup> 113.

<sup>105</sup> S4(3)(a) National Health Act 61 of 2003.

<sup>106</sup> S4(3)(b).

<sup>107</sup> S4(2); Uniform Patient Fee Schedule Government Notice no 770 of 21 July 2008 in Government Gazette 31249.

<sup>108</sup> ANC 52<sup>nd</sup> National Conference (2007) Resolution 53 <<http://www.anc.org.za/content/52nd-national-conference-resolutions>> (accessed 10 June 2016).

<sup>109</sup> Department of Health *Green Paper on National Health Insurance in South Africa* (2012) Government Gazette 34428 (1 July 2011).

<sup>110</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15.

<sup>111</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017; see chapter five part 2.

## 2 4 Current context of the right to health in South Africa and the need for reform

### 2 4 1 Inequalities in access to and quality of health care

There are still many inequalities in current access to health care. These range from urban-rural discrepancies, rich-poor discrepancies, public-private discrepancies and Western-traditional discrepancies. These inequalities, inherited from the colonial and apartheid past, are arguably being perpetuated by the current system.<sup>112</sup> The current two-tier system, which consists of a public sector and a private sector, manifests the discrepancies in access to and quality of care. The private sector serves 16% of the population.<sup>113</sup> However, out of the 8.9% of South Africa's Gross Domestic Profit ("GDP") which is spent on health care, over 50% is spent in the private sector.<sup>114</sup> The public sector thus has more people to provide for with fewer resources, resulting in diminished access to and quality of care.

In addition to the inequalities between the private sector and public sector, there are inequalities within the sectors too. Medical aid schemes cover only 17.5% of the population of South Africa.<sup>115</sup> The racial demographics of this 17.5% reflects the past,

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<sup>112</sup> M Pieterse *Can Rights Cure?* (2014) 43.

<sup>113</sup> World Health Organisation *World Health Statistics* (2015) <<http://www.who.int/countries/zaf/eg>> (accessed 2 June 2016). Pretorius, a researcher for Africa Check, claims that this statistic is misleading because it is based on the percentage of people that belong to medical aid schemes. She argues that the number of people who rely on the private sector surpasses those who belong to medical aid schemes. Although there is some merit to her assertions, she neglects to consider those who belong to medical aid schemes who are still unable to access the private sector due to high contributory payments and package structures. This study submits that it is acceptable to base access to the private sector on the number of people who have medical aid schemes as this is the primary means of accessing the private sector and overcoming the financial burden of accessing private health care. L Pretorius "Does South Africa's Private Healthcare Sector only Serve 16% of the Population?" 08-08-2017 <<https://africacheck.org/reports/does-sas-private-healthcare-sector-only-provide-care-for-16-of-the-population/>> (accessed 10 August 2017).

<sup>114</sup> World Health Organisation *World Health Statistics* (2015) <<http://www.who.int/countries/zaf/eg>> (accessed 2 June 2016).

<sup>115</sup> Statistics South Africa "General Household Survey" (2015) <<http://www.statssa.gov.za>> (accessed 5 September 2016).

where private health insurance was almost entirely inaccessible and unaffordable to the black African population. While 73.3% of white South Africans are beneficiaries of medical aid schemes, only 10.6% percent of the black African population are covered.<sup>116</sup> In its problem statement, the Policy Document depicts who receives the benefits of health care and who needs it.<sup>117</sup> The benefits and needs share is depicted as a percentile of the total population health care benefits and needs. The poorest 20% of the population only receive 12.5% of health care benefits despite their health needs share comprising of more than 25%.<sup>118</sup> The richest 20% of the population, with a needs share of less than 10% enjoy 36% of the total health care benefits.<sup>119</sup>

In the private sector persons earning a low income (approximately R2000 per month) are contributing almost 40% thereof to medical insurance while persons earning over R15 000 per month are contributing less than 10%.<sup>120</sup> This illustrates the financial burden of private medical insurance on the poor. Within the public sector, there are stark inequalities regarding physical accessibility and availability of resources between urban and rural service providers.<sup>121</sup> The standard of quality in the public sector is currently a major concern and a contributor to the inequity in the enjoyment of access to health care. Currently, only 46% of public health facilities comply with the quality standards set by the Office of Health Standards and Compliance.<sup>122</sup> Without significant intervention, these inequalities in access to and quality of health care will manifest in perpetuity. The division of resources between the

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<sup>116</sup> 19.3% of the coloured population are covered by medical aid schemes and 44.5% of the Indian/Asian population, Statistics South Africa “General Household Survey” (2015) <<http://www.statssa.gov.za>> (accessed 5 September 2016).

<sup>117</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 41.

<sup>118</sup> Para 81.

<sup>119</sup> Para 81.

<sup>120</sup> A Hassim et al *Health and Democracy* (2007) 165; World Health Organisation *World Health Statistics* (2015) <<http://www.who.int/countries/zaf/eg>> (accessed 2 June 2016). See also J E Ataguba & D McIntyre “The Incidence of Health Financing in South Africa: Findings from a Recent Data Set” (2017) *Health Economics, Policy and Law* 1 10.

<sup>121</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 99.

<sup>122</sup> Section 27 Submission on the White Paper <[http://www.nhisa.co.za/B\\_submissions.asp](http://www.nhisa.co.za/B_submissions.asp)> (accessed 10 June 2016) para 6.1.

public and private sectors do not reflect the needs of the population.<sup>123</sup> Pieterse argues that current legislation is not adequately translating the right of access to health care into a tangible reality for most of the population.<sup>124</sup> The proposed NHI scheme seeks to address these disparities and distributional inequalities to effectively realise the right of access to health care for all.

#### 2 4 2 Investigations into South Africa's health care system

There are differences between the promises of the Constitution and the lived experiences of people. The health care system has been subject to various investigations, particularly concerning the adequacy of the public sector.<sup>125</sup> The South African Human Rights Commission inquired into the reality of access to health care services in 2007.<sup>126</sup> Highlighting the underlying determinants of health care and the direct barriers such as transport costs and long waiting periods, the Human Rights Commission concluded that these constraints denied people their right of access to health care.<sup>127</sup> The Human Rights Commission recommended that resource allocation should reflect a needs-based system and long-term commitment to a national health system ensuring access for all.<sup>128</sup>

The Office for Health Standards and Compliance, a body, introduced by the Department of Health to address quality standards in health care, has identified

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<sup>123</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 99; World Health Organisation *World Health Statistics* (2015) <<http://www.who.int/countries/zaf/eg>> (accessed 2 June 2016).

<sup>124</sup> M Pieterse *Can Rights Cure?* (2014) 9.

<sup>125</sup> The private sector has also been subject to investigations, such as by the Competition Commission for the high prices in the private sector, and more recently for the cost of cancer treatments, L Rutter "Coalition Welcomes Landmark Competition Commission Probe into Prices of Cancer Medicines" *Treatment Action Campaign* 13 June 2017 <<http://www.tac.org.za/news/coalition-welcomes-landmark-competition-commission-probe-prices-cancer-medicines>> (accessed 19 July 2017).

<sup>126</sup> South African Human Rights Commission 'Public Enquiry: Access to Health Care Services' (2007) <<http://www.sahrc.org.za/home/21/files/Health%20Report.pdf>> (accessed 31 January 2017).

<sup>127</sup> 56.

<sup>128</sup> 7.

inequalities in expenditure per capita as a problem which needs to be addressed.<sup>129</sup> South Africa's National Development Plan for 2030 highlights health care as one of the nine primary challenges as the "public health system cannot meet demand or sustain equality".<sup>130</sup>

The Eastern Cape Department of Social Development also released a report on the socio-economic circumstances of the Eastern Cape population.<sup>131</sup> These articulated that the health profile of the Eastern Cape "follows a pattern of poverty that is rooted in historical socio-economic deprivation".<sup>132</sup> The historical context reveals that the inequalities stem from the colonial and apartheid past of our country. Coupled with the challenges of resources and disease, the health care system has been unable to adequately address these disparities in access to and quality of care.

More recently, the Office for Health Standards and Compliance released a report on their investigation into the circumstances surrounding the deaths of mentally ill patients in Gauteng Province.<sup>133</sup> The report investigated over 94 deaths of mentally ill patients who had been transferred from Life Esidimeni to various Non-Governmental Organisations ("NGOs") when the health department terminated their contract with Life Esidimeni. These NGOs were incapable of tending to the needs of the patients. Ultimately, as the NGO's were not operating under valid licenses, the circumstances of the deaths were deemed unlawful. The report concludes that the termination of the contract and subsequent deaths, in excruciating circumstances, amounted to human rights violations, breached the Constitution and contravened the National Health Act

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<sup>129</sup> Office for Health Standards and Compliance *Annual Report 2015/16* 19.

<sup>130</sup> National Development Plan 2030: *Our Future-Make it Work* 15 August 2012 <<http://www.gov.za/issues/national-development-plan-2030>> (accessed 2 January 2017).

<sup>131</sup> Research and Population Unit: Eastern Cape Department of Social Development "The People Matter: The State of the Population in the Eastern Cape" (2010) <<http://www.hsrc.ac.za/uploads/pageContent/558/ECapefullreport.pdf>> (accessed 2 January 2017).

<sup>132</sup> 110.

<sup>133</sup> M W Makgoba *Final Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province* (2017) <<http://www.ohsc.org.za/index.php/news/media-releases/129-report-into-deaths-of-mentally-ill-patients-gauteng-province-3>> (accessed 21 February 2017).



and the Mental Health Care Act 17 of 2002.<sup>134</sup> The NHI scheme must also provide for quality mental health care services. For purposes of an example, this illustrates the fatal inadequacy of the public sector to provide access to quality health care, coupled with maladministration by health care officials. The NHI scheme seeks to improve the quality of health care in the public sector, and this incorporates the administration and governance of the health sector.

## 2.5 Conclusion

An examination of the past provides insight into the fragile system and the need for reform to rectify the manifested inequality in access to health care. Differential treatment, segregation, oppression and the disenfranchisement of the black African population of South Africa has resulted in a health profile skewed in favour of the wealthy and white population. The discrepancy in the quality of health care between public and private, as well as urban and rural, reflects the past discrimination.

South Africa's transformation to a constitutional democracy, together with the recognition of socio-economic rights, enhanced the progress of realising a better life for all as purported by the preamble of the Constitution. Many challenges remain in ensuring effective, equitable access to health care for all. This examination of the past and current context of the right to health care and the legislative framework in South Africa provides a contextual understanding in which to analyse the obligations imposed by the right. It is within this context that the NHI scheme has been developed. The following chapter will build on this context by examining the normative content of the right to health care and the obligations imposed by it under the Constitution.

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<sup>134</sup> M W Makgoba *Final Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province* (2017) <<http://www.ohsc.org.za/index.php/news/media-releases/129-report-into-deaths-of-mentally-ill-patients-gauteng-province-3>> (accessed 21 February 2017). On mental health and disabilities specifically see C Ngwena "Western Cape Forum for Intellectual Disability v Government of the Republic of South Africa: A Case Study of Contradictions in Inclusive Educations" (2013) *African Disability Rights Yearbook* 139-164; C Ngwena "Deconstructing the Definition of 'Disability' under the Employment Equity Act: Social Deconstruction" (2006) 22 *SAJHR* 613-646 and C Ngwena "Deconstructing the Definition of 'Disability' under the Employment Equity Act: Legal Deconstruction" (2007) 23 *SAJHR* 116-156.

## CHAPTER 3: CONSTITUTIONAL OBLIGATIONS IMPOSED BY THE RIGHT OF ACCESS TO HEALTH CARE

### 3 1 Introduction

Section 27(1)(a) read with (2) of the Constitution of the Republic of South Africa, 1996 (“the Constitution”) provides for the right of access to health care. Children’s right to “basic health care” is provided for in section 28(1)(c). This chapter will examine the obligations imposed by the right of access to health care through analysing the relevant Constitutional Court jurisprudence. This chapter, together with chapter four on the international law obligations imposed by the right to health care, lay the basis for evaluating the National Health Insurance (“NHI”) scheme proposed for South Africa in chapter six. This chapter will consider the text of section 27(1)(a) read with (2) as well as section 28(1)(c), the overarching obligations to “respect, protect, promote and fulfil the rights in the Bill of Rights” under section 7(2), and the Constitutional Court’s socio-economic rights jurisprudence pertaining to these provisions. Relevant academic literature will also be considered in this analysis. This chapter will also examine the obligations imposed on private entities by the right of access to health care.

### 3 2 Health rights and obligations under the Constitution: textual analysis

#### 3 2 1 The right of access to health care in the Constitution

Section 27(1)(a) provides that everyone has the right of access to health care services, including reproductive health care.<sup>1</sup> It is to be read with section 27(2) which provides:

“The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.”

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<sup>1</sup> The explicit provision for reproductive health care suggests that this should receive some degree of prioritisation, M Pieterse *Can Rights Cure* (2014) 104. For reproductive health rights specifically see C Ngwena & E Durojaye (eds) *Strengthening the Protection of Sexual and Reproductive Health Rights in the African Region through Human Rights* (2014).

Section 27(2) defines the scope of the positive duties imposed by the right. The normative content of the right is developed through judicial interpretation as well as through the executive and the legislature giving effect to the right through relevant policies and legislation. Although negative obligations are immediately enforceable,<sup>2</sup> the positive obligations imposed on the State by section 27(2) do not create an immediately enforceable entitlement to access to health care.<sup>3</sup>

Porter warns against focusing solely on the obligations imposed by the right and neglecting its normative content.<sup>4</sup> He claims that the positive measures seeking to realise the right can challenge patterns of exclusion.<sup>5</sup> The content of the right informs the obligations. A lack of normative content leaves rights “conceptually empty” and leaves ambiguity to what it is that the positive measures are seeking to achieve.<sup>6</sup>

Pieterse argues that the transformative objective of the Constitution should be reflected in the understanding of the right of access to health care.<sup>7</sup> He argues for a rights-based approach to health care system reform to instil accountability, participation and transparency in health care decisions and processes.<sup>8</sup> Heyns and Brand hold that the right “to have access to” means that the State is not obliged to provide food (per their example), only to ensure that food is reasonably available and affordable.<sup>9</sup> This position is subject to criticism concerning those without means to afford or access to food, water, housing or health care. The issue of whether the State owes a different obligation to the vulnerable will be examined below through jurisprudence.

Section 27(3) provides that “[n]o one may be refused emergency medical treatment.” As a separate provision, it is not subject to section 27(2). It may, therefore,

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<sup>2</sup> See chapter three part 3.

<sup>3</sup> D Bilchitz “Health” in S Woolman et al (eds) *Constitutional Law of South Africa* 2 ed (OS 5 2012) 56A-1 1.

<sup>4</sup> B Porter “The Crisis of Economic, Social and Cultural Rights and Strategies for Addressing It” in J Squires, M Langford & B Thiele (eds) *The Road to a Remedy: Current Issues in the Litigating of Economic, Social and Cultural Rights* (2005) 43 55.

<sup>5</sup> 56.

<sup>6</sup> M Pieterse *Can Rights Cure?* (2014) 30-31.

<sup>7</sup> 3.

<sup>8</sup> 123.

<sup>9</sup> C Heyns & D Brand “Introduction to Socio-Economic Rights in the South Africa Constitution” (1998) *Law, Development and Democracy* 153 158.

be immediately enforceable.<sup>10</sup> It follows that the right to emergency medical treatment may only be limited in terms of section 36 of the Constitution.<sup>11</sup> Pieterse interprets section 27(3) as containing a positive obligation on the State to make emergency medical care available.<sup>12</sup>

### 3 2 2 Children's right to basic health care under the Constitution

Although section 27(1)(a) affords the right of access to health care to “everyone”, including children, section 28(1)(c) provides specifically for children's socio-economic rights. It reads as follows that every child has the right:

“[T]o basic nutrition, shelter, basic health care services and social services”.

Similarly to section 27(1), the right to basic health care is grouped among other socio-economic rights, reflecting the interdependence of these rights. Section 28(1)(b) provides every child with the right to “family care or parental care, or to appropriate alternative care when removed from the family environment”. The analysis of the jurisprudence will examine the relationship between sections 28(1)(b) and (c) regarding the obligations imposed.

Unlike section 27(1)(a), children's right to basic health care is not explicitly qualified by available resources, progressive realisation or reasonable legislative and other measures.<sup>13</sup> The only inherent qualification is the reference to “basic” health care. Liebenberg holds that “basic” implies the essentials for survival and proper development.<sup>14</sup> The current health care jurisprudence does not clarify if this provision creates a direct entitlement to health care for children. However, in *Governing Body of*

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<sup>10</sup> M Pieterse *Can Rights Cure?* (2014) 22.

<sup>11</sup> 22.

<sup>12</sup> 23. See also M Pieterse “Enforcing the Right to Not to Be Refused Emergency Medical Treatment: Towards Appropriate Relief” (2007) 18 *Stell LR* 75 78-79.

<sup>13</sup> S27(2) of the Constitution.

<sup>14</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 235.

*the Juma Masjid Primary School and Others v Essay N.O.*<sup>15</sup> (“*Juma Masjid*”) the Court interpreted the right to basic education under section 29(1) as follows:

“Unlike some of the other socio-economic rights, this right is immediately realisable. There is no internal limitation requiring that the right be ‘progressively realised’ within ‘available resources’ subject to ‘reasonable legislative measures’. The right to a basic education in section 29(1)(a) may be limited only in terms of a law of general application which is ‘reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom’.”<sup>16</sup>

Therefore, given the likeness in the phrasing of section 29(1)(a) and children’s right to basic health care, it can be inferred that the same interpretation would apply to section 28(1)(c).

The Court has warned against children becoming “stepping stones”<sup>17</sup> for the enforcement of rights. In other words, if section 28(1)(c) affords children a direct entitlement to basic health care then applicants will avoid relying on section 27(1)(a) and opt for reliance on section 28(1)(c). In addition to the relationship between these provisions, the relationship between sections 28(1)(b) and (c) also implicates the obligations imposed by children’s right to basic health care. This relationship will be further examined below.<sup>18</sup>

### 3 2 3 Section 7(2): the obligation to respect, protect, promote and fulfil

Section 7(2) imposes an overarching obligation on the State to “respect, protect, promote and fulfil the rights in the Bill of Rights”.<sup>19</sup> In *Glenister v President of the Republic of South Africa*<sup>20</sup> (“*Glenister*”) the Court interpreted section 7(2) as follows:

“This obligation goes beyond a mere negative obligation not to act in a manner that would infringe or restrict a right. Rather, it entails positive duties on the state to take deliberate,

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<sup>15</sup> 2011 8 BCLR 761 (CC). See also *Minister of Basic Education v Basic Education for All* 2016 4 SA 63 (SCA) paras 36-37.

<sup>16</sup> 2011 8 BCLR 761 (CC) para 37.

<sup>17</sup> *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 71.

<sup>18</sup> See chapter three part 5.

<sup>19</sup> See chapter four part 4 2 for more on tripartite obligations.

<sup>20</sup> 2011 3 SA 347 (CC).

reasonable measures to give effect to all of the fundamental rights contained in the Bill of Rights”.<sup>21</sup>

The Court also clarified that the measures to be taken are at the State’s discretion.<sup>22</sup> Liebenberg contends that the value of these overarching duties lies in their potential for a “substantive and contextual approach to the adjudication of human rights.”<sup>23</sup>

### 3 2 3 1 *The obligation to respect*

The obligation to respect requires the State to refrain from infringing on existing rights.<sup>24</sup> For example, the State may not unfairly interfere with people’s existing access to health care services, both in public and private sectors.<sup>25</sup> This obligation also requires abstaining from any discriminatory practices.<sup>26</sup> Violations of this obligation would include deliberate retrogressive measures, conduct which harms health, and measures which obstruct existing access.<sup>27</sup>

### 3 2 3 2 *The obligation to protect*

Significant to this study is the obligation to protect. The obligation to protect is positive, requiring the State to take positive measures and to protect people from third parties interfering with rights.<sup>28</sup> Therefore, it is especially relevant in evaluating the NHI scheme’s positive measures and the impact it may have on private entities.<sup>29</sup> The obligation to protect includes ensuring that there is a legal framework in place to

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<sup>21</sup> Para 105.

<sup>22</sup> Para 107.

<sup>23</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 235.

<sup>24</sup> A Hassim et al *Health and Democracy* (2007) 30.

<sup>25</sup> 30.

<sup>26</sup> D Bilchitz “Health” in S Woolman et al (eds) *Constitutional Law of South Africa* 2 ed (OS 5 2012) 56A-1 39.

<sup>27</sup> M Pieterse *Can Rights Cure?* (2014) 21.

<sup>28</sup> S Woolman “Application” in S Woolman et al (eds) *Constitutional Law of South Africa* 2ed (OS 2 2005) 31-1 123.

<sup>29</sup> See chapter five part 5 4 and chapter six part 7.

prevent third parties from interfering with rights.<sup>30</sup> Legislation, regulations and other measures must be introduced to protect the right. Pieterse argues that for the right of access to health care to be effectively protected, the health care system should be regulated.<sup>31</sup> In *S v Baloyi*<sup>32</sup> the Court interpreted the obligation to protect to include both preventative and preemptive measures by the State, as long as the measures are seeking to fulfil a constitutional obligation, such as, in this instance, the right of access to health care.<sup>33</sup>

Regulation of the health care sector may limit competing rights in the Bill of Rights. For such a limitation to be constitutionally justifiable, it would need to be legal, reasonable, justifiable and proportional as per the general limitations clause in section 36 of the Constitution. However, the purpose of the regulatory measure carries considerable weight in such a balancing exercise, particularly when a regulatory measure is pursuing transformation.<sup>34</sup> In this regard, Pieterse holds:

“[T]he constitutional entrenchment of the right to have access to health care services provides a powerful counterweight to the hegemony of neo-liberal arguments against market intervention and significantly assists in countering the potential of civil and political rights challenges to thwart state attempts at social transformation.”<sup>35</sup>

Thus, in pursuing social transformation, regulatory measures that limit other rights may pass constitutional scrutiny. The weight attached to the purpose should be influenced by the underlying values of human dignity, equality and freedom as well as the Constitution’s transformative objective of improving “the quality of life of all citizens and [to] free the potential of each person”.<sup>36</sup>

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<sup>30</sup> A Hassim et al *Health and Democracy* (2007) 33.

<sup>31</sup> M Pieterse *Can Rights Cure?* (2014) 129. See also S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 332.

<sup>32</sup> 2000 2 SA 4 425 (CC).

<sup>33</sup> Para 11.

<sup>34</sup> M Pieterse *Can Rights Cure?* (2014) 130.

<sup>35</sup> 130.

<sup>36</sup> Preamble of the Constitution.

### 3 2 3 3 *The obligation to promote*

Promoting the right of access to health care requires measures that “create, maintain and restore”<sup>37</sup> the population's health. The State is obliged to ensure the existence of a legal framework which enables the realisation of the right.<sup>38</sup> A legal framework can facilitate the realisation of the right by ensuring availability of resources, access and quality.<sup>39</sup> The obligation to promote the right of access to health care also includes making information about health and the health care system adequately known to enable people to realise their right of access to health care and make informed choices regarding their health.<sup>40</sup>

### 3 2 3 4 *The obligation to fulfil*

Similar to the obligation to promote the right of access to health care, the State is obliged to ensure people can access health care services.<sup>41</sup> The State is thus required to create conditions in which the realisation of the right is attainable.<sup>42</sup> This includes, *inter alia*, providing access to social security and ensuring the availability of resources for health care services.<sup>43</sup> This obligation includes facilitating and providing services when people are unable to realise the right within their means.<sup>44</sup> Pieterse notes that while aspects of the obligations to protect and respect are immediately enforceable, the obligation to fulfil is subject to progressive realisation and available resources as articulated in section 27(2) of the Constitution.<sup>45</sup> Failing to create conditions in which

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<sup>37</sup> D Bilchitz “Health” in S Woolman et al (eds) *Constitutional Law of South Africa* 2 ed (OS 5 2012) 56A-1 39.

<sup>38</sup> A Hassim et al *Health and Democracy* (2007) 33.

<sup>39</sup> 33.

<sup>40</sup> D Bilchitz “Health” in S Woolman et al (eds) *Constitutional Law of South Africa* 2 ed (OS 5 2012) 56A-1 39.

<sup>41</sup> A Hassim et al *Health and Democracy* (2007) 33.

<sup>42</sup> 34.

<sup>43</sup> 33-34.

<sup>44</sup> D Bilchitz “Health” in S Woolman et al (eds) *Constitutional Law of South Africa* 2 ed (OS 5 2012) 56A-1 39.

<sup>45</sup> M Pieterse *Can Rights Cure?* (2014) 21.



the right of access to health care is progressively realisable would offend this obligation. The focus now turns to the judicial interpretation of the specific obligations imposed by socio-economic rights.

### **3 3 Judicial interpretation of the negative obligations imposed by socio-economic rights**

The Constitutional Court has read negative obligations into sections 26(1) and 27(1) of the Constitution.<sup>46</sup> In *Government of the Republic of South Africa v Grootboom*<sup>47</sup> (“*Grootboom*”) the Court held that section 26(1) “at the very least” implies a negative obligation not to prevent or impair the right of access to adequate housing.<sup>48</sup> Liebenberg notes that this goes beyond the obligation to refrain from interfering with existing access, but extends to policies that may bar access to socio-economic rights.<sup>49</sup> In *Minister of Health v Treatment Action Campaign*<sup>50</sup> (“*TAC*”), the Court applied this interpretation of a negative obligation to section 27(1)(a).<sup>51</sup> The interference with access to the anti-retroviral drug nevirapine arguably amounted to a breach of the negative obligations imposed and the failure to provide the drug amounted to a violation of the positive obligations.<sup>52</sup> However, the Court in *TAC* focused on section 27(2).<sup>53</sup>

The result of the Court reading in an implied negative obligation in sections 26(1) and 27(1)(a) is that an infringement of this negative obligation cannot be justified by

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<sup>46</sup> *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 34; *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC) para 46.

<sup>47</sup> 2001 1 SA 46 (CC).

<sup>48</sup> Para 34. For an in depth analysis of *Grootboom* see S Liebenberg *Socio-Economic Rights under a Transformative Constitution* (2010) 151-154.

<sup>49</sup> S Liebenberg “The Interpretation of Socio-Economic Rights” in S Woolman et al (eds) *Constitutional Law of South Africa* 2ed (OS 3 2012) 33-1 18.

<sup>50</sup> 2002 5 SA 721 (CC).

<sup>51</sup> Para 46.

<sup>52</sup> D Bilchitz “Towards a Reasonable Approach to The Minimum Core: Laying the Foundation for Future Socio-Economic Rights Jurisprudence” (2003) 19 *SAJHR* 1 7.

<sup>53</sup> S Liebenberg “The Interpretation of Socio-Economic Rights” in S Woolman et al (eds) *Constitutional Law of South Africa* 2ed (OS 3 2012) 33-1 18.

sections 26(2) or 27(2), but only by the general limitations clause in section 36.<sup>54</sup> In *Jaftha v Schoeman*<sup>55</sup> (“*Jaftha*”) the Court confirmed that only the general limitations clause could justify a violation of this negative obligation.<sup>56</sup> *Jaftha* concerned a challenge to the constitutionality of section 66(1)(a) of the Magistrates’ Courts Act 32 of 1944 which permit for debt to be satisfied through the sale in execution of people’s homes and *in casu* the appellants would face eviction.<sup>57</sup> The Court held that because the contentious section deprived persons of existing access to adequate housing, it amounted to a violation of the negative obligation imposed by section 26(1).<sup>58</sup> In conducting a limitations analysis in terms of section 36 of the Constitution, the limitation was found to be unjustifiable.<sup>59</sup>

The Constitutional Court upheld the negative obligation imposed by section 27(1)(a) in *Law Society of South Africa v Minister for Transport*<sup>60</sup> (“*Law Society*”). The regulation at issue deprived paraplegic and quadriplegic road accident victims of existing access and thus could only be justified by section 36, not merely the financial implications of the Road Accident Fund (“RAF”).<sup>61</sup> Pieterse notes that the *Law Society* judgment illustrates that the negative obligations imposed by the right of access to health care could have consequences for health care reform.<sup>62</sup> The issue of reform interfering with existing access to health care services will be analysed below<sup>63</sup> and then evaluated regarding the NHI scheme in chapter six.

Bilchitz distinguishes between negative and positive obligations as follows:

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<sup>54</sup> M Pieterse *Can Rights Cure?* (2014) 30.

<sup>55</sup> 2005 2 SA 140 (CC).

<sup>56</sup> Paras 35-51.

<sup>57</sup> Para 17.

<sup>58</sup> Paras 31-34.

<sup>59</sup> Para 35.

<sup>60</sup> 2001 1 SA 400 (CC); M Pieterse *Can Rights Cure?* (2014) 118.

<sup>61</sup> 2011 1 SA 400 (CC) para 98; Regulation 5(1) of July 2008 under s17(4B) of the Road Accident Fund Act 56 of 1996.

<sup>62</sup> M Pieterse *Can Rights Cure?* (2014) 140.

<sup>63</sup> See chapter three part 4 3 2.

“[A] negative obligation consists in having a duty not to interfere with the ability of someone to do something they are entitled to do; a positive obligation, on the other hand, requires one to act in a particular way to provide something for someone.”<sup>64</sup>

However, the distinction between negative and positive obligations imposed by socio-economic rights is arguably inappropriate as these obligations become “intertwined”.<sup>65</sup> A formalistic approach to reviewing socio-economic rights violations would result in differing State accountability based on whether a violation is framed as a breach of a positive or a negative obligation.<sup>66</sup> The State’s failure to act positively would be subject to less accountability than its interference with existing access. As Liebenberg argues:

“Evaluating State omissions more leniently is premised on the assumption that the state is not implicated in the current distribution of resources and services. This ignores the myriad ways in which the State structures and legitimates current distributions through a plethora of institutions, policies, legislation and the enforcement of common law rules.”<sup>67</sup>

Indeed, it is hard to deny the role the State plays in facilitating the current access to (or lack thereof) health care services. Liebenberg further argues that a transformative approach to facilitating the realisation of socio-economic rights “requires transcending the dichotomies between negative and positive” rights and obligations.<sup>68</sup>

This chapter seeks to use Liebenberg’s approach of surpassing the formalistic distinction and consider both positive and negative obligations throughout the analysis. The negative obligations imposed by section 27(1) overlap with the issue of retrogression, which is examined below.<sup>69</sup> In chapter six the NHI scheme will be evaluated for its compliance with both the negative and positive obligations imposed by the right of access to health care.

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<sup>64</sup> D Biltchz “Towards a Reasonable Approach to The Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence” (2003) 19 *SAJHR* 1 7.

<sup>65</sup> S Liebenberg “The Interpretation of Socio-Economic Rights” in S Woolman et al (eds) *Constitutional Law of South Africa* 2ed (OS 3 2012) 33-1 19.

<sup>66</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 218.

<sup>67</sup> 218.

<sup>68</sup> 220. See also A E Yamin “Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage” (2017) 39 *Human Rights Quarterly* 341 346.

<sup>69</sup> See chapter three part 4 3 2.

### 3 4 Judicial interpretation of the positive obligations imposed by socio-economic rights

#### 3 4 1 Minimum core obligations

The Constitutional Court has held that socio-economic rights do not impose minimum core obligations on the State. In *Grootboom* and *TAC*, a minimum core standard was argued for as a standard of review to determine compliance with socio-economic rights obligations imposed on the State.<sup>70</sup> In *Grootboom* it was submitted by the *amici* that a minimum core obligation is imposed by section 26(1) read with (2) to provide shelter to those in crisis.<sup>71</sup> It was also argued that section 28(1)(c) manifested a minimum core obligation on the State to provide for children's socio-economic needs.<sup>72</sup> The argument relied on the United Nations Committee on Economic, Social and Cultural Rights' ("the Committee") interpretation of the nature of obligations imposed on states, which endorses a minimum core standard for each right that states are obliged to fulfil.<sup>73</sup> The Court acknowledged the important interpretive role of international law,<sup>74</sup> and although obliged to consider it,<sup>75</sup> held that the weight attached to the principles would vary.<sup>76</sup> The Court thus rejected the minimum core standard, emphasising the difficulties in determining a minimum core as individual needs are different.<sup>77</sup> The Court did not dismiss the possibility of, if provided with sufficient evidence, considering minimum core standards in its assessment of reasonableness.<sup>78</sup>

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<sup>70</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 148.

<sup>71</sup> 148.

<sup>72</sup> S Liebenberg "The Interpretation of Socio-Economic Rights" in S Woolman et al (eds) *Constitutional Law of South Africa 2ed* (OS 3 2012) 33-1 23.

<sup>73</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No 3: *The Nature of State Parties' Obligations (art 2(1))* UN Doc E/C.14/12/90.

<sup>74</sup> 2001 1 SA 46 (CC) para 26.

<sup>75</sup> S39(1)(b) of the Constitution.

<sup>76</sup> 2001 1 SA 46 (CC) para 26; the role and status of international law will be examined in chapter four part 2.

<sup>77</sup> 2001 1 SA 46 (CC) para 33.

<sup>78</sup> Para 33.

In *TAC*, the *amici* argued that section 27(1)(a) contains a minimum core entitlement exempt from the qualifications under section 27(2).<sup>79</sup> Section 27(2) was argued to operate separately from the individual entitlement to a basic core of health care services provided under section 27(1)(a).<sup>80</sup> The particular basic core, in this case, was the provision of the anti-retroviral drug, nevirapine, required by HIV positive pregnant women to reduce mother-to-child-transmission (“MTCT”) of HIV.<sup>81</sup> The *amici* argued that if only section 27(2) were to provide for the positive duties imposed on the State, then nothing definite could be claimed from the State directly by rights holders.<sup>82</sup> The rights-holders would only have a right to a reasonable measure in place to progressively realise their rights within available resources. The Court rejected this argument and held that section 27(1)(a) is defined and limited by section 27(2).<sup>83</sup>

In both cases, the Court held that the formulation of the text in sections 26 and 27 did not support the endorsement of a minimum core standard.<sup>84</sup> In addition to this textual objection, the Court also objected on the ground that practically a provision of a minimum core was unrealistic.<sup>85</sup> Furthermore, the Court held that its institutional competence did not allow it to determine a minimum core standard.<sup>86</sup>

In *Mazibuko v City of Johannesburg*<sup>87</sup> (“*Mazibuko*”) the Court was approached by the residents of Phiri alleging that the policy providing free six kilolitres of water per household per month was impugning on the right to sufficient water under section 27(1)(b) of the Constitution. The Water Services Act 108 of 1997 defined “basic water supply” as quality water as necessary to support life and hygiene.<sup>88</sup> The Court avoided substantive engagement with the right and held that it was inappropriate for them to

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<sup>79</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 149.

<sup>80</sup> 2002 5 SA 721 (CC) para 26.

<sup>81</sup> Para 26.

<sup>82</sup> S Liebenberg “The Interpretation of Socio-Economic Rights” in S Woolman et al (eds) *Constitutional Law of South Africa* 2ed (OS 3 2012) 33-1 24.

<sup>83</sup> 2002 5 SA 721 (CC) para 39.

<sup>84</sup> 32; *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 95.

<sup>85</sup> *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC) para 35.

<sup>86</sup> Paras 37-38.

<sup>87</sup> 2010 4 SA 1 (CC).

<sup>88</sup> Para 22.

determine what a sufficient quantity of water is.<sup>89</sup> The Court held that the argument for such a determination must fail on the same grounds that the minimum core failed in *Grootboom* and *TAC*.<sup>90</sup> The Court thus declined to determine what a sufficient quantity of water is because, in line with the reasoning of *Grootboom* and *TAC* in this regard, of the text of the Constitution and the role of the Courts.<sup>91</sup>

The rejection of the minimum core concept has been subject to much criticism, and a thorough engagement thereof is beyond the scope of this study. Briefly, the minimum core concept arguably contains potential to guide the allocation, appropriation and distribution of resources.<sup>92</sup> Pieterse and Liebenberg hold that the urgent material needs of the vulnerable could be prioritised through the application of minimum core standards.<sup>93</sup> Similarly, Roux argues that the Court failed to prioritise the vulnerable groups' basic needs by rejecting the minimum core concept.<sup>94</sup> Bilchitz interprets the concept of the minimum core as setting a standard for provision to meet needs.<sup>95</sup> He disagrees with the Court in *Grootboom* that because needs differ it is too difficult to determine a minimum core. He elaborates that differing needs are a result of different abilities to access rights and therefore varying degrees of assistance is required.<sup>96</sup>

Bilchitz recognises two ways in which the minimum core concept can be understood: the principled minimum core and the pragmatic minimum core.<sup>97</sup> The principled minimum core consists of the "minimum basic resources necessary to allow individuals to survive and achieve a minimal level of well-being".<sup>98</sup> This approach is difficult regarding health care because the same benchmarks for essential needs

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<sup>89</sup> Paras 52, 56.

<sup>90</sup> Para 55.

<sup>91</sup> Para 56.

<sup>92</sup> M Pieterse *Can Rights Cure?* (2014) 115.

<sup>93</sup> 22; S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 172-173.

<sup>94</sup> T Roux "Understanding *Grootboom*: A Response to Cass Sunstein" (2002) 12 *Constitutional Forum* 41 47.

<sup>95</sup> D Bilchitz "Giving Socio-Economic Rights Teeth: Minimum Core and Its Importance" (2002) 118 *SALJ* 484 487.

<sup>96</sup> 488-489.

<sup>97</sup> D Bilchitz "Health" in S Woolman et al (eds) *Constitutional Law of South Africa* 2 ed (OS 5 2012) 56A-1 31.

<sup>98</sup> 31.

cannot be set as with, for example, food.<sup>99</sup> It can be determined what an individual needs regarding food for survival, but problems arise in applying the same approach to health care. Firstly, the costs are undeterminable.<sup>100</sup> Additionally, “focusing expenditure purely on health-care services that meet survival needs can be self-defeating”<sup>101</sup> as other rights’ resources will be implicated, affecting the standard of living and health status.<sup>102</sup> However, Bilchitz argues that a failure to focus on a principled minimum core could detract from the urgency of individuals health interests.<sup>103</sup> He also notes that the principled minimum core is not determined in a vacuum and can, therefore, at least, aid in developing practical standards for State action.<sup>104</sup> A pragmatic understanding minimum core consists of the principled minimum core plus other theoretical considerations.<sup>105</sup> A pragmatic approach would allow for a context-sensitive approach and arguably coincides with the Courts’ view that the minimum core can be used to inform reasonableness.

Section 27(1)(a) read with (2) does not impose a minimum core obligation on the State. The Court has emphasised that section 27(1)(a) does not provide a direct entitlement exempt from section 27(2) qualifications. The possibility remains for using minimum core standards to assess the reasonableness of measures taken by the State.

### 3 4 2 The obligation to take reasonable legislative and other measures

Section 27(2) requires measures taken by the State, legislative and other, to be reasonable. This obligation specifically mentions legislative measures. Legislation is crucial for effectively realising rights as it can provide a more detailed elaboration of the scope of the relevant right, and the programmes and institutional mechanisms through which the right will be fulfilled, including the obligations of various role-players

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<sup>99</sup> 31.

<sup>100</sup> 32.

<sup>101</sup> 32.

<sup>102</sup> 32-33.

<sup>103</sup> 33.

<sup>104</sup> 34.

<sup>105</sup> 34.

in the sector. It can also facilitate the protection and realisation of the right through, for example, regulating the private health care sector.<sup>106</sup> Legislation can make provision for immediate needs as well as progressive realisation. It can manage the accumulation and distribution of resources in a manner which is equitable and in favour of transformation.

In *Grootboom*, the Court held that the obligation on the State to provide access to housing includes enabling, through legislation and other measures, members of society to access housing.<sup>107</sup> In *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd*<sup>108</sup> (“*Blue Moonlight*”) the Court, relying on *Grootboom*, held:

“[W]ithout a national policy to get the ball rolling from a legislative and budgetary perspective, it would be impossible for the other spheres of government to do anything meaningful.”<sup>109</sup>

Legislation and policy have an important role in facilitating the realisation of socio-economic rights. In both *Minister of Health v New Clicks South Africa (Pty) Ltd*<sup>110</sup> (“*New Clicks*”) and *Law Society*, the Court scrutinised the regulatory framework to determine whether it hindered access to the right to health care. In *New Clicks*, the Court held that the regulations seeking to regulate the dispensing fees of pharmacies were aimed at the realisation of section 27(1)(a).<sup>111</sup> The right of access to health care includes the right of access to medicines.<sup>112</sup> The Court articulated that the State has a constitutional

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<sup>106</sup> S Liebenberg “The Protection of Economic, Social and Cultural Rights in Domestic Legal Systems” in A Eide, C Krause & A Rosas (eds) *Economic, Social and Cultural Rights* (2001) 55 79.

<sup>107</sup> 2001 1 SA 46 (CC) para 35.

<sup>108</sup> 2012 2 SA 104 (CC).

<sup>109</sup> Para 56.

<sup>110</sup> 2006 2 SA 311 (CC).

<sup>111</sup> Paras 1, 16.

<sup>112</sup> Paras 14, 16, 18. Regarding access to medicines see Department of Trade and Industry *Draft Intellectual Property Policy of the Republic of South Africa Phase I* (2017). The objective of this policy is, *inter alia*, to promote public health through making medicines more accessible. It seeks to balance interests regarding patents of medicines and the right of access to health care which includes access to medicines. See also J Berger & A Prabhala “Draft Patent Policy a Vital Step for Increasing Access to Medicines” *Business Day* 16-08-2017



obligation to make medicines more affordable, in order not to “frustrate access to quality health care.”<sup>113</sup> The fixed dispensing fee would, however, impact on rural and courier pharmacies as the monetary reduction would hinder their ability to serve rural communities.<sup>114</sup> The regulations would thus have the effect of limiting access for the people dependent on rural and courier pharmacies. These regulatory efforts to curb pharmaceutical profit margins were declared unconstitutional, primarily on the principle of legality in administrative law.<sup>115</sup> Pieterse contends that the judgment suggests that the profit regulation would be constitutional but for the negative impact on access for rural communities and the administrative defects.<sup>116</sup> He argues regulations seeking to make health care more accessible would pass constitutional scrutiny.<sup>117</sup>

In *Law Society*, the constitutionality of a regulation regarding access to medical treatment was challenged.<sup>118</sup> Regarding the regulation, the RAF was obliged to compensate road accident victims as per the Uniform Patient Fee Schedule (“UPFS”).<sup>119</sup> The limitation on compensation consequentially rendered paraplegic and quadriplegic victims unable to access medical treatment as the public sector could not adequately accommodate their needs, and the private sector prices surpassed the compensation received. The Constitutional Court found that the regulation infringed on section 27(1)(a) read with (2) as it limited access to health care services for paraplegic and quadriplegic victims and scaled back on their existing access.<sup>120</sup> Although the purpose of the regulations and compensation was to facilitate access to

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<https://www.businesslive.co.za/bd/opinion/2017-08-16-draft-patent-policy-a-vital-step-for-increasing-access-to-medicines/> (accessed 21 August 2017).

<sup>113</sup> 2006 2 SA 311 (CC) para 714.

<sup>114</sup> Paras 19, 556.

<sup>115</sup> Para 22.

<sup>116</sup> M Pieterse *Can Rights Cure?* (2014) 72.

<sup>117</sup> 72-73.

<sup>118</sup> Regulation 5(1) of July 2008 under s17(4B) of the Road Accident Fund Act 56 of 1996.

<sup>119</sup> The Uniform Patient Fee Schedule provides for the amounts needed to cover the costs of treatment in the public sector, Government Notice no 770 of 21 July 2008 in Government Gazette 31249.

<sup>120</sup> 2011 1 SA 400 (CC) para 135.

health care, the regulation unreasonably breached the right as the UPFS restricted access for these victims.<sup>121</sup>

These cases illustrate the need for regulatory measures to facilitate access to health care. Legislative and other measures can create barriers to access to health care, but can also enhance access. Pieterse contends that despite such attempts to regulate profit margins, there is a significant lack of legislation aimed at ensuring equal and adequate access to health care.<sup>122</sup> The current legislative framework is insufficient for providing universal access to quality health care for all. It is however not enough for the State simply to enact legislation or provide measures; these must be reasonable and comply with the obligation to take reasonable legislative and other measures. Reasonableness is the overarching standard of evaluation for the positive duties imposed by socio-economic rights in terms of sections 26(2) and 27(2). The following part proceeds to examine the nature of the reasonableness standard.

### 3 4 2 1 *The reasonableness standard*

The Constitutional Court has adopted reasonableness as a model of review for assessing measures taken by the State. In *Soobramoney v Minister of Health (Kwa-Zulu Natal)*<sup>123</sup> (“*Soobramoney*”), the Court considered the rationality of the treatment guidelines dictating the use of renal dialysis machines which disqualified persons suffering from heart problems or chronic conditions.<sup>124</sup> The appellant had diabetes and suffered from ischaemic heart disease and was therefore denied access to treatment.<sup>125</sup> The Court held that the treatment guidelines had not been applied unfairly or irrationally and were conceived by authorities more competent than the Court on the use of resources.<sup>126</sup>

In *Grootboom* the Constitutional Court departed from the rationality standard applied in *Soobramoney*. In rejecting the minimum core standard of review, the Court

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<sup>121</sup> Para 135.

<sup>122</sup> M Pieterse “Legislative and Executive translation of the Right to Have Access to Health Care Services” (2010) 14 *Law, Democracy and Development* 231 238.

<sup>123</sup> 1998 1 SA 865 (CC).

<sup>124</sup> Para 1.

<sup>125</sup> Para 1.

<sup>126</sup> Paras 25, 29-30.

opted for enquiring if the measures taken by the State were reasonable.<sup>127</sup> The following sections will elaborate on the factors of reasonableness.

#### *3 4 2 2 Facilitating the realisation of the right*

A measure will be reasonable if it can facilitate the realisation of the right.<sup>128</sup> In *Grootboom* the Court emphasised that an assessment of reasonableness will not “enquire whether other more desirable or favourable measures”<sup>129</sup> exist, but will only enquire if the adopted measure is reasonable. The Court recognises that obligations can be met through a number of different measures and that more than one of these could be reasonable.<sup>130</sup> In *TAC* it was held that the measure denied by the State (the administration of the anti-retroviral nevirapine) was capable of facilitating the right of access to health care and is a “simple, cheap and potentially lifesaving medical intervention.”<sup>131</sup>

#### *3 4 2 3 Measures must be reasonable in conception and implementation*

A measure must be reasonable in its conception and implementation.<sup>132</sup> In *Grootboom* it was held that it is not just the formulation of a measure that must meet the standard of reasonableness, but also the implementation thereof.<sup>133</sup> Furthermore, reasonableness recognises the different spheres of government and the separation of powers.<sup>134</sup> Accordingly, a comprehensive, co-ordinated measure requires that each “sphere of government must accept responsibility for the implementation of particular parts of the programme” but that the national sphere of government assumes the

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<sup>127</sup> 2001 1 SA 46 (CC) para 33.

<sup>128</sup> Para 41.

<sup>129</sup> Para 41.

<sup>130</sup> Para 41.

<sup>131</sup> 2002 5 SA 721 (CC) para 73.

<sup>132</sup> 2001 1 SA 46 (CC) paras 40-43.

<sup>133</sup> Para 42; 2002 5 SA 721 (CC) para 50.

<sup>134</sup> 2001 1 SA 46 (CC) para 39.

ultimate responsibility of discharging the obligations imposed by socio-economic rights.<sup>135</sup>

#### 3 4 2 4 *Measures must be comprehensive, co-ordinated and transparent*

Reasonableness requires measures to be comprehensive, co-ordinated and transparent.<sup>136</sup> In *TAC* the Court explicitly declared that section 27(1) read with (2) requires “the government to devise and implement within its available resources a comprehensive and co-ordinated programme”.<sup>137</sup> In this case, the State policy which restricted access to the anti-retroviral, nevirapine, was held to be unreasonable for two reasons. Firstly, the needs of the vulnerable, poor HIV positive pregnant women and new-born babies, were not adequately considered under the rigid policy.<sup>138</sup> Secondly, the rigid policy restricting access to nevirapine implicated the whole MTCT of HIV policy, and thus the State was held to have failed in developing a comprehensive MTCT of HIV prevention plan.<sup>139</sup> The Court provided:

“In order for it to be implemented optimally, a public health programme must be made known effectively to all concerned, down to the district nurse and patients. Indeed, for a public programme such as this to meet the constitutional requirement of reasonableness, its contents must be made known appropriately.”<sup>140</sup>

Reasonableness thus also requires transparency.<sup>141</sup> This case illustrates that courts will not direct the government to implement specific programmes but will only assess the measures taken or programmes adopted for the reasonableness.<sup>142</sup>

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<sup>135</sup> Para 40.

<sup>136</sup> Paras 39, 40; 2002 5 SA 721 (CC) para 123.

<sup>137</sup> 2002 5 SA 721 (CC) para 135.

<sup>138</sup> Para 81.

<sup>139</sup> Paras 82, 95.

<sup>140</sup> Para 123.

<sup>141</sup> See also *Minister of Health v New Clicks South Africa (Pty) Ltd* 2006 2 SA 311 (CC) paras 627, 634-637 and 666 where Sachs J, in a minority concurring judgment, considered the reasonableness of the contested regulations.

<sup>142</sup> S Liebenberg “The Interpretation of Socio-Economic Rights” in S Woolman et al (eds) *Constitutional Law of South Africa* 2ed (OS 3 2012) 33-1 38.

Accordingly, the State has a margin of discretion in facilitating the realisation of socio-economic rights.

*3 4 2 5 Measures must be balanced and flexible, and provide for human and financial resources*

In *Grootboom* the Court held that balance and flexibility require the measure to be considered in the social, economic and historical context.<sup>143</sup> The institutional capacity for those responsible for implementation is also considered.<sup>144</sup> In *TAC* the Court, in finding the measure to be excessively rigid, held that flexibility means that a policy can change at any time as needed.<sup>145</sup> Balance also incorporates the roles of the different spheres of government as examined above.<sup>146</sup>

To meet the requirement of reasonableness, the measure must make the necessary financial and human resources available for implementation of the measure.<sup>147</sup> In *TAC* the financial resources were available to the state.<sup>148</sup> The Court held that by limiting the availability of such an important drug when it was within available resources breached the state's obligations under section 27(2).<sup>149</sup> The obligation to realise the right "within available resources" will be analysed below.

*3 4 2 6 Short, medium and long-term needs, emergencies and the vulnerable must be provided for*

To be reasonable, a measure must provide for short, medium and long-term needs.<sup>150</sup> It may not exclude a section of the population and must be responsive to emergency situations and those in desperate need.<sup>151</sup> In *Grootboom*, the Court held:

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<sup>143</sup> 2001 1 SA 46 (CC) para 43.

<sup>144</sup> Para 43.

<sup>145</sup> 2002 5 SA 721 (CC) para 114.

<sup>146</sup> Para 38.

<sup>147</sup> 2001 1 SA 46 (CC) para 39.

<sup>148</sup> 2002 5 SA 721 (CC) para 71.

<sup>149</sup> Para 80.

<sup>150</sup> Para 43.

<sup>151</sup> 2001 1 SA 46 (CC) paras 44, 64, 68, 99; 2002 5 SA 721 (CC) para 78.

“To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right.”<sup>152</sup>

It was on this basis that the government’s housing programme failed. The housing programme did not provide short-term relief for those in desperate need.<sup>153</sup> Similarly, in *TAC* the Court emphasised the desirability of making nevirapine available to those who urgently need it.<sup>154</sup> Therefore is it fundamental that for a measure to be reasonable, it must make provision for those in immediate need and the most vulnerable.<sup>155</sup>

### 3 4 2 7 *Non-discrimination*

In *Khosa v The Minister of Social Development*<sup>156</sup> (“*Khosa*”) the Court held that for a measure to be reasonable it could not unfairly discriminate against a group on a prohibited ground of discrimination in terms of section 9 of the Constitution.<sup>157</sup> The Court held that the standard of reasonableness went further than an inquiry into rationality.<sup>158</sup> Thus, a rational basis for the criteria of allocating welfare that does not mean the criteria is not unfairly discriminatory.<sup>159</sup> Citizenship is not a listed ground of differentiation under section 9(3) of the Constitution. However, the Court found the legislation<sup>160</sup> limiting access to social assistance grants to South African Citizens to be unfairly discriminatory due to the adverse impact on the dignity of the people affected.<sup>161</sup> Therefore, for a programme or measure to be reasonable, it cannot

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<sup>152</sup> 2001 1 SA 46 (CC) para 44.

<sup>153</sup> Para 99.

<sup>154</sup> 2002 5 SA 721 (CC) para 131.

<sup>155</sup> 2001 1 SA 46 (CC) paras 44, 64, 68, 99; 2002 5 SA 721 (CC) para 78.

<sup>156</sup> 2004 6 SA 505 (CC).

<sup>157</sup> Para 68.

<sup>158</sup> Para 67.

<sup>159</sup> Para 67.

<sup>160</sup> Social Assistance Act 59 of 1992 and the Welfare Laws Amendment Act 106 of 1997.

<sup>161</sup> 2004 6 SA 505 (CC) para 72.

discriminate unfairly against certain groups<sup>162</sup> nor can it, as held in *TAC* and *Mazibuko*, restrict or exclude groups of people.<sup>163</sup>

### 3 4 2 8 *Participation and meaningful engagement*

The State is obliged to meaningfully engage with communities and stakeholders for policy development to be considered reasonable.<sup>164</sup> Liebenberg holds that meaningful engagement can promote contextual sensitivity.<sup>165</sup> She argues that this could facilitate participation with communities through stimulating systemic administrative and political reform.<sup>166</sup> This pertains to all levels of government.<sup>167</sup>

### 3 4 2 9 *Conclusion on reasonableness*

The jurisprudence has developed significantly since *Soobramoney*.<sup>168</sup> Liebenberg argues that the lack of substantive engagement with the normative content of section 27(1)(a) in *Soobramoney* was a missed opportunity by the Court to use socio-

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<sup>162</sup> *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) paras 66, 78, 95; *Khosa v Minister of Social Development* 2004 6 SA 505 (CC) para 67.

<sup>163</sup> *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC) paras 69, 122; *Mazibuko v City of Johannesburg* 2010 4 SA 1 (CC) paras 65, 67.

<sup>164</sup> C Chenwi “‘Meaningful Engagement’ in the Realisation of Socio-Economic Rights: The South African Experience” (2011) 26 *SAPL* 128 135. See also *Occupiers of 51 Olivia Road Berea Township and 197 Main Street Johannesburg v City of Johannesburg* 2008 2 SA 208 (CC) para 17; *Residents of Joe Slovo Community, Western Cape v Thubelisha Homes* 2010 3 SA 454 (CC) para 378; *Mazibuko v City of Johannesburg* 2010 4 SA 1 (CC) paras 133-134. See also A E Yamin “Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage” (2017) 39 *Human Rights Quarterly* 341 356.

<sup>165</sup> S Liebenberg “Engaging the Paradoxes of Universal and Particular in Rights Adjudication: The Possibilities and Pitfalls of Meaningful Engagement” (2012) 12 *AHRLJ* 1 26.

<sup>166</sup> 26. See also C Chenwi “‘Meaningful Engagement’ in the Realisation of Socio-Economic Rights: The South African Experience” (2011) 26 *SAPL* 128 129.

<sup>167</sup> *Occupiers of 51 Olivia Road Berea Township and 197 Main Street Johannesburg v City of Johannesburg* 2008 2 SA 208 (CC) para 17-18.

<sup>168</sup> C Ngwenya “The Historical Development of the Modern South African Healthcare System: From Privilege to Egalitarianism” (2004) 37 *De Jure* 290 309.

economic rights in pursuit of transformation.<sup>169</sup> Pieterse describes the *Soobramoney* judgement as “clothed in defeatism”<sup>170</sup> because it implied that the right and the Court was not able to address the inequalities of the health care system and the needs of the poor.<sup>171</sup> Although critical of reasonableness review’s lack of substantive engagement with the content of rights, Pieterse praises the standard of review for the way it balances tensions between the judiciary, legislature and executive.<sup>172</sup> Reasonableness provides courts with tools to evaluate measures taken by the State without appropriating the role of translating the right and implementation from the legislature and executive.<sup>173</sup>

The distinctive set of criteria developed by the Court for assessing reasonableness can be applied in the development of health care policy and legislation. In chapter six the NHI scheme will be evaluated for its reasonableness through an application of these criteria as well as the other obligations imposed by section 27. The next section discusses the specific obligations of “progressive realisation” and “within available resources” provided for in section 27(2).

### 3 4 3 The obligation to progressively realise the right of access to health care

#### 3 4 3 1 *Progressive realisation and resource constraints*

Section 27(2) obliges the State to realise the right of access to health care progressively. This obligation reflects an understanding of the constantly changing socio-economic circumstances within the country. Progressive realisation requires constant review and development.<sup>174</sup> It recognises that socio-economic rights such as

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<sup>169</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 139.

<sup>170</sup> M Pieterse *Can Rights Cure?* (2014) 65.

<sup>171</sup> 65.

<sup>172</sup> 53.

<sup>173</sup> 53.

<sup>174</sup> *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 43; *Mazibuko v City of Johannesburg* 2010 4 SA 1 (CC) para 40.



health care are not always immediately realisable and that it takes time to facilitate meaningful access to health care.<sup>175</sup>

In *Soobramoney* the Court held that progressive realisation is dependent on resources.<sup>176</sup> It held that the resources available influenced the time in which the State could facilitate the realisation of access to health care.<sup>177</sup> In *Grootboom* the Court recognised that the realisation of socio-economic rights cannot happen immediately and thus progressive realisation acts as a limitation on the pace of fulfilment.<sup>178</sup> It acknowledged that article 2 of the International Covenant on Economic, Social and Cultural Rights<sup>179</sup> (“ICESCR”) influences this obligation. The Court held that there is no reason not to afford it the same meaning as the Committee affords to article 2 since it is in harmony with the Constitution.<sup>180</sup> Progressive realisation was interpreted as an obligation to reduce barriers to access to housing.<sup>181</sup> Compliance with this obligation requires a plan to be in place indicating how to realise the right over time.

In *Mazibuko* the Court held that progressive realisation requires that State policies be subject to constant review and revision.<sup>182</sup> *In casu*, the City’s policy was under constant review and was revised and therefore found to comply with the obligation of progressive realisation.<sup>183</sup> In *New Clicks* the Court considered the obligation to realise the right of access to health care progressively.<sup>184</sup> Ngcobo J (as he then was) held that the regulations in question sought to realise the right of access to health care progressively and although the interests of the pharmacists are to be considered, they must yield to the interests of the public in the light of this constitutional obligation.<sup>185</sup>

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<sup>175</sup> C Ngwenya “Access to Health Care Services as a Justiciable Socio-Economic Right under the South African Constitution” (2003) 6 *Medical Law International* 13 17.

<sup>176</sup> 1998 1 SA 865 (CC) para 11.

<sup>177</sup> Para 43.

<sup>178</sup> *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 45.

<sup>179</sup> Para 45; International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3; see chapter four part 3.3.

<sup>180</sup> *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 45.

<sup>181</sup> Para 45.

<sup>182</sup> 2010 4 SA 1 (CC) paras 40, 67.

<sup>183</sup> Para 40.

<sup>184</sup> 2006 2 SA 311 (CC) para 519.

<sup>185</sup> Para 519.

Progressive realisation does not, however, negate any immediate obligations imposed upon the State. Aspects of the right to health care which are immediately realisable, such as non-discrimination, are to be given immediate effect. The concept of progressive realisation cannot justify failure to fulfil obligations.<sup>186</sup> Liebenberg argues that progressive realisation is both a sword and a shield in that the State is obliged to take deliberate, concrete and targeted steps to meet the basic needs of all and show measurable progress in doing so.<sup>187</sup>

Furthermore, when seeking to realise the right of access to health care progressively, immediate steps are to be taken, especially to address the needs of the most vulnerable.<sup>188</sup> Bilchitz maintains that the State is obliged to ensure the meeting of everyone's urgent needs while at the same time also taking measures to improve the standard of provision over time.<sup>189</sup> He contends that progressive realisation does not mean that some have a direct entitlement while others do not, but that everyone "is entitled as a matter of priority" to a minimum core of rights which the State is required to improve over time.<sup>190</sup> According to Pieterse, progressive realisation requires removing barriers over time and striking a balance between the short, medium and long-term needs of people.<sup>191</sup>

The obligation to progressively realise socio-economic rights is context and resource sensitive, without disregarding the immediate needs of the vulnerable. It requires the State to have a comprehensive plan, cognisant of all needs, barriers and competing interests.

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<sup>186</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 189.

<sup>187</sup> S Liebenberg "The Right to Social Assistance: The Implications of Grootboom for Policy Reform in South Africa" (2001) 17 *SAJHR* 232 252.

<sup>188</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 187.

<sup>189</sup> D Bilchitz "Towards a Reasonable Approach to The Minimum Core: Laying the Foundations for the Future of Socio-Economic Rights Jurisprudence" (2003) 19 *SAJHR* 1 11.

<sup>190</sup> D Bilchitz *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (2007) 193.

<sup>191</sup> M Pieterse *Can Rights Cure?* (2014) 116.

### 3 4 3 2 *Presumption against retrogressive measures*

In *Grootboom* the Court endorsed the Committee's understanding of progressive realisation, which includes that retrogressive measures are not permissible unless sufficiently justified.<sup>192</sup> Retrogressive measures are those which scale back on current access to or enjoyment of the right. One of the issues in *Mazibuko* was whether the introduction of prepaid meters amounted to a retrogressive measure.<sup>193</sup> The Court held that to determine if the measure was retrogressive, it had to be compared to the measures in place before it.<sup>194</sup> The Court decided that the comparison was to be made on the assumption that all accounts are paid.<sup>195</sup> The Court compared the cost of 20 kilolitres per house per month under the old flat rate system, under the new prepaid meter system, and under the new prepaid meter system but where households were on the indigent register.<sup>196</sup> The tariff under the prepaid meters was cheaper than the flat rate, and the Court concluded that it, therefore, could not be considered a retrogressive step.<sup>197</sup> However, the Court may have erred in this conclusion as it failed to acknowledge that many people could not afford to pay their accounts. The comparison used to determine if the measures were retrogressive did not consider the circumstances and needs of the people holistically. Retrogression needs to be determined within the context of all socio-economic circumstances.

In *Law Society*, the Court grappled with regulatory measures and subsequent retrogressive effects. The constitutionality of a regulation was challenged due to the restrictive impact it would have on motor vehicle accident victims rendered paraplegic or quadriplegic.<sup>198</sup> The applicants argued that the retrogressive effect was that these victims were previously compensated sufficiently to cover private treatment but under the regulation were only compensated to be treated in the public sector.<sup>199</sup> The Court found that the regulation infringed on section 27(1)(a) read with (2) as it limited access

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<sup>192</sup> 2001 1 SA 46 (CC) para 45.

<sup>193</sup> 2010 4 SA 1 (CC) para 105.

<sup>194</sup> Para 183.

<sup>195</sup> Para 183.

<sup>196</sup> Para 140.

<sup>197</sup> Para 142.

<sup>198</sup> 2011 1 SA 400 (CC) pars 100, 108.

<sup>199</sup> Para 87.

to health care services for paraplegic and quadriplegic victims and scaled back on their existing access.<sup>200</sup> Scaling back on existing access to health care services under these circumstances was not permitted because the public sector was not able to provide adequate care for these victims.

When determining whether a measure may be retrogressive, it is necessary to decide whether to assess the impact in terms of the entire population, or only in terms of individuals or specific groups.<sup>201</sup> If assessed in terms of the entire population, the State would not be obliged to justify the retrogressive impacts on individuals or specific groups if the whole population is better off as a result of the measure taken.<sup>202</sup> The converse would apply when assessing retrogression in terms of individuals or specific groups.<sup>203</sup> Liebenberg argues:

“The concern with regard to a presumption against retrogression in favour of individuals or groups is that it can obstruct redistributive measures which reduce or even eliminate the benefits received by more advantaged groups in order to achieve a more equitable distribution of benefits.”<sup>204</sup>

Arguably, the impact of retrogression should favour the vulnerable or disadvantaged. For example, if the private health care sector were to be more accessible, there would be a retrogressive consequence as those with current access would now be diluted into a bigger patient pool, affecting *inter alia* doctor-to-patient ratios. If the entire population, most of which do not have adequate access to health care, were to benefit from such a retrogressive measure, then an approach focusing on the impact of the whole population would be more appropriate. This would not require the State to justify the retrogressive measures, although a justification based on constitutional goals and objectives would carry considerable weight. On the other hand, as the Court held in *Grootboom*, advancements in the realisation of socio-economic rights will not be reasonable if the measures taken do not consider all

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<sup>200</sup> Para 135.

<sup>201</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 189.

<sup>202</sup> 189.

<sup>203</sup> 189.

<sup>204</sup> 190.

affected with due care.<sup>205</sup> However, similarly to *Law Society*, the circumstances from which that argument arose concerned a vulnerable group, not an advantaged group with adequate means and access.

Progressive realisation and the presumption against retrogressive measures require the State, on the one hand, to move as expeditiously as possible to realise the right while, on the contrary, not scaling back on existing access without justification. As highlighted above, the obligation to progressively realise the right is resource-dependent. The following part proceeds to examine the role of resource availability in the realisation of the right of access to health care.

#### 3 4 4 The obligation to realise the right “within available resources”

The State is obliged to realise the right of access to health care within its available resources. Resources include finances, facilities, equipment, medicines, information, technology and human resources.<sup>206</sup> As articulated by Mohamed DP in *Azanian Peoples Organisation v President of the Republic of South Africa*:<sup>207</sup>

“The resources of the state have to be deployed imaginatively, wisely, efficiently and equitably, to facilitate the reconstruction process in a manner which best brings relief and hope to the widest sections of the community, developing for the benefit of the entire nation the latent human potential and resources of every person who has directly or indirectly been burdened with the heritage of the shame and pain of our racist past.”<sup>208</sup>

This obligation concerns resource availability, resource appropriation, and resource distribution.<sup>209</sup> These three facets determine the extent to which the right of access to health care is realised. In *Soobramoney*, the Court was aware that if the treatment was provided to the appellant then all those similarly placed would also be entitled to

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<sup>205</sup> 2001 1 SA 46 (CC) para 44.

<sup>206</sup> R E Robertson “Measuring State Compliance with the Obligation to Devote the ‘Maximum Available Resources’ to Realising Economic, Social and Cultural Rights” (1994) 16 *Human Rights Quarterly* 693 697; M Pieterse *Can Rights Cure?* (2014) 77.

<sup>207</sup> 1996 4 SA 672 (CC).

<sup>208</sup> Para 43.

<sup>209</sup> M Pieterse *Can Rights Cure?* (2014) 77.

treatment.<sup>210</sup> It thus held that in managing limited resources, the State might be required to favour the larger needs of society over individual needs.<sup>211</sup> The case reflects the challenge of seeking to fulfil the constitutional promise of access to health care within limited resources.<sup>212</sup> The Court deferred to the existing budget and resources over the potential interpretation that the State must make resources available for the realisation of socio-economic rights.<sup>213</sup>

In *Grootboom* the Court emphasised that the State is not required to go beyond what is possible within available resources and held:

“There is a balance between goals and means. The measures must be calculated to attain the goal expeditiously and effectively but the availability of resources is an important factor in determining what is reasonable.”<sup>214</sup>

The availability of resources also determines the speed at which the State is obliged to fulfil its obligations.<sup>215</sup> The State can raise limited resources as a defence for failing to realise a socio-economic right.<sup>216</sup> In *TAC* the resources were available. The manufacturers of the anti-retroviral, nevirapine, were willing to supply the South African Government for free for five years.<sup>217</sup> The Court held that to extend testing, counselling and treatment facilities was not an insurmountable task and thus that the administration of the drug was within available resources.<sup>218</sup> The potential life-saving impact of the medicine on the vulnerable group outweighed the cost and capacity arguments made by the State.<sup>219</sup>

In *Khosa* the Court found that in the light of the overall welfare budget, that the extension of these grants to the non-citizens was minor and thus limited resources

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<sup>210</sup> 1998 1 SA 865 (CC) para 28.

<sup>211</sup> Para 31.

<sup>212</sup> Para 40.

<sup>213</sup> Para 40.

<sup>214</sup> 2001 1 SA 46 (CC) para 46.

<sup>215</sup> Para 46.

<sup>216</sup> S Liebenberg “The Interpretation of Socio-Economic Rights” in S Woolman et al (eds) *Constitutional Law of South Africa* 2ed (OS 3 2012) 33-1 44.

<sup>217</sup> 2002 5 SA 721 (CC) para 19.

<sup>218</sup> Para 95.

<sup>219</sup> Paras 90-21, 115-120.

was not a reason to deny doing so.<sup>220</sup> In *Blue Moonlight* the City argued that only the resources budgeted for were available resources.<sup>221</sup> Unanimously the Court rejected this argument and held:

“This Court’s determination of the reasonableness of measures within available resources cannot be restricted by budgetary and other decisions that may well have resulted from a mistaken understanding of constitutional obligations or statutory obligations. In other words, it is not good enough for the City to state that it has not budgeted for something, if it should indeed have planned and budgeted for it in the fulfilment of its obligations.”<sup>222</sup>

Thus, budgets may be scrutinised for reasonableness, and available resources extend beyond only those in the budget.<sup>223</sup>

In South Africa, the divide between the private health care sector and the public health care sector distorts the representation of resources available. The private sector has far more and better resources than the public sector, despite only serving 16% of the population.<sup>224</sup> This brings into question whether available resources include private sector resources. Bilchitz argues that private resources are included under this obligation, especially when resources in the public sector have been exhausted.<sup>225</sup> *Law Society* arguably supports Bilchitz’s argument that available resources are inclusive of private resources where public resources are depleted, or as in this case, inadequate.<sup>226</sup> The State is required to provide evidence that all resources are utilised to their full potential in giving effect to the right.<sup>227</sup>

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<sup>220</sup> 2004 6 SA 505 (CC) para 82.

<sup>221</sup> 2012 2 SA 104 (CC).

<sup>222</sup> Para 74.

<sup>223</sup> See also A E Yamin “Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage” (2017) 39 *Human Rights Quarterly* 341 361.

<sup>224</sup> See chapter two part 4 2.

<sup>225</sup> D Bilchitz *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (2008) 228-230.

<sup>226</sup> 2011 1 SA 400 (CC) paras 100, 108.

<sup>227</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 197.

Bilchitz identifies three facets of the Court's approach to examining available resources.<sup>228</sup> Firstly, courts will consider existing budget allocations, as it did in *Soobramoney*. Secondly, courts would be more willing to reprioritise within an existing budget than to direct an increase. Lastly, a lack of resources will not hold as a sufficient defence where the affected group are vulnerable, where there is unfair discrimination or where there has been an infringement of human dignity.<sup>229</sup> The jurisprudence illustrates this last aspect. In *TAC*, the Court carefully considered whether the State had the resources and capacity to provide access to nevirapine outside the pilot sites. The interests of the vulnerable trumped the State's unsupported concerns of availability and safety of resources.<sup>230</sup> Similarly, in *Khosa*, the State's concerns over the budgetary changes required yielded to the interests of the vulnerable group that had been subject to unfair discrimination.<sup>231</sup>

In emphasising the transformative potential of socio-economic rights, Liebenberg argues that courts should look beyond the existing budget allocation when considering available resources.<sup>232</sup> She maintains that a failure to look beyond current allocations will hinder transformation and preserve existing inequalities.<sup>233</sup> Williams claims that budgetary limitations are not "facts of nature" but political choices.<sup>234</sup> Ngwenya observes that in *Soobramoney*:

"The court did not inquire into whether the state and the province were in fact according due priority to the realisation of the right sought by making available resources that *ought* to be available and utilising such resources effectively."<sup>235</sup>

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<sup>228</sup> D Bilchitz "Health" in S Woolman et al (eds) *Constitutional Law of South Africa* 2 ed (OS 5 2012) 56A-1 10-12.

<sup>229</sup> 10-12; *Khosa v Minister of Social Development* 2004 6 SA 505 (CC) para 82.

<sup>230</sup> 2002 5 SA 721 (CC) paras 78-79.

<sup>231</sup> 2004 6 SA 505 (CC) para 82.

<sup>232</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 195.

<sup>233</sup> 211.

<sup>234</sup> L Williams "Issues and Challenges in Addressing Poverty and Legal Rights: A Comparative United States/ South Africa Analysis" (2003) 21 *SAJHR* 436 438.

<sup>235</sup> C Ngwenya "The Historical Development of the Modern South African Health-care System: From Privilege to Egalitarianism" (2003) 37 *De Jure* 290 309, original emphasis.



Pieterse also argues for interrogation beyond the present state of affairs and criticises the “tragic reality” approach.<sup>236</sup> He holds that courts cannot simply view resource availability as a fact of nature. According to Pieterse, because health care is framed as a right in the Constitution, barriers to access, such as lacking resources, is not a tragic reality but a *prima facie* infringement.<sup>237</sup> The use of words such as “tragic reality” cannot exempt budgets from scrutiny.<sup>238</sup> Framing the lack of resources as just a “tragic reality” is problematic because it suggests that the Court cannot assess the broader socio-economic and fiscal context to determine if resources can and should be made available. The finding in *Blue Moonlight* supports the notion that courts are to engage beyond the allocated budget to address socio-economic inequalities and ensure that the constitutional promises do not have a “hollow ring”.<sup>239</sup>

The obligation thus extends into the realm of how the State prioritises socio-economic rights and addressing the grave inequalities in access to and quality of health care. In the light of these obligations, the NHI scheme, as a financing system, can be evaluated for its prioritisation of health care as a socio-economic right and its object of addressing inequalities in access to and quality of health care. This framework will be used in chapter six to determine the NHI scheme’s compliance with the constitutional and international law obligations. The analysis proceeds to the obligations imposed by children’s socio-economic rights and how they differ from those examined above.

### **3 5 Obligations imposed by children’s socio-economic rights**

The overlap between section 27(1) read with (2), and section 28(1)(c) creates confusion regarding whether children have a direct entitlement to socio-economic rights and whose responsibility it is to fulfil these rights. The jurisprudence has not

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<sup>236</sup> M Pieterse *Can Rights Cure?* (2014) 93.

<sup>237</sup> 98.

<sup>238</sup> M Pieterse “Health Care Rights, Resources and Rationing” (2007) 124 *SALJ* 514 517.

<sup>239</sup> *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 1 SA 865 (CC) para 8.

clarified the nature of the obligations imposed by children's socio-economic rights under section 28(1)(c).<sup>240</sup>

In *Grootboom* the applicants relied on children's right to shelter under section 28(1)(c). The High Court interpreted this provision with reference to a dictionary definition of shelter and concluded that section 28(1)(c) provided a right to protected from the elements without qualifications. It held that this created a derivative right for parents to maintain the family unit.<sup>241</sup> The Constitutional Court disagreed with this interpretation that children's socio-economic rights could trump the progressive realisation of socio-economic rights.<sup>242</sup> The Constitutional Court held that section 28(1)(c) had to be read with section 28(1)(b). Therefore, the obligations imposed by section 28(1)(c) rests primarily on parents, guardians or family and only alternatively on the State where such care is lacking.<sup>243</sup> The State is obliged to ensure that the legal and administrative infrastructure enables the caregivers to realise the socio-economic rights of the children.

The Court failed to consider the Convention on the Rights of the Child<sup>244</sup> ("CRC"), which provides elaboration on the relationship between sub sections 28(1)(b) and (c).<sup>245</sup> The CRC places obligations on parents regarding the upbringing and development of the child,<sup>246</sup> and, within their ability and means to do so, ensure living conditions suitable for the development of the child.<sup>247</sup> Chirwa argues that these

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<sup>240</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 235. See also *Governing Body of the Juma Masjid Primary School v Essay N.O.* 2011 8 BCLR 761 (CC) on children's right to education under section 29(1) of the Constitution.

<sup>241</sup> *Grootboom v Oostenberg Municipality* 2000 3 BCLR 277 (C).

<sup>242</sup> *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 77.

<sup>243</sup> Para 77.

<sup>244</sup> United Nations Convention on the Rights of the Child (adopted 30 November 1989 and entered into force 2 September 1990) 1577 UNTS 3. South Africa signed the Convention on the Rights of the Child in 1993 and ratified it in 1995. See chapter four part 3 5.

<sup>245</sup> L Stewart "The *Grootboom* Judgment, Interpretative Manoeuvring and Depoliticising Children's Rights" (2011) 26 *SAPL* 97 107.

<sup>246</sup> Art 18(1) United Nations Convention on the Rights of the Child (adopted 30 November 1989 and entered into force 2 September 1990) 1577 UNTS 3.

<sup>247</sup> Art 27(1).

articles support the notion that parents are primarily responsible for the realisation of children's socio-economic rights.<sup>248</sup> However, he cautions:

“The importance of parents to children's upbringing cannot be underestimated, but the acknowledgment of parental responsibility should in no way be interpreted as a claw-back clause on states' direct responsibilities towards children.”<sup>249</sup>

The State is not relieved of responsibility for fulfilment of children's socio-economic rights by the parental duty to also do so. The obligation to provide a framework enabling the realisation of section 28(1)(c) was held in *Grootboom* that the legislative and common law provisions that enforce maintenance obligations, parental protection and social welfare programmes.<sup>250</sup> Pieterse raised concerns about the burden this places on indigent families and that section 28(1)(c) did not provide relief from socio-economic hardships for the poor.<sup>251</sup>

TAC addressed these concerns. The Court confirmed the interpretation of *Grootboom* but extended it to recognise instances where the parents or family was unable to provide for the realisation of children's socio-economic rights.<sup>252</sup> The State's obligation to provide is thus not only triggered when there is physical separation of children from the family but also when the parents or family are unable to provide for their socio-economic needs. The Court held:

“The state is obliged to ensure that children are accorded the protection contemplated by section 28 that arises when the implementation of the right to parental or family care is lacking. Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means. They and their children are in the main dependent on the state to make health care services available to them.”<sup>253</sup>

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<sup>248</sup> D Chirwa *Child Poverty and Children's Rights of Access to Food and Basic Nutrition in South Africa* (2009) 11.

<sup>249</sup> 11.

<sup>250</sup> 2001 1 SA 46 (CC) paras 75, 78.

<sup>251</sup> M Pieterse “Reconstructing the Private/Public Dichotomy? The Enforcement of Children's Constitutional Social Rights and Care Entitlements” (2003) 19 *TSAR* 1 6.

<sup>252</sup> 2002 5 SA 721 (CC) para 79.

<sup>253</sup> Para 79.

The Court did not conclude that children have a direct entitlement to basic health care but used this interpretation of section 28(1)(c) to inform its finding of unreasonableness.<sup>254</sup> The children's needs were recognised as urgent because the lack of access to nevirapine would impact significantly on their life and well-being.<sup>255</sup> This recognition of vulnerability was also evident in *Khosa*. However, in *Khosa* the Court did not elaborate on the obligations imposed by children's socio-economic rights but merely held that children are deserving of special protection.<sup>256</sup>

In *Juma Musjid* the issue was whether children's right to education under section 29(1) created a direct entitlement to education. The Court held that Section 29(1) was immediately realisable and a limitation thereof, or failure to fulfil the right, could only be justified under section 36 of the Constitution.<sup>257</sup> Although this case concerned the right to education, the Court's interpretation of section 29(1) could be imposed on children's right to basic health care. Given the similarity in phrasing and lack of a linked qualifying provision, it could be argued by analogy that children's right to basic health care creates a direct entitlement such as section 29(1) did in *Juma Musjid*.<sup>258</sup>

Brand is critical of the approach of the Court in *Grootboom*.<sup>259</sup> He argues that the Court failed to recognise that alternative care may sometimes result in children being better off than in the care of their parents or family due to poverty.<sup>260</sup> According to Brand, the Court should have determined whether children's needs should "enjoy material priority".<sup>261</sup> Liebenberg recommends using children's rights in measures taken to address the needs of the vulnerable.<sup>262</sup> Children are considered vulnerable because of their developing capacities, both physical and emotional, their dependency

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<sup>254</sup> Para 78.

<sup>255</sup> Para 78.

<sup>256</sup> 2004 6 SA 505 (CC) para 86.

<sup>257</sup> 2011 8 BCLR 761 (CC) para 37.

<sup>258</sup> See chapter three part 2 2.

<sup>259</sup> D Brand *Courts, Socio-Economic Rights and Transformation policies* (Unpublished LLD Thesis, Stellenbosch University 2009) 145-146.

<sup>260</sup> 145-146.

<sup>261</sup> 146.

<sup>262</sup> S Liebenberg "Taking Stock: The Jurisprudence on Children's Socio-Economic Rights and its Implications for Government Policy" (2004) *ESR Review* 5 5.

and lack of legal capacity.<sup>263</sup> Furthermore, children are not entitled to the right to vote,<sup>264</sup> and thus do not always participate in decisions which affect them.<sup>265</sup> Poverty leads to further vulnerability.<sup>266</sup> The requirement of reasonableness to make provision for the vulnerable and those in urgent need<sup>267</sup> creates a way to invoke children's socio-economic rights. Children are considered vulnerable and, as held in *TAC*, those without means of access are particularly vulnerable and deserving of protection.<sup>268</sup> Proudlock maintains that the provision of a right to basic health care for children is "informed by a recognition of the particular vulnerability" and requires some degree of prioritisation.<sup>269</sup> Thus although it is unclear whether children could claim a direct entitlement to the right to basic health care, it is possible to facilitate the realisation of children's socio-economic rights through the obligations imposed by section 27(2).

Although the obligations imposed by section 28(1)(c) differ to those imposed by section 27(1)(a) read with (2), they cannot be considered in isolation from one another. Given the limited jurisprudence, this study argues that the Court's interpretation of section 29(1) in *Juma Musjid* could be relied on in arguing for a direct entitlement to basic health care for children. Additionally, the vulnerability of children makes a case for prioritising their needs, especially when their parents or family are unable to do so.

The NHI scheme must make provision to fulfil section 28(1)(c). Chapter six will evaluate the NHI scheme's compliance with the obligations imposed by children's right to basic health care. The analysis now proceeds to an analysis of the obligations imposed on entities in the private health care sector in facilitating the realisation of the right of access to health care.

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<sup>263</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 228.

<sup>264</sup> S19(3)(a) of the Constitution.

<sup>265</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 228.

<sup>266</sup> 228. See also S Rosa & M Dutschke "Child Rights at the Core: The Use of International Law in South Africa Cases on Children's Socio-Economic Rights" (2006) 22 *SAJHR* 224 226.

<sup>267</sup> *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) paras 44, 64, 68, 99; *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC) para 78.

<sup>268</sup> *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC) para 78.

<sup>269</sup> P Proudlock "Children's Socio-Economic Rights: Do They Have a Right to Special Protection?" (2002) 3 *ESR Review* 6 6.

## 3 6 Obligations imposed by health rights on the private health care sector

### 3 6 1 Introduction

The private sector has assumed a role in the provision of health care services and effectively also facilitates the realisation of sections 27(1)(a) read with (2) and 28(1)(c). Arguably, some degree of responsibility or accountability should be attached to this role of providing access.<sup>270</sup> Speaking to the perceived public-private divide of the two-tiered system, Pieterse notes:

“Over time, however, the distinction between the public and private spheres as respectively being appropriate and inappropriate venues for the application of human rights norms has been unmasked as artificial, counterproductive and oppressive, especially in a lived reality where most harm is suffered by vulnerable members of society at the hands of powerful private entities.”<sup>271</sup>

This section seeks to examine the obligations imposed on the private health care sector. This will be done through consideration of constitutional provisions and socio-economic rights jurisprudence on the horizontal applicability of the Bill of Rights.

### 3 6 2 The duty to protect the right of access to health care

There is a relationship between the obligations imposed on private parties and the duty on the State to protect the right of access to health care. As examined above,<sup>272</sup> the duty to protect is particularly relevant regarding the impact that the NHI scheme may have on the private health care sector. The State is obliged to protect rights from interference. Legislation and regulation can facilitate the obligations imposed by the right of access to health care on private parties.<sup>273</sup> The NHI scheme, as a legislative framework, has the potential to fulfil the State’s obligation to protect the right of access

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<sup>270</sup> M Pieterse “Indirect Horizontal Application of the Right to Have Access to Health Care Services” (2007) 23 *SAJHR* 157 159.

<sup>271</sup> 157.

<sup>272</sup> See chapter three part 2 3 2.

<sup>273</sup> S Liebenberg “The Application of Socio-Economic Rights to Private Law” (2008) 3 *TSAR* 464 471; A Hassim et al *Health and Democracy* (2007) 33.

to health care by ensuring that the actions of private parties are regulated in a way to facilitate the realisation of the right.

### 3 6 3 Indirect horizontal application of the Bill of Rights

The Bill of Rights can be applied indirectly through interpreting legislation or developing the common or customary law rules to align with constitutional rights and values in terms of section 39(2) of the Constitution. Section 39(2) provides:

“When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.”

Thus, any interpretation must promote the purposes and values underlying the socio-economic rights in the Constitution. Socio-economic rights purport to provide a better quality of life to all.<sup>274</sup> Therefore, when interpreting legislation in this regard, (perhaps for its impact on the private sector), due consideration must be given to the purpose of the right of access to health care, and also to the transformative goals of the Constitution.

### 3 6 4 Direct horizontal application of the Bill of Rights

The Bill of Rights is binding on private entities. Subsection 8(2) of the Constitution establishes that if the provision binds the relevant entity and then subsection 8(3) dictates the execution of the horizontal application. Section 8(3)(a) indicates a preference for legislative measures for giving effect to the right in the Bill of Rights.<sup>275</sup> In determining whether a provision can be directly horizontally applied, the Court considers the nature of the constitutional right at issue and the potential interference

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<sup>274</sup> Preamble to the Constitution.

<sup>275</sup> S Liebenberg “The Application of Socio-Economic Rights to Private Law” (2008) 3 *TSAR* 464 471. For the methodology of interpreting legislation in conformity with the Constitution in terms of section 8(3), see *Govender v Minister of Safety and Security* 2001 4 SA 273 (SCA) para 11 where the Court set out principles in this regard.

by third parties.<sup>276</sup> These subsections do not exclude socio-economic rights, but the phrasing and considerations imposed recognise that not all rights and obligations can necessarily be horizontally applied.<sup>277</sup>

Despite the Constitution's explicit provision that rights (including socio-economic rights) can be horizontally applied, private entities are often spared of obligations regarding socio-economic rights. This is due to the perception that such obligations are too onerous to impose on private entities.<sup>278</sup> Pieterse points out, "there is nothing inherent in socio-economic rights that render them incapable of horizontal application."<sup>279</sup> The counter-argument to such horizontal application lies in the wording of section 27(2) which explicitly mentions that the *State* is to progressively realise the right within available resources through legislative and other measures.<sup>280</sup> However, section 27(2) does not say that *only* the state has obligations in this regard.<sup>281</sup>

The NHI scheme purports to fulfil the State's obligations regarding sections 27(1)(a) read with 27(2) and 28(1)(c). However, the legislative framework also needs to acknowledge the role played by private parties in the provision of health care services and the obligations imposed in this regard. Judicial interpretation of socio-economic rights obligations imposed on private parties is examined below.

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<sup>276</sup> *Khumalo v Holomisa* 2002 5 SA 401 (CC) para 33.

<sup>277</sup> M Pieterse "Indirect Horizontal Application of the Right to Have Access to Health Care Services" (2007) 23 *SAJHR* 157 160.

<sup>278</sup> 158; I Currie & J de Waal *The Bill of Rights Handbook* (2013) 49.

<sup>279</sup> M Pieterse "Indirect Horizontal Application of the Right to Have Access to Health Care Services" (2007) 23 *SAJHR* 157 158.

<sup>280</sup> 163.

<sup>281</sup> S Ellman "A Constitutional Confluence: American 'State Action' Law and the Application of South Africa's Socio-Economic Rights Guarantees to Private Actors" in P Andrews & S Ellman (eds) *The Post-Apartheid Constitutions: Perspectives on South Africa's Basic Law* (2001) 444 459. See also S Liebenberg "The Application of Socio-Economic Rights to Private Law" (2008) 3 *TSAR* 464 468 and M Pieterse "Indirect Horizontal Application of the Right to Have Access to Health Care Services" (2007) 23 *SAJHR* 157 159.



### 3 6 5 Judicial interpretation of the application of socio-economic rights obligations on the private sector

The private sector is bound to the Bill of Rights. Therefore it cannot operate in a conflicting manner. Horizontal application and the State's duty to protect the right justify regulation of the private sector to ensure conformity with the Bill of Rights.<sup>282</sup> Albeit in a different context to health care, the Constitutional Court stressed in *Grootboom*:

“A right of access to adequate housing also suggests 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 legislation and other measures to provide housing.”<sup>283</sup>

*Juma Masjid* concerned the eviction of a public school situated on private property.<sup>284</sup> One of the issues was whether the trustees (a private entity) had obligations under section 29(1) of the Constitution.<sup>285</sup> The Court was required to balance the children's right to education and the trustee's property rights.<sup>286</sup> The Court held that the trust bears no “primary positive obligation” to provide education<sup>287</sup> and held:

“It needs to be stressed however that the purpose of section 8(2) of the Constitution is not to obstruct private autonomy or to impose on a private party the duties of the state in

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<sup>282</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 332.

<sup>283</sup> 2001 1 SA 46 (CC) para 25. See chapter three part 3 regarding *Jaftha*, where the Court elaborated on the negative obligations imposed by socio-economic rights. See also *Gundwana v Steko Developments CC* 2011 3 SA 608 (CC) which concerned a similar issue regarding the sale in execution of property which then results in eviction. The Court relied on *Jaftha* and affirmed that interfering with existing access to adequate housing amounts to a violation of the negative obligation imposed by section 26.

<sup>284</sup> 2011 8 BCLR 761 (CC) para 1.

<sup>285</sup> Para 7.

<sup>286</sup> Para 7.

<sup>287</sup> Para 57.

protecting the Bill of Rights. It is rather to require private parties not to interfere with or diminish the enjoyment of a right.”<sup>288</sup>

The Court concluded that the right to education imposed a negative obligation on the trust not to impair realisation or enjoyment of the right.<sup>289</sup>

*Daniels v Scribante*<sup>290</sup> (“*Daniels*”) dealt with socio-economic rights obligations and the private sector. The case concerned a domestic worker, Ms Daniels, who lived on Chardonne farm with her children for 16 years.<sup>291</sup> The owner did not maintain her small home, and she sought to, at her own expense, level the floor, have a ceiling put in, as well as an indoor water supply and wash basin.<sup>292</sup> The Court noted the basic nature of these improvements.<sup>293</sup> She informed the owner of her intentions, received no response and proceeded with the improvements.<sup>294</sup> The owner then sought to have her evicted on grounds that the improvements were unlawful.<sup>295</sup> Daniels was unsuccessful in challenging the eviction in both the High Court as well as the Land Claims Court.<sup>296</sup>

In the Constitutional Court, the respondents, although acknowledging that the living conditions implicated human dignity, argued that an owner is not obliged to ensure that living conditions do not impair human dignity.<sup>297</sup> The Court acknowledged that the obligations imposed on the State could not reasonably be imposed on private persons to the same extent.<sup>298</sup> However, Madlanga J (for the majority) held:

“Whether private persons will be bound depends on a number of factors. What is paramount includes: what is the nature of the right; what is the history behind the right; what does the

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<sup>288</sup> Para 58.

<sup>289</sup> Para 60.

<sup>290</sup> (CCT50/16) 2017 ZACC 13 (11 May 2017).

<sup>291</sup> Para 4.

<sup>292</sup> Paras 6- 7.

<sup>293</sup> Para 7.

<sup>294</sup> Para 8.

<sup>295</sup> Para 9.

<sup>296</sup> On the basis that the right to reside, under the Extension of Security of Tenure Act 62 of 1997, did not include the right to make improvements without the owner’s permission, para 10.

<sup>297</sup> (CCT50/16) 2017 ZACC 13 (11 May 2017) para 37.

<sup>298</sup> Para 38.

right seek to achieve; how best can that be achieved; what is the 'potential of invasion of that right by persons other than the state or organs of state'; and, would letting private persons off the net not negate the essential content of the right? If, on weighing up all the relevant factors, we are led to the conclusion that private persons are not only bound but must in fact bear a positive obligation, we should not shy away from imposing it".<sup>299</sup>

The Court concluded that the owner's consent could not trump the need to live in conditions consistent with human dignity.<sup>300</sup> Positive obligations necessarily have to apply to private persons regarding the security of tenure when the land is privately owned.<sup>301</sup> The Court upheld the appeal and held that the applicant is entitled to make the improvements to her home.<sup>302</sup> The Court also ordered that the parties engage meaningfully about the improvements.<sup>303</sup>

The factors provided by the Court in *Daniels* can be used to determine when socio-economic rights impose positive obligations on private entities. These factors will be used to consider the obligations imposed on the private sector by the right of access to health care and to determine if regulation through the NHI scheme is justified regarding the horizontal application of the right.

### 3 7 Conclusion

This chapter examined the constitutional law obligations imposed by sections 27(1)(a) read with (2) and 28(1)(c). The socio-economic rights jurisprudence provides interpretations of the nature of the obligations imposed by the right of access to health care. This chapter has identified and analysed the criteria that will be used to evaluate the NHI scheme's compliance with constitutional law obligations in chapter six. The nexus of obligations, both positive and negative, imposed by section 27(1)(a) read with (2), and 28(1)(c) provides the framework for what the NHI scheme should comply with

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<sup>299</sup> The Court held that horizontal application in terms of section 8(2) was relevant as the source of the right, despite the elaboration in the Extension of Security of Tenure Act 62 of 1997, is the Bill of Rights. Therefore the Court considered the constitutional obligations imposed on private parties, para 39.

<sup>300</sup> (CCT50/16) 2017 ZACC 13 (11 May 2017) para 60.

<sup>301</sup> Para 49.

<sup>302</sup> Para 71.

<sup>303</sup> Para 71.

to facilitate the realisation of the right. The factors for assessing reasonableness are particularly relevant as it provides nuanced considerations for what is constitutionally required by measures seeking to progressively realise the right within available resources. The private sector also incurs obligations from the right of access to health care. As private entities are bound to the Bill of Rights, they must operate in conformity with the Constitution. The State is obliged to ensure compliance in this regard to protect the rights in the Bill of Rights.

Having considered the obligations imposed by health rights under the Constitution, the following chapter examines the obligations imposed by health rights under international law. Chapter four will identify and analyse the international law obligations imposed by the right to health care to be used to evaluate the NHI scheme is chapter six.

## **CHAPTER 4: THE INTERNATIONAL FRAMEWORK OF THE RIGHT TO HEALTH CARE**

### **4 1 Introduction**

International law is important for understanding both the content of the right to health care and the obligations imposed by it. Before examining the international framework of the right to health care, this chapter will consider the role and status of international law under the Constitution of the Republic of South Africa, 1996 (“the Constitution”). Once the reliance on international law is justified, this chapter will consider international law instruments that provide a legal basis for the right to health under international law.<sup>1</sup>

This chapter will examine the development of the right to health under international law and the understanding, interpretation and practice of international bodies regarding the right to health. Following this discussion of the normative content of the right under international law, the obligations imposed by the right will be examined. International experience and research can inform the South African mission to realise access to health care for all.

### **4 2 The role and status of international law under the Constitution**

#### **4 2 1 Introduction**

Section 27(2) of the Constitution reflects the International Covenant on Economic, Social and Cultural Rights<sup>2</sup> (“ICESCR”) formulation of the obligations imposed by socio-economic rights.<sup>3</sup> The Constitution makes provision for reliance on and implementation of international law in two ways. Firstly, through the recognition and status of international law in South African domestic law,<sup>4</sup> and secondly, through the

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<sup>1</sup> M Ssenyonjo *Economic, Social and Cultural Rights in International Law* (2009) 317.

<sup>2</sup> International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 933 UNTS 3. South Africa signed the ICESCR in 1995 and ratified it in 2015.

<sup>3</sup> See chapter four part 4 1.

<sup>4</sup> Ss231, 233 of the Constitution.

interpretation clause.<sup>5</sup> These two methods will be examined to justify the role of and reliance on international law.

#### 4 2 2 Section 39 of the Constitution

Section 39(1)(b) of the Constitution provides that when a court, tribunal or forum is interpreting any right in the Bill of Rights, international law must be considered. “Consider” has been interpreted by the Court to mean that international law must be taken into account.<sup>6</sup> However, this is not to say that courts are bound to apply the international norms considered.<sup>7</sup> Both binding and non-binding international law may be used to interpret rights in the Bill of Rights.<sup>8</sup> The ICESCR is an example of binding international law as South Africa has signed and ratified it.<sup>9</sup> The General Comments issued by the Committee on Economic, Social and Cultural Rights (“the Committee”) are examples of non-binding international law or soft law which may be used as a tool of interpretation by courts.<sup>10</sup>

#### 4 2 3 Section 231 of the Constitution

Section 231 of the Constitution governs international agreements. Section 231(2) provides:

“An international agreement binds the Republic only after it has been approached by resolution in both the National Assembly and the National Council of Provinces, unless it is an agreement referred to in subsection 231(3).”

Section 231(3) provides for self-executing treaties:

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<sup>5</sup> S39.

<sup>6</sup> *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) paras 26-33.

<sup>7</sup> Paras 26-33.

<sup>8</sup> *S v Makwanyane* 1995 3 SA 391 (CC) para 35.

<sup>9</sup> South Africa signed the treaty in 1995 and ratified it in 2015, ICESCR Depository Notification C.N.23.2015-TREATIES-IV.3.

<sup>10</sup> In *Grootboom* the Constitutional Court referred to General Comment 4 on the Right to adequate housing, *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 29.

“An international agreement of a technical, administrative or executive nature, or an agreement which does not require either ratification or accession, entered into by the national executive, binds the Republic without approval by the National Assembly and the National Council of Provinces, but must be tabled in the Assembly and the Council within a reasonable time.”

Section 231(4) provides:

“Any international agreement becomes law in the Republic when it is enacted into law by national legislation; but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament.”

In *Glenister v The President of the Republic of South Africa*<sup>11</sup> (“*Glenister*”) the Court reiterated this position on the status of international law. The Court held that a ratified agreement binds South Africa internationally, but not within the national legal system until incorporated into domestic law through national legislation.<sup>12</sup> The exception to this is self-executing treaties as provided for in section 231(3) of the Constitution. Thus, international law on the right to health care will bind South Africa internationally if ratified, but the State will not incur domestic obligations unless the provisions have been incorporated into domestic legislation or are of a technical, administrative or executive nature and fall under section 231(3). To be incorporated into national legislation, a treaty may be incorporated in an Act of Parliament, or it may be added as a schedule to an Act. Parliament may also, through an enabling Act, authorise the executive to incorporate a treaty into national law by making a proclamation or notice in the Government Gazette.<sup>13</sup>

#### 4 2 4 Section 233 of the Constitution

Section 233 of the Constitution concerns the application of international law. It provides that when interpreting legislation, courts must favour any interpretation consistent with international law. This coincides with the Committee’s understanding

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<sup>11</sup> 2011 3 SA 347 (CC).

<sup>12</sup> Para 374.

<sup>13</sup> Para 99.

of the ICESCR's application domestically. General Comment 9 on the Domestic Application of the Covenant<sup>14</sup> ("General Comment 9") provides:

"It is generally accepted that domestic law should be interpreted as far as possible in a way which conforms to a State's international legal obligations. Thus, when a domestic decision maker is faced with a choice between an interpretation of domestic law that would place the state in breach of the Covenant, international law requires the choice of the latter. Guarantees of equality and non-discrimination should be interpreted, to the greatest extent possible, in ways which facilitate the full protection of economic, social and cultural rights."<sup>15</sup>

Thus, courts must interpret legislation in a manner consistent with international law. General Comment 9 explicitly provides that interpretations should guarantee equality and non-discrimination in protecting socio-economic rights. Legislation seeking to give effect to the right of access to health care under the Constitution should be interpreted to be consistent with international law, especially regarding equality and non-discrimination. International law on the right to health can inform national understanding and enforcement of the right.

#### 4 2 5 Role of international law in South African socio-economic rights jurisprudence

In *Government of the Republic of South Africa v Grootboom*<sup>16</sup> ("*Grootboom*") the Court obliged with section 39(1)(b) and considered international law in interpreting the right of access to adequate housing.<sup>17</sup> The Court held that relevant international law is a valuable interpretive guide but that the weight attached to it will vary between cases.<sup>18</sup> This reflects the understanding that courts must take international law into account, but are not bound to apply it. The Court further held that General Comments have interpretive value which can be considered by a court in interpreting socio-economic rights.<sup>19</sup> The role and status of international law as held in *Grootboom* was

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<sup>14</sup> United Nations Committee on Economic, Social and Cultural Rights *General Comment No. 9: The Domestic Application of the Covenant* (1998) UN Doc.E/C.12/1998/24.

<sup>15</sup> Para 15.

<sup>16</sup> 2001 1 SA 46 (CC).

<sup>17</sup> S26 of the Constitution.

<sup>18</sup> 2001 1 SA 46 (CC) para 26.

<sup>19</sup> Para 26.



affirmed in *Minister of Health v Treatment Action Campaign*<sup>20</sup> (“TAC”) in the context of the right of access to health care. International law was relied on in argument for a minimum core<sup>21</sup>, but the Court followed the approach of *Grootboom* in that they are not obliged to apply it, but obliged to consider it.<sup>22</sup>

*Grootboom* illustrates that international law can be used to guide domestic evaluations of policy and legislation. International law can also guide domestic policy and legislative development. The expertise of the Committee provides valuable insight on the normative content of rights and the nature of the obligations. The following sections consider the relevant international law on the right to health that can be relied upon to inform, guide and interpret the nature of the right and its obligations.

### 4 3 The right to health in international law

#### 4 3 1 The United Nations Charter

The right to health was first recognised under international law in the United Nations Charter.<sup>23</sup> Article 55 provides that the United Nations (“UN”) promote “higher standards of living, full employment, and conditions of economic and social progress and development” and to promote solutions to health problems.<sup>24</sup> The UN Charter recognises health and medicine to be essential to international peace and security.<sup>25</sup> This provision does not recognise the right to health of individuals explicitly but only

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<sup>20</sup> 2002 5 SA 721 (CC).

<sup>21</sup> See chapter three part 4 1.

<sup>22</sup> 2002 5 SA 721 (CC) para 29.

<sup>23</sup> Charter of the United Nations (adopted 26 June 1945, entered into force 24 October 1945) 1 UNTS XVI.

<sup>24</sup> Art 55(a) and (b).

<sup>25</sup> Art 55; D M Chirwa “The Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine” (2003) 19 *SAJHR* 541 544; World Health Organisation *The First Ten Years of the World Health Organisation* (1958).

commits the UN to promote the solution of health problems and a higher standard of living.<sup>26</sup>

#### 4 3 2 The Universal Declaration of Human Rights

In 1948 the Universal Declaration of Human Rights<sup>27</sup> (“UDHR”) was adopted, and it included a specific provision regarding health. Article 25 provides:

“Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age and other lack of livelihood in circumstances beyond his control.”

The UDHR treats health as a means to realise the right to a certain standard of living and not as a stand-alone right.<sup>28</sup> This phrasing of the right to a “standard of living” also indicates the inherent relationships between health and other socio-economic factors such as housing, food and social security. Tobin argues for a “biopsychosocial” approach to the right to health as it recognises the social factors and the role they play in the realisation of the right.<sup>29</sup> This approach informs both the normative content of the right and the nature of the obligations imposed.

As the UDHR is a UN General Assembly resolution, it is not legally binding. It demonstrates an accepted standard of achievement of rights of all nations.<sup>30</sup> Its non-binding nature motivated the UN Commission on Human Rights to draft the ICESCR

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<sup>26</sup> Art 55 Charter of the United Nations (adopted 26 June 1945, entered into force 24 October 1945) 1 UNTS XVI; S D Jamar “the International Human Right to Health” (1994) 22 *Southern University Law Review* 1 19.

<sup>27</sup> Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III).

<sup>28</sup> S D Jamar “the International Human Right to Health” (1994) 22 *Southern University Law Review* 1 21; R Cook & C Ngwena “Rights Concerning Health” in D Brand & C Heyns (eds) *Socio-Economic Rights in South Africa* (2005) 107 111.

<sup>29</sup> J Tobin *The Right to Health in International Law* (2012) 122.

<sup>30</sup> H Hannum “The United Nations and Human Rights” in C Krause & M Scheinin (eds) *International Protection of Human Rights: A Textbook* 2 ed (2012) 61 63. Some articles of the UDHR have attained the status of customary international law, O De Schutter “The Status of Human Rights in International Law” in C Krause & M Scheinin (eds) *International Protection of Human Rights: A Textbook* 2 ed (2012) 39 41.

and the International Covenant on Civil and Political Rights,<sup>31</sup> which do impose legal obligations on member states.

#### 4 3 3 The International Covenant on Economic, Social and Cultural Rights

The most significant binding international human rights treaty at the UN level providing for the right to health is the ICESCR. The ICESCR seeks to protect and enable the realisation of economic, social and cultural rights. It explicitly recognises the right to health. Article 12(1) provides:

“The States Parties to the present Covenant recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

Article 12(2) provides for steps to be taken by states to realise the right to health fully. These include *inter alia* the “creation of conditions which would assure to all medical service and medical attention in the event of sickness”.<sup>32</sup> The phrasing “highest attainable standard of health” contemplates both individual preconditions (such as biology and socio-economic circumstances) and the state’s available resources.<sup>33</sup> The choice of wording of “recognise” implies that the right is not as

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<sup>31</sup> International Covenant on Civil and Political Rights (adopted) 16 December 1966, entered into force 23 March 1976) 999 UNTS 171.

<sup>32</sup> Art 12(2) provides:

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

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the health development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

The creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

<sup>33</sup> Art 12(1); M Ssenyonjo *Economic, Social and Cultural Rights in International Law* (2009) 322.

immediate in nature as the rights that states must “guarantee”.<sup>34</sup> This wording will be examined in following sections.<sup>35</sup>

Academic literature has interpreted article 12 of the ICESCR as seeking two goals: the recognition of a right to health and an obligation on states to ensure a certain standard of health care.<sup>36</sup> Ssenyonjo further argues that this formulation conceptualises the right into two essential aspects: the health care and then the range of socio-economic conditions which impact on health.<sup>37</sup> The first aspect provides that individuals are entitled to access to health care services which protect and seek to realise the right.<sup>38</sup> The second aspect concerns the underlying determinants of health.<sup>39</sup> The explicit recognition of the right to health, including the underlying determinants, and the articulated need to create conditions which enable access to health care, provide a legal foundation of the right to health under international law.

The ICESCR has had a significant influence on the phrasing and interpretation of socio-economic rights in the South African Constitution.<sup>40</sup> Therefore, it is appropriate to use the Committee’s understanding of the right to inform the normative content of the right and the obligations imposed within the South African context. As South Africa has signed and ratified the ICESCR, it imposes legal obligations on the state. The NHI scheme must seek to fulfil these international law obligations, which would consequently aid in fulfilling the constitutional obligations imposed by the right to health.

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<sup>34</sup> Under the International Covenant on Civil and Political Rights states are required to guarantee rights such as life and equality, (adopted) 16 December 1966, entered into force 23 March 1976) 999 UNTS 171; B C A Toebes *The Right to Health as a Human Right in International Law* (1999) 300.

<sup>35</sup> See chapter four part 4.2.

<sup>36</sup> B Saul et al *The International Covenant on Economic, Social and Cultural Rights* (2014) 979; M Ssenyonjo *Economic, Social and Cultural Rights in International Law* (2009) 324; B C A Toebes *The Right to Health as a Human Right in International Law* (1999) 300.

<sup>37</sup> M Ssenyonjo *Economic, Social and Cultural Rights in International Law* (2009) 324.

<sup>38</sup> 325.

<sup>39</sup> See chapter two part 3.2.

<sup>40</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 19.

## 4 3 4 General Comment 14

The Committee issues General Comments to provide clarity and interpretive guidance on rights and aspects of the ICESCR.<sup>41</sup> General Comments seek to take the experience and insight gained by the Committee and make it available in a manner which can guide standards in orientating their actions and policies to realise better the rights provided for in the ICESCR.<sup>42</sup> Accordingly, such General Comments provide for the Committee's understanding of the rights and their general practice regarding the rights. General Comments also elaborate on the nature of obligations imposed by the ICESCR and are thus used to measure State compliance with the ICESCR, for example, in the periodic reporting procedure.<sup>43</sup> General Comments are not legally binding *per se* but have persuasive value as authoritative interpretations by the treaty-supervisory body concerning the obligations imposed by the ICESCR on State parties.<sup>44</sup>

In 2000 the Committee issued General Comment 14 on the Rights to Health<sup>45</sup> ("General Comment 14"). General Comment 14 emphasises the fundamental nature of the right to health and that everyone is "entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity."<sup>46</sup> General Comment 14 reiterates the definition of health provided for in article 12 of the ICESCR, accompanied by a non-exhaustive list of obligations.<sup>47</sup> Similarly to academic

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<sup>41</sup> M Langford & J A King "Committee on Economic, Social and Cultural Rights" in M Langford (ed) *Social Rights Jurisprudence* 9 ed (2008) 477 480.

<sup>42</sup> 484.

<sup>43</sup> Articles 16-25 of the ICESCR concern reporting procedures; A Hendricks "The Right to Health" (1994) *European Journal of Health Law* 187 187; E Riedel "Economic, Social and Cultural Rights" in C Krause & M Scheinin (eds) *International Protection of Human Rights* 2 ed (2012) 131 144.

<sup>44</sup> E Riedel "Economic, Social and Cultural Rights" in C Krause & M Scheinin (eds) *International Protection of Human Rights: A Textbook* 2 ed (2012) 131 145-146.

<sup>45</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4.

<sup>46</sup> Para 1.

<sup>47</sup> Para 4.

understanding and interpretation of article 12 of the ICESCR,<sup>48</sup> General Comment 14 opts for an inclusive interpretation of the right to health by including health care services, facilities and socio-economic circumstances which impact on health.<sup>49</sup>

General Comment 14 asserts that the essential elements of the right to health comprise of availability, acceptability, quality, and accessibility.<sup>50</sup> Tobin views these essential elements as an appropriate interpretive tool for determining the content of the right to health which then translates the right into a concept which can be applied when developing policies and legislation.<sup>51</sup>

Regarding availability, General Comment 14 provides that “functioning public health and health care facilities, goods and services, as well as programmes, must be available in sufficient quantity within the State party.”<sup>52</sup> Saul recognises sufficiency of services and facilities and political willfulness as components of availability.<sup>53</sup> The State needs sufficient resources to make health care available and needs to be willing to raise and allocate resources accordingly.<sup>54</sup> The element of accessibility has four dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility.<sup>55</sup> There are many barriers hindering accessibility such as costs of transport, water and sanitation, food and income. Health care should be made accessible in terms of all four of these dimensions.

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<sup>48</sup> M Ssenyonjo *Economic, Social and Cultural Rights in International Law* (2009) 324 336; R Cook & C Ngwena “Rights Concerning Health” in D Brand & C Heyns (eds) *Socio-Economic Rights in South Africa* (2005) 107 115.

<sup>49</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 11.

<sup>50</sup> Para 12.

<sup>51</sup> E Riedel “Economic, Social and Cultural Rights” in C Krause & M Scheinin (eds) *International Protection of Human Rights: A Textbook* 2 ed (2012) 131 145-146; J Tobin *Right to Health in International Law* (2001) 174.

<sup>52</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 12(a).

<sup>53</sup> B Saul et al *The International Covenant of Economic, Social and Cultural Rights* (2014) 996.

<sup>54</sup> 996.

<sup>55</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 12(b).

Services and means to address health and its social determinants must be acceptable and conform to medical ethics.<sup>56</sup> Quality requires that “health facilities, goods and services must also be scientifically and medically appropriate and of good quality”.<sup>57</sup> The Committee has observed issues concerning the quality of health care services, affected by poorly equipped services, underfunding, the prohibitive costs of the private sector, urban favouritism and the absence of sufficient planning.<sup>58</sup> These essential elements aid in understanding the normative content of the right to health and what the obligations imposed seek to achieve.

Article 12(2) of the ICESCR is elaborated on in General Comment 14. For example, the right to maternal, child and reproductive health under article 12(2)(d) is elucidated to seek improvement of child and maternal health, sexual and reproductive services, emergency obstetric services and access to information.<sup>59</sup> The importance of preventative care and social determinants of health is recognised regarding the right to prevention, treatment and control of disease, particularly that of HIV/AIDS.<sup>60</sup> General Comment 14 holds the right to health facilities, goods and services under article 12(2)(d) of the ICESCR to include:

“[T]he provision of equal and timely access to basic preventative, curative, rehabilitative health services and education; regular screen programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care.”<sup>61</sup>

General Comment 14 also requires that the population participates in the political process of organising the health sector, the health insurance system and the realisation of the right to health.<sup>62</sup>

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<sup>56</sup> Para 12(c).

<sup>57</sup> Para 12(d).

<sup>58</sup> The Committee has repeatedly raised concerns over the quality of health care in its concluding observations, highlighting the importance of this dimension. See, for example, the Concluding Observations on Sri Lanka E/C.12/LKA/CO/5 (23 June 2017) para 57.

<sup>59</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 14.

<sup>60</sup> Para 16.

<sup>61</sup> Para 17.

<sup>62</sup> Para 17.

General Comment 14 also elaborates on “special topics of applications”.<sup>63</sup> Regarding non-discrimination and equal treatment, the Committee emphasises the importance of access to health care services. A disproportionate distribution of resources may amount to discrimination.<sup>64</sup> General Comment No. 20 on Non-Discrimination in Economic, Social and Cultural Rights<sup>65</sup> (“General Comment 20”) defines non-discrimination as an immediate obligation regarding all economic, social and cultural rights.<sup>66</sup> State parties must guarantee non-discrimination.<sup>67</sup> This corresponds with General Comment 14, where non-discrimination is considered as part of the essential element of accessibility.<sup>68</sup>

The Committee has also elaborated on the right to sexual and reproductive health, an integral aspect of the right to health. General Comment No 22 on the Right to Sexual and Reproductive Health<sup>69</sup> highlights availability, accessibility, acceptability and quality as the essential elements of the right and is concerned with the underlying determinants of the right. This aspect of the right to health is encompassed in the concerns regarding access and quality and the development and implementation of South Africa’s NHI scheme will necessarily also address the obligations regarding sexual and reproductive health, though this study will consider it under the broad scope of ‘right to health care’.

The elaboration on the normative content of the right to health provided by General Comment 14 articulates what states should be seeking to achieve in the realisation of the right to health. The detailed elaboration on the essential elements of the right provides a foundation for what a health policy should address. General Comment 14

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<sup>63</sup> Paras 18-29.

<sup>64</sup> Para 19; R Cook & C Ngwenya “Rights Concerning Health” in D Brand & C Heyns (eds) *Socio-Economic Rights in South Africa* (2005) 107 115.

<sup>65</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.20: *Non-discrimination in Economic, Social and Cultural Rights (art 2(2))* UN Doc E/C.12/GC/20.

<sup>66</sup> Para 7.

<sup>67</sup> Para 8.

<sup>68</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 12(b)(i); also emphasised is equality of access to health care and services, para 19.

<sup>69</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 22: *Right to Sexual and Reproductive Health (art 12)* UN Doc E/C.12/GC/22.



has influenced the interpretation of other international law instruments on the right to health. The normative content provided by General Comment 14 provides much of the basis for examining the nature of the obligations imposed by the right to health. The following sections will consider other international law instruments.

#### 4.3.5 The Convention on the Rights of the Child

The Convention on the Rights of the Child<sup>70</sup> (“CRC”), in a similar phrasing as the ICESCR but regarding children specifically, provides:

“States parties recognise 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. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”<sup>71</sup>

The Committee on the Rights of the Child<sup>72</sup> has also issued a General Comment on the “Right of the Child to the Enjoyment of the Highest Attainable Standard of Health”<sup>73</sup> (“General Comment 15”). The aim of General Comment 15 is to approach children’s health issues from a child rights perspective.<sup>74</sup> Thus, General Comment 15 highlights crucial aspects of the child’s right to health, including the indivisibility and interdependence of children’s rights, the best interests of the child, the determinants of children’s health and the evolving capacities and the life course of the child.<sup>75</sup>

Replicating the ICESCR’s wording of the “highest attainable standard of health”, the CRC recognises the child’s biology and circumstances, as well as the state’s resources.<sup>76</sup> Article 24 of the CRC explicitly mentions primary health care (“PHC”)

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<sup>70</sup> United Nations Convention on the Rights of the Child (adopted 20 November 1989, entered into force 21 October 1986) 1577 UNTS 3.

<sup>71</sup> Art 24(1).

<sup>72</sup> Art 43.

<sup>73</sup> United Nations Committee on the Rights of the Child General Comment No. 15: *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art 24)* UN Doc CRC/C/GC/15.

<sup>74</sup> Part I.

<sup>75</sup> Part II.

<sup>76</sup> Para 23.

which is elaborated on in General Comment 15 as crucial to eliminate exclusion and reduce health disparities.<sup>77</sup> The core obligations of the right to health of the child include ensuring universal coverage of PHC, to respond to the underlying determinants affecting the health of children, and to develop policies from a human rights approach to the right to health.<sup>78</sup>

Although the normative understanding of the right to health of children coincides with that provided for in the ICESCR and General Comment 14, the inclusion of PHC provides for specific content that needs to be provided to realise the right effectively. This is significant in understanding not only the valuable role of a PHC approach but also what the obligations imposed seeks to achieve.<sup>79</sup>

#### 4 3 6 African Charter on Human and Peoples' Rights

At a regional level, the African Charter on Human and Peoples' Rights<sup>80</sup> ("African Charter") recognises the right to health. The African Charter is significant as it recognises civil and political rights and socio-economic rights as indivisible.<sup>81</sup> Without this usual separation, the link between the realisation of the right to health and civil liberties such as equality and dignity are explicit.<sup>82</sup> Moreover, the African Charter is framed within the regional context, with a greater understanding of the problems and challenges faced by African countries and how these may be addressed. Article 16 provides that "every individual shall have the right to the best attainable state of physical and mental health". Article 16 seeks to address the specific health challenges faced by the continent such as the HIV/AIDS pandemic and server resource

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<sup>77</sup> Para 4.

<sup>78</sup> Para 73; these obligations will be elaborated on in chapter four part 5.

<sup>79</sup> See discussion on PHC in chapter four part 2 8 1.

<sup>80</sup> African (Banjul) Charter on Human and Peoples' Rights (adopted 28 June 1981, entered into force 21 October 1986) 1520 UNTS 217. South Africa signed and ratified the African Charter in 1996.

<sup>81</sup> L Chenwi "Unpacking 'Progressive Realisation', its Relation to Resources, Minimum Core and Reasonableness, and Some Methodological Considerations for Assessing Compliance" (2013) *De Jure* 742 745.

<sup>82</sup> Preamble to African (Banjul) Charter on Human and Peoples' Rights (adopted 27 June 1982, entered into force 21 October 1986) 1520 UNTS 217.

shortages.<sup>83</sup> Unlike the ICESCR, the African Charter does not explicitly emphasise the underlying social and economic determinants to health but focuses on curative care by reference to “medical attention for those who are sick”.<sup>84</sup>

The African Commission grappled with the meaning of the right to health in *Purohit and Moore v The Gambia*.<sup>85</sup> The case concerned the treatment of mental health patients at a psychiatric institute in the Gambia. The communication alleged that the Lunatics Detention Act and the treatment of the mental health patients was in violation of the African Charter.<sup>86</sup> The African Commission elaborate on the content of the right to health in addressing the national legislation of the Gambia governing mental health patients. The African Commission considered the regional realities of the right to health and acknowledged that:

“Millions of people in Africa are not enjoying the right to health maximally because African countries are generally faced with the problem of poverty which renders them incapable to provide the necessary amenities, infrastructure and resources that facilitate the full enjoyment of this right.”<sup>87</sup>

While recognising the realities of resources constraints, a violation of article 16 was found on the basis of the relationship between the rights of disabled persons, the right to equality and the right to health. This approach and understanding of the right to health coincide with that of the Committee as evidenced by General Comment 14.<sup>88</sup>

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<sup>83</sup> E Durojaye “The Approach of the African Commission to the Right to Health under the African Charter” (2013) 17 *Law, Democracy & Development* 393 399.

<sup>84</sup> African (Banjul) Charter on Human and Peoples’ Rights (adopted 27 June 1982, entered into force 21 October 1986) 1520 UNTS 217 art 16(2); E Durojaye “The Approach of the African Commission to the Right to Health under the African Charter” (2013) 17 *Law, Democracy & Development* 393 397. See also C Mbazira “The Right to Health and the Nature of Socio-Economic Obligations under the African Charter” (2004) 6 *ESR Review* 15 17.

<sup>85</sup> *Purohit and Moore v The Gambia* Communication 241/2001 (2003) AHRLR 96.

<sup>86</sup> In terms of art 16 regarding the right to health and 18(4) regarding special measures for disabled peoples.

<sup>87</sup> *Purohit and Moore v The Gambia* Communication 241/2001 (2003) AHRLR 96 para 84.

<sup>88</sup> E Durojaye “The Approach of the African Commission to the Right to Health under the African Charter” (2013) 17 *Law, Democracy & Development* 393 406.

Mbazira argues that the influence of the Committee's understanding of the right to health is evident in the African Commission's recognition of resource limitations.<sup>89</sup>

The African Commission issued Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights under the African Charter.<sup>90</sup> Similarly to the Committee, the African Commission adopts a broad interpretation of the right to health recognising that the right includes the underlying determinants of health, despite the phrasing of the African Charter.<sup>91</sup> The UN instruments very much inform this regional understanding of the right to health, and there is consistency in the understanding of the right to health and what should be addressed by the obligations imposed by it.

The African Charter allows for consideration of the continental context of Africa when interpreting the right to health. This contextual understanding informs the national framework and understanding of the right. The continental context is relevant to the NHI scheme especially regarding resource constraints and regional health concerns such as HIV/AIDS.

#### 4 3 7 African Charter on the Rights and Welfare of the Child

The African Charter on the Rights and Welfare of the Child<sup>92</sup> ("African Children's Charter") provides for children's right to health in the same wording as the African Charter but elaborates with a list of measures to be taken in seeking to realise this right.<sup>93</sup> The African Children's Charter was enacted to reflect the rights of the child in an African context.<sup>94</sup> Similarly to the CRC, it outlines the measures to be taken by

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<sup>89</sup> C Mbazira "The Right to Health and the Nature of Socio-Economic Rights Obligations under the African Charter: the Purohit Case" (2005) 6 *ESR Review* 15 19.

<sup>90</sup> African Commission on Human and Peoples' Rights *Principles and Guidelines on the Implementation on Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (2010).

<sup>91</sup> Para 61.

<sup>92</sup> African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1991) OAU Doc. CAB/LEG/24.9/49. South Africa signed and ratified the African Children's Charter in 1997 and ratified it in 2000.

<sup>93</sup> African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1991) OAU Doc. CAB/LEG/24.9/49 art 14.

<sup>94</sup> Preamble; O Ekundayo "Does the African Charter on the Rights and Welfare of the Child only underlines and repeats the Convention of the Rights of the Child's Provisions?: Examining

State parties to fully realise the right to health for children. It also emphasises PHC, recognising it as an effective means to give effect to the right to health.<sup>95</sup> It does not replace the CRC but adds to it, addressing certain issues which are more prevalent in Africa such as HIV/AIDS, harmful cultural practices and rural access to services. Like the African Charter, the context-sensitive framework of the regional system allows for appropriate provision to be made regarding PHC and children's right to health, to adequately address the problems and challenges and effectively realise the right.

#### 4 3 8 The World Health Organisation

The World Health Organisation ("WHO") is a specialised agency formed in terms of article 57 of the UN Charter.<sup>96</sup> WHO seeks to direct and coordinate health within the UN's system and articulates their goal as seeking to realise the right to health for all.<sup>97</sup> The first explicit mention of health as a right is found in the WHO's Constitution which defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."<sup>98</sup> WHO recognises that governments are responsible for the health of their people and that to fulfil this responsibility requires the "provision of adequate health *and* social measures."<sup>99</sup> This recognises the determinants of health. The work of WHO is of value when seeking to realise the right as WHO provides information and means by which to address health issues and policy

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the Similarities and Differences between the ACRWC and the CRC" (2015) 5 *International Journal of Humanities and Social Science* 143 147. See also A Llyod "A Theoretical Analysis of the Reality of Children's Rights in Africa: An Introduction to the African Charter on the Rights and Welfare of the Child" (2002) 2 *African Human Rights Law Journal* 11 15.

<sup>95</sup> D M Chirwa "The Merits and Demerits of the African Charter on the Rights and Welfare of the Child" (2002) 10 *The International Journal of Children's Rights* 157 164.

<sup>96</sup> Charter of the United Nations (adopted 26 June 1945, entered into force 24 October 1945) UNTS XVI art 57.

<sup>97</sup> World Health Organisation Constitution (adopted June 1946, entered into force 7 April 1948) 14 UNTS 185 preamble. See also R Cook & C Ngwena "Rights Concerning Health" in D Brand & C Heyns (eds) *Socio-Economic Rights in South Africa* (2005) 107 118.

<sup>98</sup> Preamble.

<sup>99</sup> Preamble, emphasis added.

development.<sup>100</sup> WHO has particularly emphasised both PHC and universal health coverage as important aspects in seeking to realise their goal and promote the enjoyment of the right to health.

#### 4 3 8 1 *Primary health care*

The WHO Declaration of Alma-Ata International Conference on Primary Health Care<sup>101</sup> (“Alma-Ata Declaration”) affirmed WHO’s definition of health and elaborated on PHC, viewing it as a framework in which to realise the right to health.<sup>102</sup> The Alma-Ata Declaration defines PHC as:

“Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community.”<sup>103</sup>

Governments are called upon to facilitate a PHC approach in their national health systems.<sup>104</sup> PHC, as provided for by the Alma-Ata Declaration, overlaps considerably with the specific measures provided for by article 12 of the ICESCR, General Comment 14 and the African Commission’s Principles and Guidelines.<sup>105</sup> The CRC and the African Children’s Charter specifically mention PHC, indicating its fundamental basis for the enjoyment of the right to health. PHC consists of, at least: education on health issues, promotion of proper nutrition and food resources, provision of safe water

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<sup>100</sup> World Health Organisation *World Health Report: Primary Healthcare: Now More Than Ever* (2008); World Health Organisation *World Health Report: Health Systems Financing: the Path to Universal Coverage* (2010); World Health Organisation *World Health Report: Research for Universal Health Coverage* (2013).

<sup>101</sup> World Health Organisation Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata USSR 6-12 September 1978.

<sup>102</sup> Para I.

<sup>103</sup> Para VI.

<sup>104</sup> Para VIII.

<sup>105</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 43; African Commission on Human and Peoples’ Rights *Principles and Guidelines on the Implementation on Economic, Social and Cultural Rights in the African Charter on Human and Peoples’ Rights* (2010) para 67.

and nutrition, child and maternal health care, immunisation, prevention and control of endemic diseases of the particular area, medical treatment for common diseases and injuries, and provision of essential medicine.<sup>106</sup> This emphasises the importance of the underlying determinants of health and the need to approach health problems from both a curative and a preventative angle. The Alma-Ata Declaration further recognises that “the people have the right and duty to participate individually and collectively in the planning and implementation of their health care.”<sup>107</sup> It interprets PHC to include participation.<sup>108</sup> This holistic framing of health has influenced the international approach and understanding of the normative content of the right to health.

The influence of the Alma-Ata Declaration and PHC is evident in WHO’s approach to realising the right to health.<sup>109</sup> In 2008 the World Health Report reiterated the role of PHC in striving towards universal health coverage.<sup>110</sup> More recently, the UN General Assembly recognised the value of PHC and that its fundamental principles of equity, participation and universal access can aid in accelerating the transition to universal health care.<sup>111</sup>

#### 4 3 8 2 *Universal health coverage*

WHO refers to universal health coverage as the practical expression of the right to health.<sup>112</sup> It provides a means by which to realise the right to health for all. The goal of

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<sup>106</sup> World Health Organisation Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata USSR 6-12 September 1978 para VII(3).

<sup>107</sup> Para IV.

<sup>108</sup> Para VII.

<sup>109</sup> World Health Assembly Resolution *Sustainable Health Financing, Universal Coverage and Social Health Insurance* (2005) A58/VR/9.

<sup>110</sup> World Health Organisation *World Health Report: Primary Healthcare: Now More than Ever* (2008).

<sup>111</sup> United Nations General Assembly Statement by the President *Promoting the Rights of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health by Enhancing Capacity-Building in Public Health Against Pandemics* (2015) A/HRC/30/L.43.

<sup>112</sup> World Health Organisation Discussion Paper *Positioning Health in the Post-2015 Development Agenda* (2012)

<[http://www.int.topics/millennium\\_development\\_goals/post2015/WHOdiscussionpaper\\_2012pdf](http://www.int.topics/millennium_development_goals/post2015/WHOdiscussionpaper_2012pdf)> (accessed 13 May 2016). See also G Ooms et al “Is Universal Health Coverage the

universal health coverage is to provide people with the health services needed without exposing them to the risk of financial ruin.<sup>113</sup> Universal health coverage consists of three dimensions: the health services needed; the people who need them; and the costs of providing them.<sup>114</sup>

WHO identifies PHC as playing an important role in seeking to realise universal health coverage.<sup>115</sup> The 2010 World Health Report by WHO focuses on health care financing mechanisms, with universal health coverage clearly in mind.<sup>116</sup> The 2010 World Health Report emphasises the need to address inequality in health care services.<sup>117</sup> Cognisant of the competing goals within health systems,<sup>118</sup> the report articulates the need to consider socio-economic circumstances when assessing the costs and financial risks pertaining to health care.<sup>119</sup> Subsequent to this, the UN General Assembly 2012 Resolution on Global Health and Foreign Policy recognises “the importance of universal coverage in national systems, especially through PHC and social protection mechanisms, to provide access to health services for all, in particular, the poorest segments of the population.”<sup>120</sup> This resolution mandates governments to facilitate the transition to universal health coverage systems to increase access to affordable and quality health care services.<sup>121</sup> Furthermore, the

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Practical Expression of the Right to Health Care?” (2014) 4 *BioMed Central International Health and Human Rights* 1.

<sup>113</sup> World Health Organisation *World Health Report: Research for Universal Health Coverage* (2013) 4.

<sup>114</sup> World Health Organisation *World Health Report: Health Systems Financing: the Path to Universal Coverage* (2010) XV.

<sup>115</sup> World Health Organisation *World Health Report: Primary Healthcare: Now More than Ever* (2008) 18.

<sup>116</sup> World Health Organisation *World Health Report: Health Systems Financing: the Path to Universal Coverage* (2010).

<sup>117</sup> Para 1.

<sup>118</sup> Competing goals may include: improving the level of health in society, reducing inequalities, responding to the needs of communities; profit; and ensuring financial fairness, para 78.

<sup>119</sup> Para 78.

<sup>120</sup> United Nations General Assembly Resolution on Global Health and Foreign Policy (6 December 2012) A/67/L.36.

<sup>121</sup> Para 21. See also J E Ataguba & D McIntyre “The Incidence of Health Financing in South Africa: Findings from a Recent Data Set” (2017) *Health Economics, Policy and Law* 1 1.



Sustainable Development Goals<sup>122</sup> includes universal health coverage as a goal to be achieved, “including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable medicines and vaccines for all.”<sup>123</sup>

Universal health coverage provides a means by which to realise the right to health. Implementation of universal health coverage systems has accumulated gained support on the international plane.<sup>124</sup> It is thus within the framework of universal health coverage that the obligations imposed by the right to health should be examined, to determine whether such an approach is viable for the effective fulfilment of the right to health.

#### 4 4 International law obligations imposed by the right to health

##### 4 4 1 Introduction

The right to health in international law imposes obligations on states. These obligations stem from various international law instruments. While this study focuses primarily on the ICESCR, as it is the leading instrument imposing binding legal obligations on South Africa since its ratification, references to other binding legal instruments will be incorporated where relevant. Article 2(1) of the ICESCR provides:

“Each party to the present Covenant undertakes to take steps, individually and through international assistance and co-operations, especially economic and technical, to the

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<sup>122</sup> United Nations Sustainable Development Goals para 54 of United Nations Resolution A/RES/70/1 of 25 September 2015.

<sup>123</sup> Goal 3.8. The slogan of the Sustainable Development Goals is “leave no one behind” and this coincides with the goal of achieving universal health coverage. See A E Yamin “Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage” (2017) 39 *Human Rights Quarterly* 341 363. See also M P Kiely et al. “Strengthening Health Systems for Universal Health Coverage and Sustainable Development” (2017) *Bulletin of World Health Organisation* 1-8.

<sup>124</sup> United Nations General Assembly Resolution on Global Health and Foreign Policy (6 December 2012) A/67/L.36; United Nations Sustainable Development Goals para 54 of United Nations Resolution A/RES/70/1 of 25 September 2015 Goal 3.8; World Health Assembly Resolution *Sustainable Health Financing, Universal Coverage and Social Health Insurance* (2005) A58/VR/9.

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.”

The influence of this provision is evident in other instruments, such as the CRC which imposes obligations on State parties in very similar phrasing.<sup>125</sup> The African Charter departs slightly from this phrasing as its article 1 provides that states “shall recognise the rights, duties and freedoms enshrined in the Charter and shall undertake to adopt legislative or other measures to give effect to them.” The African Children’s Charter mimics the wording of the African Charter, with some elaboration.<sup>126</sup> These provisions oblige states to realise the right by taking steps to use all available resources through appropriate means. These aspects will be discussed in addition to the overarching obligation on states to respect, protect and fulfil rights.

The Committee issued a General Comment elaborating on “The Nature of States Parties’ Obligations” regarding article 2(1) of the ICESCR (“General Comment 3”).<sup>127</sup> General Comment 3 explains the obligations imposed through articulating the Committee’s understanding and practice of the obligations. General Comment 3 also articulates a minimum core obligation imposed on the State to satisfy the minimum essential levels of each right.<sup>128</sup> Somewhat similarly, the African Commission’s Principles and Guidelines address the obligations imposed by the social, economic

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<sup>125</sup> United Nations Convention of the Rights of the Child (adopted 20 November 1989, entered into force 21 October 1986) 1577 UNTS 3 art 4:

“State parties shall undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the present convention. With regard to economic, social and cultural rights, states parties shall undertake measures to the maximum extent of their resources and, where needed, within the framework of international co-operation.”

<sup>126</sup> African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1991) OAU Doc. CAB/LEG/24.9/49 art 1(1):

“Member states of the Organisation of African unity parties to the present Charter shall recognise the rights, freedoms and duties enshrined in this charter and shall undertake to take the necessary steps, in accordance with their constitutional processes and with the provisions of the present Charter, to adopt such legislative or other measures as may be necessary to give effect to the provisions of this Charter.”

<sup>127</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.3: *The Nature of State Parties’ Obligations (art 2(1))* UN Doc E/C.14/12/90.

<sup>128</sup> Para 10.

and cultural rights contained in the African Charter. These two instruments provide valuable interpretive value in ascertaining in more detail what exactly is expected from State parties in seeking to realise the right to health effectively. Furthermore, the Optional Protocol to the ICESCR<sup>129</sup> introduces a standard of reasonableness by which to assess the measures taken by States. Article 8(4) requires the Committee to consider the reasonableness of the State's efforts to realise the rights in the Covenant.<sup>130</sup>

#### 4 4 2 The obligation to respect, protect and fulfil

The obligations imposed on States by the right to health can be categorised under the tripartite typology of State obligations to respect, protect and fulfil human rights.<sup>131</sup> This typology generates an understanding as to the nature of the State obligations imposed by a right, which is both negative and positive obligations.<sup>132</sup> These

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<sup>129</sup> Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, United Nations General Assembly Resolution A/RES/63/117 (10 December 2008).

<sup>130</sup> Art 8(4):

“When examining communications under the present Protocol, the Committee shall consider the reasonableness of the steps taken by the State Party in accordance with Part II of the Covenant. In doing so, the Committee shall bear in mind that the State Party may adopt a range of possible policy measures for the implementation of the rights set forth in the Covenant.”

See B Porter “Reasonableness and Article 8(4)” in M Langford et al (eds) *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights: A Commentary* (2016) 215 220. See also S Liebenberg “The Protection of Economic, Social and Cultural Rights in Domestic Legal Systems” in A Eide, C Krause & A Rosas (eds) *Economic, Social and Cultural Rights* (2002) 55 79.

<sup>131</sup> The origin of this tripartite typology can be traced back to the work of Henry Shue in 1980. He referred to the duty to avoid depriving, to protect from deprivation and to aid the deprived. H Shue *Basic Rights, Subsistence, Affluence and US Foreign Policy* (1980). This was then adopted by the United Nations Committee on Economic, Social and Cultural Rights General Comment No. 12: *The Right to Food (art 11)* UN Doc E/C.12/2999/5. See also M Scheinin “Characteristics of Human Rights Norms” in C Krause & M Scheinin (eds) *International Protection of Human Rights* 2 ed (2012) 27.

<sup>132</sup> J Tobin *Right to Health in International Law* (2012) 185; M Scheinin “Characteristics of Human Rights Norms” in C Krause & M Scheinin (eds) *International Protection of Human Rights* 2 ed (2012) 19 27.

obligations directly address State activity regarding health care. They also address private sector activity regarding health care, but indirectly. The obligation to respect, protect and fulfil the right to health indirectly addresses private sector activity through State obligations in the context of business activities.<sup>133</sup> The obligation to respect, protect and fulfil insofar as private business activities are concerned will be elaborated on in below.<sup>134</sup> This section focuses on these obligations regarding State action.

The obligation to respect is a negative obligation as it requires the State to refrain from interfering with the enjoyment of the right and refrain from taking any action which may negatively impact on the right.<sup>135</sup> An example of a violation of the obligation to respect would be laws, actions or policies which result in harm, such as denial of access to health goods, services or facilities.<sup>136</sup> Dissimilarly, the obligation to protect requires positive action to be taken by the State to prevent third party interference with the right and to ensure equal access to health care services.<sup>137</sup> General Comment 14 elaborates on this obligation, holding that it includes adopting legislation or taking other measures to ensure equal access to health care; ensuring that privatisation of the health care sector does not negatively impact on the availability, accessibility, acceptability or quality of health care; and that the vulnerable and marginalised should be protected through special measures.<sup>138</sup> Tobin argues that the obligation to protect

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<sup>133</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 24: *State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities* UN Doc E/C.12/GC/24. See chapter four part 6.

<sup>134</sup> See chapter four part 6.

<sup>135</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc.12/2000/4; W Kalin & J Kunzil *The Law of International Human Rights Protection* (2009) 336.

<sup>136</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 50.

<sup>137</sup> M Ssenyonjo *Economic, Social and Cultural Rights in International Law* (2009) 339; B Toebe "The Right to Health" in A Eide et al *Economic, Social and Cultural Rights* (2001) 1698 190; J Tobin *The Right to Health in International Law* (2012) 169 190.

<sup>138</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc.12/2000/4 para 35.

requires the State to regulate activity which may affect the right to health.<sup>139</sup> Ssenyonjo also observes that the promotion of the right to health may be practically affected by the private sector's concern for profits.<sup>140</sup> The obligation to fulfil the right to health requires measures to be taken to realise the right. This obligation depends on the State's capability to fulfil the right in terms of its resources.<sup>141</sup> States are obliged to recognise the right and to adopt a national health policy seeking to effectively fulfil the right to health, providing the necessary health care facilities as well as creating conditions ensuring the adequate and equal access to health care services.<sup>142</sup>

#### 4 4 3 The obligation to take steps

States have an obligation to take immediate steps towards the realisation of the right to health.<sup>143</sup> Steps are to be deliberate, concrete and targeted.<sup>144</sup> To comply with this obligation to take immediate steps, States are required to show evidence of a national health policy seeking universal access to PHC. It must be indicated what measures have been taken.<sup>145</sup> General Comment 3 emphasises that this obligation in

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<sup>139</sup> J Tobin *The Right to Health in International law* (2012) 190. See also R Cook & C Ngwena "Rights Concerning Health" in D Brand & C Heyns (eds) *Socio-Economic Rights in South Africa* (2005) 107 115.

<sup>140</sup> M Ssenyonjo *Economic, Social and Cultural Rights in International law* (2009) 340.

<sup>141</sup> W Kalin & J Kunzil *The Law of International Human Rights Protection* (2009) 97; J Tobin *The Right to Health in International Law* (2012) 196; R Cook & C Ngwena "Rights Concerning Health" in D Brand & C Heyns (eds) *Socio-Economic Rights in South Africa* (2005) 107 116.

<sup>142</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 36; M Ssenyonjo *Economic, Social and Cultural Rights in International Law* (2009) 183; J Tobin *The Right to Health in International Law* (2012) 54. See also C Anyangwe "Obligations of States parties to the African Charter on Human and Peoples' Rights" (1998) 10 *RADIC* 625 644.

<sup>143</sup> M Ssenyonjo *Economic, Social and Cultural Rights in International Law* (2009) 322.

<sup>144</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 30.

<sup>145</sup> M Ssenyonjo *Economic, Social and Cultural Rights in International Law* (2009) 323.

unqualified.<sup>146</sup> Specific to children’s rights, General Comment 15 declares that States must take immediate steps towards the realisation of the right to health, regardless of the State’s level of development.<sup>147</sup>

This obligation was read into article 16 of the African Charter in the case of *Purohit and Moore v The Gambia*.<sup>148</sup> The African Commission held that the right to health includes the right to have access to facilities, goods and services.<sup>149</sup> The Gambia was found to be violating the right to health, and thus the African Commission read into the right to the obligation “to take concrete and targeted steps, while making full use of its available resources, to ensure that the right to health is fully realised in all aspects without discrimination.”<sup>150</sup> This aligns the obligations imposed by the right to health in the African Charter with those imposed by the ICESCR. Concurrence on this obligation indicates the necessity of immediate steps to realise the right to health.

#### 4 4 4 The obligation to utilise maximum resources

States are obliged to use all available resources to realise the right to health. Two questions are raised in this regard: the nature of the resources available and the extent to which they can be utilised.<sup>151</sup> Resources include finances, information and human resources.<sup>152</sup> Ssenyonjo argues that because the distribution of resources is an issue, States should, under this obligation, provide evidence that the resources available are

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<sup>146</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 3: *The Nature of State Parties’ Obligations (art 2(1))* UN Doc E/C.14/12/90 para 2.

<sup>147</sup> United Nations Committee on the Rights of the Child General Comment No. 15: *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art 24)* UN Doc.CRC/C/GC/15 para 72.

<sup>148</sup> *Purohit and Moore v The Gambia* Communication 241/2001 (2003) AHRLR 96.

<sup>149</sup> Para 84.

<sup>150</sup> Para 84.

<sup>151</sup> B Saul et al *The International Covenant on Economic, Social and Cultural Rights* (2014) 143.

<sup>152</sup> R E Robertson “Measuring State Compliance with the Obligation to Devote the ‘Maximum Available Resources’ to Realising Economic, Social and Cultural Rights” (1994) 16 *Human Rights Quarterly* 693 697.

being distributed in an equitable manner, targeted to address the disparities in access to health care and to provide for the most vulnerable.<sup>153</sup>

General Comment 3 provides that a State must show that all efforts have been made to use all resources available to give effect to a right.<sup>154</sup> In 2007 the Committee issued a statement on the obligation of taking steps to the “maximum of available resources” under the Optional Protocol to the ICESCR.<sup>155</sup> The statement provides that when considering a State’s decision to (or not to) allocate resources to the realisation of a right; the Committee will evaluate whether there has been compliance with international human rights standards.<sup>156</sup> The Committee will also consider the time frame in which the steps to use the maximum available resources taken and whether the State party has opted for the option which is least restrictive on other Covenant rights.<sup>157</sup> The Committee also recognises the importance of participation and provides that:

“In its assessment of whether a State party has taken reasonable steps to the maximum of its available resources to achieve progressively the realization of the provisions of the Covenant, the Committee places great importance on transparent and participative decision-making processes at the national level.”<sup>158</sup>

How revenue is raised and spent by the government constitutes a relevant consideration under this obligation.<sup>159</sup> In South Africa, the concern lies with the

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<sup>153</sup> M Ssenyonjo “Reflection on State Obligations with Respect to Economic, Social and Cultural Rights in International Human Rights Law” (2011) 15 *The International Journal of Human Rights* 969 980.

<sup>154</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 3: *The Nature of State Parties’ Obligations (art 2(1))* UN Doc E/C.14/12/90 para 10.

<sup>155</sup> United Nations Committee on Economic, Social and Cultural Rights Statement: *An Evaluation of the Obligation to Take Steps to the “Maximum of Available Resources” under the Optional Protocol to the Covenant* UN Doc E/C.12/2007/1.

<sup>156</sup> Para 8.

<sup>157</sup> The Committee also takes into consideration whether the measures were deliberate, concrete and targeted; whether the measures were arbitrary or discriminatory; and how they served the vulnerable, para 8.

<sup>158</sup> Para 11.

<sup>159</sup> The African Commission on Human and Peoples’ Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and*

expenditure of resources. South African spends 8.9% of its annual GDP on health care, though WHO recommends 5%.<sup>160</sup> This indicates that the economic resources are available, but are not being distributed in a manner that effectively provides equal access to health care.

This obligation is considerate of resource restraints but still requires governments to use all resources that are available. Thus, a lack of resources can only be used to justify the non-fulfilment of a right where the government has shown that it is using everything available. How resources are raised and distributed under the NHI scheme must comply with this obligation. The government must use the maximum of available resource to realise the right to health effectively and to fulfil its international law obligation in this regard.

#### 4 4 5 The obligation to progressively realise the right to health

Article 2(1) of the ICESCR provides that full realisation of rights should be achieved progressively. The concept of progressive realisation does recognise the realities of resource constraints<sup>161</sup> though General Comment 3 requires States to “move as expeditiously and effectively as possible.”<sup>162</sup>

The African Charter does not explicitly provide for progressive realisation in its chosen terminology. However, the African Commission’s Principles and Guidelines provides that socio-economic rights in accordance with interpreted by articles 61 and

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*Peoples’ Rights in the African Charter on Human and Peoples’ Rights* (2010) includes taxation as a means to raise revenue, para 15.

<sup>160</sup> World Health Organisation *World Health Statistics* (2015) <<http://www.who.int/countries/zaf/eg/>> (accessed 2 June 2016).

<sup>161</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 3: *The Nature of State Party Obligations (art 2(1))* UN Doc E/C.14/12/90 para 9; United Nations Committee on Economic, Social and Cultural Rights General Comment No. 14: *The Right to the Highest Attainable Standard of Health (art 14)* Un Doc E/C.12/2000/4 para 47. See also R Cook & C Ngwenya “Rights Concerning Health” in D Brand & C Heyns (eds) *Socio-Economic Rights in South Africa* (2005) 107 114.

<sup>162</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 3: *The Nature of State Party Obligations (art 2(1))* UN Doc E/C.14/12/90 para 9; The CRC provides for progressive realisation in the same wording, United Nations Committee on the Rights of the Child General Comment No.15: *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art 24)* UN Doc CRC/C/GC/15 para 9.



62 of the African Charter.<sup>163</sup> These embody the terminology of the ICESCR and CRC as they place States “under a continuing duty to move as expeditiously and effectively as possible towards the full realisation” of the rights.<sup>164</sup>

Chenwi has articulated three key facets of progressive realisation.<sup>165</sup> Firstly, progressive realisation requires immediate action to be taken towards the realisation of the rights represented by the obligation to “to take steps” in article 2 of the ICESCR. Secondly, progressive realisation imposes an obligation of positive action to be taken regarding vulnerable and disadvantaged persons. Lastly, retrogressive measures cannot be pursued unless justified, for example, by the necessity for the achievement of equity in the enjoyment of the rights.<sup>166</sup> Thus, progressive realisation requires States to make a continuous effort towards the fulfilment of the right to health, without infringing on the current enjoyment of the right to health of others unless satisfactorily justified, and to take action to help the vulnerable and disadvantaged most in need expeditiously.<sup>167</sup> General Comment 3 refers to progressive realisation as a “necessary flexibility device” which takes into account the obligations of realising the right as well as the realities of resource constraints.<sup>168</sup> Furthermore, progressive realisation includes a presumption against retrogressive measures.<sup>169</sup> General Comment 3 provides:

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<sup>163</sup> African Commission on Human and Peoples’ Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples’ Rights* (2010) para 13.

<sup>164</sup> African (Banjul) Charter on Human and Peoples’ Rights (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 217, art 62.

<sup>165</sup> L Chenwi “Unpacking ‘Progressive Realisation’, its Relation to Resources, Minimum Core and Reasonableness, and Some Methodological Considerations for Assessing Compliance” (2013) *De Jure* 742 744.

<sup>166</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 190.

<sup>167</sup> R Cook & C Ngwena “Rights Concerning Health” in D Brand & C Heyns (eds) *Socio-Economic Rights in South Africa* (2005) 107 114.

<sup>168</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.3: *The Nature of State Party Obligations (art 2(1))* UN Doc E/C.14/12/90 para 9.

<sup>169</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 3: *The Nature of State Parties’ Obligations (art 2(1))* UN Doc E/C.14/12/90 para 9.

“[A]ny deliberately retrogressive measures [in that regard] would require the most careful consideration and would need to be fully justified by reference of the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources.”<sup>170</sup>

This obligations considers the reality of resource constraints and the time it takes to plan and implement action but still requires continuous effort and continued action.

#### 4 4 6 The obligation to employ all appropriate means

The ICESCR, the CRC, the African Charter and the African Children’s Charter all expressly require the adoption of “legislative measures” to be taken to realise rights effectively. General Comment 14 provides for a margin of discretion on States parties in determining what constitutes as “appropriate measures”.<sup>171</sup> However, General Comment 3 requires States to substantiate their decisions of what constitutes appropriate measures and thus there is an onus on States to justify why the measures adopted should be considered appropriate in context.<sup>172</sup> To meet this obligation, the measures taken must be effective in realising the right to health as guided by General Comment 14 and other international instruments. The measures must practically seek to satisfy the minimum core of the rights, or at least be reasonable in its attempt to do so.<sup>173</sup> PHC is valuable in this regard as it provides some content to the right, as incorporated in the minimum core as per General Comment 14, General Comment 15 and the Principles and Guidelines document of the African Commission. The African Commission provides a detailed elaboration of the minimum core of the right to health. This minimum core includes ensuring that privatisation does not threaten the availability, accessibility, acceptability or quality of health facilities, goods or services.

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<sup>170</sup> Para 9.

<sup>171</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 35; J Tobin *The Rights to Health in International Law* (2012) 178.

<sup>172</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 3: *The Nature of State Parties’ Obligations (art 2(1))* UN Doc E/C.14/12/90 para 4.

<sup>173</sup> Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, United Nations General Assembly Resolution A/RES/63/117, 10 December 2008.

General Comment 3 emphasises that the adoption of legislation alone cannot relieve a State party of its obligations, but it recognises that in certain cases, like in health, that “legislation may also be an indispensable element for many purposes.”<sup>174</sup> Legislation can be used to make resources available for the realisation of the right to health.<sup>175</sup> Legislation can furthermore regulate the health sector in a manner which supports the aims of seeking universal access to health care that is adequate and affordable. This can be done by directing the distribution of resources equitably and in a way that addresses the disparities which exist in the underlying determinants of health.<sup>176</sup>

This obligation also requires States to, where necessary, introduce a national health insurance system to enable access to health care services and goods.<sup>177</sup> The implementation of a universal health care system would require legislation to guide the operational functioning of the system. Legislation can facilitate equitable distribution of resources and ensure equitable access to care. Compliance with this obligation goes further than taking steps but seeks to ensure that a framework exists in which the right to health can be realised, such as through a national health insurance system.

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<sup>174</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.3: *The Nature of State Parties’ Obligations (art 12(1))* UN Doc E/C.14/12/90 para 3.

<sup>175</sup> For example, the African Commission recognise taxation as a means to raise resources, African Commission *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights under the African Charter* (2010) para 15.

<sup>176</sup> S Skogly “The Requirement of Using ‘Maximum of Available Resources’ for Human Rights Realisation: A Question of Quality as well as Quantity?” (2012) 12 *Human Rights Law Review* 393 412.

<sup>177</sup> African Commission, in their *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights under the African Charter* (2010) paras 67P & 67BB. See J E Ataguba & D McIntyre “The Incidence of Health Financing in South Africa: Findings from a Recent Data Set” (2017) *Health Economics, Policy and Law* 1 20 where it is argued that “[i]nternational experience highlights that private health insurance is generally regressive when it is extended to cover a large section of the population.”

## 4 5 Obligations imposed by children's health rights

### 4 5 1 International framework

Children's right to health care imposes different obligations in addition to the obligations imposed by the right to health afforded to "everyone" under international law. While the international law instruments providing for children's right to health contain provisions similar to article 2(1) of the ICESCR, there is additional recognition of obligations imposed on parents or caregivers by the right. Article 10(1) of the ICESCR provides for the responsibilities of parents and caregivers and holds that:

"The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and *while it is responsible for the care and education of dependent children.*"<sup>178</sup>

This provision recognises that parents and caregivers bear a responsibility to care for children and that the State must enable this. While the CRC imposes an obligation on the State to ensure the "survival and development of the child",<sup>179</sup> the CRC is more explicit in imposing obligations on parents:

"Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child."<sup>180</sup>

Article 18(2) of the CRC then imposes a corresponding obligation on the State to ensure that parents and guardians can fulfil this obligation. In applying this to children's right to health, parents or caregivers, therefore, bear the primary responsibility of realising the right for the child, and the State is obliged to enable this through ensuring, for example, that institutions, facilities and services exist to tend to children's health care needs.<sup>181</sup>

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<sup>178</sup> Emphasis added.

<sup>179</sup> Art 6(2) United Nations Convention on the Rights of the Child (adopted 20 November 1989, entered into force 21 October 1986) 1577 UNTS 3.

<sup>180</sup> Art 18(1).

<sup>181</sup> Art 18(2).

## 4 5 2 Regional framework

In the regional framework, the African Children’s Charter explicitly states that parents have the primary responsibility for the development of the child,<sup>182</sup> and are obliged to “secure, within their abilities and financial capabilities, conditions of living necessary”<sup>183</sup> in this regard. The African Children’s Charter subsequently obliges the State to assist parents, “particularly with regard to nutrition, health, education, clothing and housing”.<sup>184</sup> The overt recognition that the State bears an obligation to ensure that parents can realise children’s right to health illustrates that despite the primary obligation resting on parents or caregivers, the State is not exempt from obligations. The State needs to ensure that the institutional framework allows for this parental obligation to be fulfilled. Article 10(2)(a) includes that the State is obliged to provide material assistance to assist parents, but also “in case of need”. This coincides with the recognition in the preamble that:

“[T]hat the child, due to the needs of his physical and mental development requires particular care with regard to health, physical, mental, moral and social development and requires legal protection in conditions of freedom, dignity and security”.<sup>185</sup>

Thus, article 10(1)(a) arguably imposes an obligation on the State to assist in providing for children’s health care needs when parents or other persons responsible are not able to.

The African Charter departs from the other international law instruments and stipulates that the state shall protect the family unit and “shall take care of its physical health and moral.”<sup>186</sup> So in addition to providing everyone with a right to health,<sup>187</sup> the African Charter holds the State responsible for the physical health of the family unit. This relationship between the State’s obligations and the parents’ obligations

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<sup>182</sup> Art 10(1) African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1991) OAU Doc. CAB/LEG/24.9/49.

<sup>183</sup> Art 10(1)(b).

<sup>184</sup> Art 10(2)(a).

<sup>185</sup> Preamble.

<sup>186</sup> Art 18(1) African (Banjul) Charter on Human and Peoples’ Rights (adopted 28 June 1981, entered into force 21 October 1986) 1520 UNTS 217.

<sup>187</sup> Art 16.

regarding the realisation of children's right to health forms part of the framework by which the NHI scheme will be evaluated in chapter six.

#### **4 6 Obligations imposed on the State in the context of private sector activities**

International human rights law instruments are traditionally only binding on States. Therefore, the State is ultimately responsible for ensuring that the operations and activities of private entities do not violate the right to health. General Comment 14 explains this framework of obligations between the State and private entities as follows:

“While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society – individuals, including health professionals, families, local communities, intergovernmental organizations and non-governmental organizations, civil society organizations, *as well as the private business sector* – have responsibilities regarding the realisation of the right to health. States Parties should therefore provide an environment which facilitates the discharge of these responsibilities.”<sup>188</sup>

Thus, although this sector considers the obligations imposed on private entities, it must be borne in mind that obligations regarding the private sector are primarily imposed on States. As examined above,<sup>189</sup> the obligation to respect, protect and fulfil the right to health directly addresses State actions. This part will consider the obligations imposed on the State to respect, protect and fulfil the right to health in the context of private sector activity. This will create the foundation for part of the evaluation of the NHI scheme in chapter six, which will consider the State's obligations to ensure that the private sector does not hinder the realisation of the right to health care.

Where General Comment 14 elaborates on the economic accessibility of the right to health, it provides that States are to ensure that health care services, “whether

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<sup>188</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 42, emphasis added. The private business sector is emphasised as this is central to the evaluation of the NHI scheme in chapter 6 regarding the competing interests of the private sector and their responsibilities in the health care system reform.

<sup>189</sup> See chapter four part 4 2.

privately or publicly provided”, are affordable for everyone.<sup>190</sup> The State is obliged to protect the right to health by ensuring that the private sector prices do not hinder economic accessibility and thereby violate the right to health under the ICESCR. Thus, if private sector prices were to interfere with the economic accessibility of the right, the State will be in violation of its obligation to protect the right. General Comment 14 further provides that States must ensure that the accessibility, availability, acceptability and quality of health care is not impeded by privatisation.<sup>191</sup>

The obligation to respect the right to health is more suited for direct application to the private sector. For example, the private sector bears the responsibility not to discriminate in the provision of health care services. However, if discriminatory practices are discovered, the State will ultimately be liable for failing to ensure compliance with the obligations imposed by the right to health.

The Committee recently adopted General Comment 24 on State Obligations in the Context of Business Activities<sup>192</sup> (“General Comment 24”). General Comment 24 seeks to address situations where private entities have had a negative impact on economic, social and cultural rights.<sup>193</sup> Again, as the State is party to the ICESCR not businesses, the State bears the primary obligations. General Comment 24 concerns the State obligations to ensure private compliance with the ICESCR. The obligations to respect, protect and fulfil are thus the focal point.

General Comment 24 provides that the obligation on States to respect will be violated if business interests are prioritised over socio-economic rights without proper justification.<sup>194</sup> The obligation to respect requires the State to prevent infringements of the right to health by private entities.<sup>195</sup> General Comment 14 provides for examples

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<sup>190</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No.14: *The Right to the Highest Attainable Standard of Health (art 12)* UN Doc E/C.12/2000/4 para 12(b)(iii).

<sup>191</sup> Para 35.

<sup>192</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 24: *State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities* UN Doc E/C.12/GC/24.

<sup>193</sup> Para 1.

<sup>194</sup> Para 1.

<sup>195</sup> Para 14.

of violations of the obligation to protect.<sup>196</sup> It holds that a State would be violating its obligation to respect if it fails “to regulate the real estate market and financial actors... to ensure access to affordable and adequate housing for all”.<sup>197</sup> Albeit in the context of the right to housing,<sup>198</sup> the recognition of failure to regulate private markets as a violation could arguably apply to other socio-economic rights to where the private sector has an influence on the accessibility of a right, such as the right to health.

On the issue of regulation, General Comment 24 provides that the obligation to protect “at times necessitates direct regulation and intervention”.<sup>199</sup> It goes on to say that privatisation is not prohibited under the ICESCR, but that private sectors should be subject to regulation. It holds that, in the context of the right to health, regulation has a role to ensure that the private sector does not hinder access to affordable and adequate health care services.<sup>200</sup> General Comment 24 further elaborates on the obligation to protect:

“The Committee is particularly concerned that goods and services that are necessary for the enjoyment of basic economic, social and cultural rights may become less affordable as a result of such goods and services being provided by the private sector, or that quality may be sacrificed for the sake of increasing profits. The provision by private actors of goods and services essential for the enjoyment of Covenant rights should not lead the enjoyment of Covenant rights to be made conditional on the ability to pay, thus creating new forms of socio-economic segregation.”<sup>201</sup>

States are therefore obliged to regulate the private sector to ensure accessibility, especially economic accessibility.<sup>202</sup> The obligation to protect places the responsibility

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<sup>196</sup> Para 18.

<sup>197</sup> Para 18.

<sup>198</sup> Art 11(1) of the International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 933 UNTS 3.

<sup>199</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 24: *State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities* UN Doc E/C.12/GC/24 para 19.

<sup>200</sup> Para 21.

<sup>201</sup> Para 22.

<sup>202</sup> Para 22. See also A E Yamin “Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage” (2017) 39 *Human Rights Quarterly* 341 366.



on the State to make sure that private entities' business activities do not impede on the right to health.

The obligation to fulfil, by nature a positive obligation, requires the State to mobilise resources and gives the enforcement of a progressive tax scheme as an example.<sup>203</sup> Mobilising resources may impact on the private sector, but the impact could be justified by the State's obligation to fulfil the right. The State is also required to fulfil the right to health by guiding private entities to seek to fulfil the right.<sup>204</sup>

The obligations to respect, protect and fulfil the right to health thus extends beyond State actions but to private sector activities too. What is required by the State under the obligation to respect, protect and fulfil the right to health in the context of private sector activities is crucial to the evaluation of the NHI scheme in chapter six.

## 4 7 Conclusion

This chapter has considered the normative content of the right to health and the obligations imposed on States by international law instruments. In considering the obligations imposed by the right to health, universal health coverage is recognised as a system by which to realise the right to health for all and to address existing disparities in access to and quality of health care. Universal health coverage is arguably able to meet the international law obligations in realising the right to health care.

The international law framework on the right to health provides criteria by which to evaluate the NHI scheme in chapter six. Before evaluation, an analysis of the NHI scheme is necessary to determine what is to be evaluated. The next chapter will provide an analysis of the NHI scheme as a financing system for universal health coverage.

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<sup>203</sup> United Nations Committee on Economic, Social and Cultural Rights General Comment No. 24: *State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities* UN Doc E/C.12/GC/24 para 23.

<sup>204</sup> Para 24.

## CHAPTER 5: AN ANALYSIS OF THE NATIONAL HEALTH INSURANCE SCHEME

### 5 1 Introduction

In 2015 the Department of Health released a White Paper on a National Health Insurance (“White Paper”) scheme for South Africa.<sup>1</sup> This was followed by the release of the National Health Insurance Policy Document (“Policy Document”) on 30 June 2017.<sup>2</sup> This chapter will examine the National Health Insurance (“NHI”) scheme, as provided for in these documents, from a rights-based perspective. This will lay the foundation for the next chapter, which will evaluate the extent to which the NHI scheme complies with the constitutional and international law obligations imposed by the right to health care.

The NHI scheme, as per the Policy Document, is a financing system for universal health coverage. It seeks to address the social determinants of health, the structural problems in the health care system, and the burden of disease. This chapter will consider issues raised by the NHI scheme, the White Paper and the Policy Document. These provide insight into possible challenges facing the development and implementation of the NHI scheme.

### 5 2 An overview of the National Health Insurance scheme

#### 5 2 1 Introducing the National Health Insurance scheme

The Policy Document reflects the State’s commitment to take reasonable legislative and other measures, within its available resources, to progressively realise the right of access to health care.<sup>3</sup> The NHI scheme proposes a policy shift to tackle poverty, the underlying determinants of health and the persisting inequalities in access to and quality of health care inherited from colonialism and apartheid.<sup>4</sup> The NHI scheme is a

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<sup>1</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15.

<sup>2</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017.

<sup>3</sup> Para 3.

<sup>4</sup> Paras 14-16; see chapter two part 2.

means to achieve universal health coverage in South Africa, and the Policy Document articulates:

“National Health Insurance (NHI) is a health care financing system that is designed to pool funds to actively purchase and provide access to quality, affordable personal healthcare services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI is intended to move South Africa towards Universal Health Coverage (UHC) by ensuring that the population has access to quality health services and that it does not result in financial hardships for individuals and their families.”<sup>5</sup>

A health care system operates through the collection of funds, pooling of these funds, the purchasing of services, and the provision of services.<sup>6</sup> As the NHI scheme is a *financing* system, it is primarily concerned with the raising of revenue, the pooling of resources and the purchasing of services. The NHI scheme will not be the service provider. The NHI Fund will purchase services from private and public service providers. This is an important characteristic in understanding the implications of the NHI scheme for the private health care sector. The Policy Document provides an extensive definition of the NHI scheme:

“National Health Insurance is a health financing system that is designed to pool funds and actively purchases services with these funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI will be implemented through the creation of a single fund that is publicly financed and publicly administered. The health services covered by NHI will be provided free at the point of care. NHI will provide a mechanism for improving cross-subsidisation in the overall health system. NHI benefits will be in line with an individual’s need for health care. Implementation of NHI is based on the need to address structural imbalances in the health system and to reduce the burden of disease.”<sup>7</sup>

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<sup>5</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 1, emphasis added.

<sup>6</sup> J Kutzin “A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements” (2001) 56 *Health Policy* 171 173.

<sup>7</sup> The Policy Document further elaborates on “structural imbalances” as a misalignment between resources and needs that undermines access, Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 29.

The core features of the NHI scheme are the provision of universal access to health care and financial risk protection.<sup>8</sup> It will offer a comprehensive list of services, funded by mandatory prepayments.<sup>9</sup> The NHI scheme will operate as a single-payer<sup>10</sup> that will strategically purchase health care services from a single fund.<sup>11</sup>

## 5.2.2 Problems which the National Health Insurance scheme seeks to address

The Policy Document identifies three categories of problems faced under the current health care system: social determinants of health, structural problems, and the burden of disease.<sup>12</sup> The White Paper only recognised the structural problems and the burden of disease.<sup>13</sup> Regarding the social determinants of health, the Policy Document recognises that:

“Health is influenced by the environment in which people are born, grow up, live and work, and societal risk conditions are also more important than individual ones in the spread of a disease. This includes exposure to polluted environments, inadequate housing and poor sanitation. Health is shaped by multiple epidemics, as well as powerful historical and social forces, such as vast income inequalities, unemployment, poverty, racial and gender

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<sup>8</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 30.

<sup>9</sup> The Policy Document defines mandatory prepayments in its glossary as “paying for health before the person is sick and this is compulsory according to income levels and the funds are pooled for the entire population.” para 30.

<sup>10</sup> The Policy Document defines a single-payers as “an entity that pays for all health care costs on behalf of the population.” Para 30. There has recently been contestation over whether the NHI scheme will be single-payer or whether medical aid schemes will retain a role in the reformed health care system. This will be elaborated on in chapter five part 4. See also J Bornman “COSATU Furious Over NHI being SA’s Version of Obamacare” *Business Day* 16-05-2017 <<https://www.businesslive.co.za/bd/national/health/2017-05-16-cosatu-furious-over-nhi-being-sas-version-of-obamacare/>> (accessed 17 May 2017).

<sup>11</sup> The Policy Document defines a strategic purchaser as “an entity that actively utilises its power as a single purchaser to proactively identify population needs and determine the most appropriate, efficient and effective mechanisms for drawing on existing health service providers.” Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 30.

<sup>12</sup> Paras 40-85.

<sup>13</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 62.

discrimination, the migrant labour system, the destruction of family life and extreme violence.”<sup>14</sup>

The Policy Document, therefore, purports to address the underlying determinants of health through the NHI scheme. The Policy Document recognises that the current two-tier structure of the health care system has created a disparity between who needs health care and those who receive health care.<sup>15</sup> Access to health care under the current system is not based on needs but on a person’s ability to pay.<sup>16</sup> People who have access to private health care benefit from the current health care system and resource structure, while those most in need are denied access by physical and financial barriers.<sup>17</sup>

According to the Policy Document, the current health care system’s inability to implement the six building blocks of health care<sup>18</sup> has resulted in the structural problems.<sup>19</sup> The six building blocks are (a) leadership and governance;<sup>20</sup> (b) health care financing;<sup>21</sup> (c) health workforce;<sup>22</sup> (d) medical products and technologies;<sup>23</sup> (e) information and research; and (f) service delivery.<sup>24</sup> The factors which contribute to these structural problems recognised by the Policy Document include resource constraints in the public sector and the poor quality of services offered by most of the public sector.<sup>25</sup>

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<sup>14</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 40.

<sup>15</sup> Para 71.

<sup>16</sup> Paras 71, 81.

<sup>17</sup> See chapter two part 4 1.

<sup>18</sup> World Health Organisation *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies* (2010) Geneva vii.

<sup>19</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 52.

<sup>20</sup> Para 53.

<sup>21</sup> Paras 64, 71.

<sup>22</sup> Paras 58-61.

<sup>23</sup> Paras 62-63.

<sup>24</sup> Para 54.

<sup>25</sup> Paras 55-56.

The high costs of the private sector and the fragmentation of funding within and between the two sectors result in inequalities and the maldistribution of resources.<sup>26</sup> The private sector is fragmented by the number of medical aid schemes and also by occupation, wealth and benefits.<sup>27</sup> The public sector is fragmented by multiple funding pools across government spheres.<sup>28</sup> Fragmentation in funding and provision creates inequalities and negatively impacts on the poor who are not protected from financial risk and unable to meet their health needs.<sup>29</sup> The burden of out-of-pocket payments required for services (applicable in both sectors, but determined by a means test in the public sector)<sup>30</sup> and the high costs of private health insurance has resulted in a financing system which “punishes the poor”.<sup>31</sup>

In addition to these structural problems, South Africa’s burden of disease is four-fold.<sup>32</sup> South Africa is burdened by: (1) communicable diseases such as HIV/AIDS and tuberculosis; (2) non-communicable diseases such as hypertension, cardiovascular diseases, diabetes, cancer, mental illnesses and lung diseases;<sup>33</sup> (3) injuries and trauma; and (4) maternal and child mortality. These burden the population and heavily influences the death rate in South Africa.<sup>34</sup> The NHI scheme seeks to address these problems through transforming the health care system.

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<sup>26</sup> Paras 64, 73-76.

<sup>27</sup> Para 74.

<sup>28</sup> Para 75.

<sup>29</sup> Para 76.

<sup>30</sup> The National Health Act 61 of 2003 provides that health care services will be provided free of charge to children under the age of six, pregnant and nursing women, and those not part of a medical insurance scheme, s4(a) and (b). Those that do not qualify for free services pay an amount determined by a means test. See chapter two part 3 2.

<sup>31</sup> The “benefit incidence” of the health care system is considered pro-rich. The richest 20% of the population have a health needs-share of only 10% yet receive 36% of all benefits. The poorest 20% of the population, with a needs-share of over 25% receive only 12.5% of health care benefits, Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 81.

<sup>32</sup> Para 44.

<sup>33</sup> Statistics South Africa *People: Causes of Death* <[http://www.statssa.gov.za/?page\\_id=737&id=3](http://www.statssa.gov.za/?page_id=737&id=3)> (accessed 13-03-2017).

<sup>34</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15. para 96; Statistics South Africa *People: Causes of Death* <[http://www.statssa.gov.za/?page\\_id=737&id=3](http://www.statssa.gov.za/?page_id=737&id=3)> (accessed 13-03-2017).

### 5 2 3 Principles and objectives of the National Health Insurance scheme

The Policy Document describes the rationale of the NHI scheme as follows:

“NHI focuses on ensuring progressive realisation of the right to health by extending coverage of health benefits to the entire population, in an environment of resource constraint whilst benefiting from efficiency gains.”<sup>35</sup>

The NHI scheme is based on a number of principles, the first being the right of access to health care as provided in the Constitution of the Republic of South Africa, 1996 (“the Constitution”).<sup>36</sup> The principle of equity refers to both equities in access and in quality.<sup>37</sup> Social solidarity is the underlying principle of the financial risk pooling as proposed by the Policy Document.<sup>38</sup> The Policy Document explains financial risk pooling as a legal measure where “risks are placed into a pool to provide a safety net for a broad cross section of society with differing medical risks with the purpose of benefiting from cross-subsidisation within the NHI Fund.”<sup>39</sup> Risk pooling allows for the cross-subsidisation between the young and old, the rich and poor, and the healthy and sick. Additionally, the NHI scheme is based on the principles of affordability, efficiency, effectiveness and appropriateness.<sup>40</sup> Considering these principles, health care services should be provided at a reasonable but sustainable cost within the available resources and allocated fairly and effectively. The health care services purchased must reflect the health needs of the population.

The objectives of the NHI scheme correlate with the principles upon which the scheme is based. The NHI scheme seeks to achieve better health outcomes for the whole population.<sup>41</sup> Other objectives include financial risk protection, reducing

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<sup>35</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 87.

<sup>36</sup> Para 32; s27(1)(a) read with (2) of the Constitution.

<sup>37</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 34.

<sup>38</sup> Para 33.

<sup>39</sup> Glossary, 11.

<sup>40</sup> Paras 36-39.

<sup>41</sup> Para 88.

fragmentation, and improving accountability.<sup>42</sup> Another significant benefit includes improving the quality of care provided in the public sector.<sup>43</sup> The NHI scheme seeks to ensure universal health coverage for the entire population and promote equity and social solidarity.

#### 5.2.4 Phased implementation of the National Health Insurance scheme

The NHI scheme will be implemented in three phases. During the first phase, from the 2012/2013 fiscal year to 2016/2017, the White Paper provides that the health system will be strengthened.<sup>44</sup> Public facilities will be upgraded. Central hospitals will become semi-autonomous to improve governance.<sup>45</sup> The first phase will also establish the NHI fund, the Office of Health Standards and Compliance, the District Management Offices, and the National Health Commission.<sup>46</sup> These will play a significant role in the rest of the implementation and operating of the NHI scheme.

The second phase (2017/2018 – 2019/2020) will build on the first phase by ensuring that the NHI fund is fully functional and that the necessary management and governance structures are in place for operation.<sup>47</sup> The second phase will also introduce, *inter alia*, the following institutions: The National Tertiary Health Services Committee;<sup>48</sup> The National Governing Body on Training and Development;<sup>49</sup> and The

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<sup>42</sup> Para 88.

<sup>43</sup> Para 88.

<sup>44</sup> Para 409.

<sup>45</sup> Para 10.

<sup>46</sup> Paras 316-317; Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 paras 411, 415.

<sup>47</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 311.

<sup>48</sup> The National Tertiary Health Services Committee will be responsible for developing the governance framework for tertiary health care services and for making central hospitals more autonomous, para 313.

<sup>49</sup> The National Governing Body on Training and Development will be responsible for coordinating human resources by aligning health sciences education with the NHI schemes needs, para 314.



Contracting Unit for Primary Healthcare Services.<sup>50</sup> The purchasing of services will begin once the NHI fund is fully functional.<sup>51</sup> The process of amending legislation will commence in the second phase. The Policy Document provides for the legislation which will need to be amended to enable the full implementation of the NHI scheme.<sup>52</sup> These include, *inter alia*: the National Health Act 61 of 2003; the Mental Health Care Act 17 of 2002; the Health Professionals Act 56 of 1974; the Traditional Health Practitioners Act 22 of 2007; the Allied Health Professions Act 63 of 1982; the Dental Technicians Act 19 of 1979; the Medical Schemes Act 131 of 1998; the Medicines and Related Substances Control Act 101 of 1965; and the Nursing Act 33 of 2005.

The final phase (2021/2022 – 2024/2025) will introduce the mandatory prepayment mechanism for contributions to the NHI fund.<sup>53</sup> The necessary amendments to current legislation, such as the Medical Schemes Act 131 of 1998, will be made.<sup>54</sup> Service providers will be contracted, and the population registered into a database.<sup>55</sup> The phased implementation strategy allows for thorough development and involvement from stakeholders. The lessons learned from the Pilot districts<sup>56</sup> will be incorporated accordingly as the phases allow for continuous review.

## 5 2 5 Pilot districts

The Green Paper<sup>57</sup> established NHI scheme pilot districts to test the new primary health care (“PHC”) streams and the referral system and whether these efforts will improve access.<sup>58</sup> The pilot districts were selected across all nine provinces,

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<sup>50</sup> The Contracting Unit for Primary Healthcare Services will operate at district level to facilitate the links between primary health care services and district hospital services, 2017 para 315.

<sup>51</sup> Para 329.

<sup>52</sup> Para 332.

<sup>53</sup> Para 424.

<sup>54</sup> Paras 426-427.

<sup>55</sup> Paras 421, 425.

<sup>56</sup> Para 406.

<sup>57</sup> Para 157; Department of Health *Green Paper on National Health Insurance in South Africa* (2012).

<sup>58</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 157.

specifically tending to areas of underserved communities.<sup>59</sup> The pilot districts sought to reduce the high maternal and child mortality rates in these designated rural and vulnerable areas. The progress is monitored by 18 indicators including child health services, maternal and reproductive health services, the supply of medicines and equipment, and HIV/AIDS and tuberculosis treatment.<sup>60</sup>

The pilot districts yielded some positive outcomes. For example, over 1.5 million doctors' consultations were provided through the contracting of doctors for PHC services.<sup>61</sup> However, concerns also emerged regarding infrastructure, resources, and equipment. The White Paper recognises the shortcomings identified from the pilot districts and seeks to strengthen service delivery accordingly.<sup>62</sup> General practitioners contracted for services at these pilot sites have reported on the lack of resources, staff shortages, and long queues.<sup>63</sup> In a study conducted by the South African Medical Journal in 2015, practitioners expressed frustration with the challenges faced in these pilot sites.<sup>64</sup> Reportedly, the pilot districts have not spent all their financial resources provided to them for upgrading facilities and increasing access to care.<sup>65</sup> The study suggests that more engagement is necessary to address these concerns and determine how to attract more doctors to contracting with the NHI scheme.<sup>66</sup>

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<sup>59</sup> A Fusheini & J Eyles "Achieving Universal Health Coverage in South Africa through a District Health System Approach: Conflicting Ideologies of Health Care Provision" (2016) 16 *BMC Health Services Research* 1 1.

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<sup>61</sup> R Surender, R van Niekerk & L Alfes "Is South Africa Advancing towards National Health Insurance? The Perspective of General Practitioners in One Pilot District" (2016) 11 *SAMJ* 1092 1095.

<sup>62</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 157.

<sup>63</sup> R Surender, R van Niekerk & L Alfes "Is South Africa Advancing towards National Health Insurance? The Perspective of General Practitioners in One Pilot District" (2016) 11 *SAMJ* 1092 1095.

<sup>64</sup> 1095.

<sup>65</sup> A Fusheini & J Eyles "Achieving Universal Health Coverage in South Africa through a District Health System Approach: Conflicting Ideologies of Health Care Provision" (2016) 16 *BMC Health Services Research* 1 9.

<sup>66</sup> 8-9; R Surender, R van Niekerk & L Alfes "Is South Africa Advancing towards National Health Insurance? The Perspective of General Practitioners in One Pilot District" (2016) 11 *SAMJ* 1092 1095.

## 5 3 Universal health coverage

### 5 3 1 Introduction

According to the World Health Organisation (“WHO”), the best way to realise the right to the “highest attainable standard of health”<sup>67</sup> is through universal health coverage.<sup>68</sup> Universal health coverage seeks to ensure access to health care services for all, without the risk of financial ruin.<sup>69</sup> WHO defines universal health coverage as:

“[E]nsuring that all people have access to needed promotive, preventative, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.”<sup>70</sup>

Rudiger argues that universal health coverage is “also a prescription for economic transformation, budget and tax reform and public sector strengthening.”<sup>71</sup> Kutzin holds that a financing scheme seeking to achieve universal health coverage should have three goals: reducing the gap between need and benefit; improving quality; and ensuring financial protection.<sup>72</sup> The global objective of universal health coverage

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<sup>67</sup> WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”, World Health Organisation Constitution (adopted June 1946 and entered into force 7 April 1948) 14 UNTS 185.

<sup>68</sup> World Health Organisation *World Health Report: Health Systems Financing: The Path to Universal Coverage* (2010) Geneva.

<sup>69</sup> World Health Organisation *World Health Report: Research for Universal Health Coverage* (2013) 4.

<sup>70</sup> World Health Organisation *Universal Health Coverage* <[http://www.who.int/healthsystems/universal\\_health\\_coverage/en/](http://www.who.int/healthsystems/universal_health_coverage/en/)> (accessed 13-03-2017).

<sup>71</sup> A Rudiger “Human Rights and the Political Economy of Universal Health Care: Designing Equitable Financing” (2016) 18 *Health and Human Rights Journal* 67 68.

<sup>72</sup> J Kutzin “A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements” (2001) 56 *Health Policy* 171 172.

systems, as evident from the Sustainable Development Goals,<sup>73</sup> recognises health as a human right and not an ordinary market commodity.<sup>74</sup>

The design and functioning of a financing scheme seeking to achieve universal health coverage consist of three facets: population, services and costs. These three aspects of coverage under the NHI scheme will be analysed.

### 5 3 2 Population coverage

Universal health coverage seeks to promote equity in access to and quality of health care.<sup>75</sup> WHO stresses that those unable to afford health care cannot be denied health care services.<sup>76</sup> The NHI scheme seeks to cover the whole population as opposed to just those that are part of a particular financing scheme such as a medical aid.<sup>77</sup> The NHI scheme is based on the right of access to health care, which the Constitution provides for everyone.

The Policy Document provides that the NHI scheme will cover all South Africans as well as all permanent residents.<sup>78</sup> The Policy Document provides that it will prioritise the vulnerable and those unable to access care.<sup>79</sup> It considers women, children, the elderly, the disabled, and rural populations to be vulnerable.<sup>80</sup> However, the Policy Document does not elaborate sufficiently on vulnerable groups such as those living with HIV/AIDS, detained persons or those living in poverty. Inclusive coverage is

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<sup>73</sup> United Nations Sustainable Development Goals para 54 of UN Resolution A/RES/70/1 of 25 September 2015 goal 3.8.

<sup>74</sup> See chapter four part 3 8 2. See also J E Ataguba & D McIntyre “The Incidence of Health Financing in South Africa: Findings from a Recent Data Set” (2017) *Health Economics, Policy and Law* 1 1.

<sup>75</sup> J Kutzin “Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy” (2013) 19 *Bull World Health Organ* 602 608.

<sup>76</sup> World Health Organisation *World Health Report: Health Systems Financing: The Path to Universal Coverage* (2010) Geneva.

<sup>77</sup> J Kutzin “Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy” (2013) 19 *Bull World Health Organ* 602 606.

<sup>78</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 98.

<sup>79</sup> Para 88.

<sup>80</sup> Glossary, 40.

essential in seeking to address the current unequal access to and quality of health care.

### 5 3 3 Service coverage

#### 5 3 3 1 *Service delivery*

Service coverage refers to the services that will be available under the NHI scheme. The Policy Document provides for three tiers of service delivery: (a) PHC services; (b) hospital and specialised services; and (c) emergency medical services.<sup>81</sup> Service delivery does not form part of the financing system of the NHI as the services will be purchased from providers, both public and private. The public sector is being upgraded to improve the quality of care. Central hospitals will become more autonomous and are regarded by the Policy Document as “training platforms, research hubs and centres of excellence”.<sup>82</sup> Hospitals becoming more autonomous through structural changes will ensure that the entire health system benefits from the expertise of those in the central hospitals. The work of central hospitals will play a crucial role in ensuring that the services covered are medically necessary based on evidence and it is envisaged that they will impact positively on population health outcomes.<sup>83</sup>

The NHI fund will purchase services from providers. The Policy Document elaborates on how services will be purchased by the NHI Fund from accredited providers.<sup>84</sup> Only providers, private and public that meet the standards set by the Office for Health Standards and Compliance will be able to accredit themselves with the NHI scheme and be contracted for services.<sup>85</sup>

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<sup>81</sup> Para 139.

<sup>82</sup> Para 10.

<sup>83</sup> Para 118.

<sup>84</sup> Paras 104-105.

<sup>85</sup> For concerns raised over the standard of quality in the public sector see chapter five part 5 2 below. See also chapter two part 4 2.

### 5 3 3 2 *Primary health care*

As per the international and national understanding, PHC includes health education, nutrition, water, child and maternal health care, immunisation, prevention and control of endemic diseases, medical treatment for diseases, injuries and the provision of medicines.<sup>86</sup> The Policy Document states that “PHC is the heart-beat of the NHI.”<sup>87</sup> A major component of the NHI scheme is the re-engineering of PHC. The Policy Document arranges PHC into four streams:

- “a) Municipal Ward-Based Primary Health Care Outreach Teams;
- b) Integrated School Health Programme;
- c) District Clinical Specialist Teams; and
- d) Contracting of private health practitioners at non-specialist level.”<sup>88</sup>

The Municipal Ward-Based Primary Health Care Outreach Teams (“Outreach Teams”) will be deployed to areas where people are vulnerable and in urgent need of access to health care.<sup>89</sup> The Department of Health recognises the health barriers to education, such as hearing, speech and eyesight impairments. The Integrated School Health Programme is aimed at addressing these issues facing learners.<sup>90</sup> The current health system is divided into 52 districts. The Department of Health will make use of this existing organisational structure in implementing the NHI scheme in a decentralised manner.<sup>91</sup>

Kutzin emphasises that health financing reforms cannot be conceived outside of the context in which they are required to operate.<sup>92</sup> He argues that the design of a health care system is to be assessed within the local context and considering the impact it has on other sectors. The re-engineering of PHC into these four streams

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<sup>86</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para VII(3).

<sup>87</sup> Para 140.

<sup>88</sup> Para 143.

<sup>89</sup> Para 144.

<sup>90</sup> Para 145.

<sup>91</sup> Para 146.

<sup>92</sup> J Kutzin “Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy” (2013) 19 *Bull World Health Organ* 602 603.

conforms with Kutzin's context-sensitive approach. The NHI scheme is inter-sectoral as it considers not only the determinants of health but also considers health as a determinant of other aspects of life such as education. The four PHC streams make use of the current structure and seek to build on the strengths of the current district system. The NHI scheme seeks to ensure access to health care on a needs basis and to improve health profiles through providing effective coverage through the four PHC streams.<sup>93</sup>

In 2013 Operation Phakisa Ideal Clinic Realisation Programme was launched to improve services in PHC facilities.<sup>94</sup> "Phakisa" is a Sesotho word meaning "hurry up", chosen to illustrate the urgency and prioritisation of the project.<sup>95</sup> The Department of Health in collaboration with the Health Systems Trust provides that:

"The Ideal Clinic project is a new initiative designed to improve the service delivery platform and ensure that PHC facilities meet and adhere to quality standards."<sup>96</sup>

The Ideal Clinic is based on Batho Pele principles<sup>97</sup> of service delivery. Ten PHC facilities were used to test the Ideal Clinic model. Given the improvements made in these sites, a national roll-out of the programme aims that by 2019 all PHC facilities will be up to Ideal Clinic standards.<sup>98</sup> The programme focuses on eight streams: service delivery, waiting times, infrastructure, human resources, financial management, supply-chain management, institutional management and sustainability.<sup>99</sup> The ideal clinic initiative is commendable for improving the quality of

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<sup>93</sup> 604; World Health Organisation *World Health Report: Health Systems Financing: The Path to Universal Coverage* (2010) Geneva.

<sup>94</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 13.

<sup>95</sup> Department of Planning, Monitoring and Evaluation *Operation Phakisa* (2013) <[www.operationphakisa.org.za](http://www.operationphakisa.org.za)> (accessed 10 April 2017).

<sup>96</sup> R Steinhobel, N Massyn & N Peer "The Ideal Clinic Programme" (2015) *Health Systems Trust and Department of Health*.

<sup>97</sup> The Batho Pele principles consist of: consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money, Department of Public Service and Administration *The Batho Pele Vision* (2014).

<sup>98</sup> Republic of South Africa *Operation Phakisa Ideal Clinic Realisation and Maintenance: Final Lab Report* (2015).

<sup>99</sup> 12.

and access to PHC services. The Ideal Clinic programme can strengthen the service delivery of PHC services and provide a foundation for further service provision.

### 5 3 3 3 *Services to be provided under the National Health Insurance scheme*

The “comprehensive set of personal health services”<sup>100</sup> to be provided under the NHI scheme will not be the same as the current premium minimum benefit packages required under the Medical Schemes Act.<sup>101</sup> Premium minimum benefits are a baseline of services that must be covered by any medical aid scheme package. The White Paper considers the premium minimum benefits to be too “hospi-centric”<sup>102</sup> and ineffective in addressing the burden of disease.<sup>103</sup> The Policy Document provides for a more extensive list of health services to be covered. PHC guides these. The open list includes reproductive and maternal health services, child health service, HIV/AIDS and tuberculosis services, mental health services, prescription medicines and emergency medical health services.<sup>104</sup>

These services coincide with the Policy Document’s problem statement of wanting to address the burden of disease. The list of services reflects the four streams of PHC as well as the international interpretation of PHC.<sup>105</sup> Furthermore, this list reflects the constitutional provisions for health care as it makes provision for reproductive, maternal and child health care as well as emergency medical services.<sup>106</sup> These services are further elaborated on in the Standard Treatment Guidelines and Essential Medicines for South Africa.<sup>107</sup> The Treatment Guidelines are established by evidence

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<sup>100</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 106.

<sup>101</sup> Para 114.

<sup>102</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 132.

<sup>103</sup> Para 132.

<sup>104</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 106.

<sup>105</sup> See chapter four part 3 8 1.

<sup>106</sup> S 27(1)(a), s 27(3) and s 28(1)(c) of the Constitution.

<sup>107</sup> Department of Health *Standard Treatment Guidelines and Essential Medicines List for South Africa* (2012).



of what the best and most cost-effective means of treatment is. The Essential Medicines List will inform which medicines are to be covered by the NHI scheme.

#### 5 3 4 Cost coverage

The Policy Document interprets cost-coverage as “the extent to which the population is protected from direct costs as well as from catastrophic health expenditure.”<sup>108</sup> Covering the cost of health care provides financial protection and enhances access. The Policy Document emphasises that health care will be provided on a need-based and subsequently cost-expenditure will also be based on needs. Once fully implemented the NHI scheme will seek to cover health care services needed as provided for in the open list above. Services that are not covered by the NHI can be obtained through medical aid schemes or out-of-pocket payments.

The Policy Document provides that financial protection is possible through increased government expenditure on health care, reduced out-of-pocket payments, and making provision for the poor.<sup>109</sup> This will improve financial risk protection and provide access to more than just those that currently qualify for free services under the National Health Act.<sup>110</sup> However, the Policy Document does not provide detailed information on how costs will be determined for the services purchased by the NHI Fund. It is indicated, to avoid over-burdening the providers and to ensure sustainability, gate-keeping will be enforced with a referral system. In other words, beyond PHC services, a patient would need to be referred to obtain further treatment. This coincides with the needs-based approach. By-pass fees will be imposed on those who do not adhere to the referral system.<sup>111</sup> Cost coverage under the NHI will operate so that South Africans and those covered by the NHI will only need to pay directly for services that are not covered and will thus be protected from financial risk in obtaining necessary health care services.<sup>112</sup>

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<sup>108</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 133.

<sup>109</sup> Para 133.

<sup>110</sup> See chapter two part 3 2.

<sup>111</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 135.

<sup>112</sup> Para 136.

## 5 4 Financing of the National Health Insurance scheme

### 5 4 1 Introduction

The NHI scheme's financing will be examined with particular reference to WHO's guidelines and the work of Kutzin. The Policy Document emphasises that the NHI scheme is a financing system for health care and that it is South Africa's way of providing universal health coverage.<sup>113</sup>

Kutzin developed a framework by which to assess the financing and resource allocation of a country's health care system and this has strongly influenced WHO's approach to assessing health care systems.<sup>114</sup> He identifies four segments to evaluate: the collection of funds, the pooling of funds, the purchasing of services, and the provision of services.<sup>115</sup> The four-pronged assessment framework will be used to examine the cost coverage of the NHI scheme. However, service provision is not directly applicable to the assessment of the NHI scheme as the NHI scheme will not be the service provider. Therefore, it will not be assessed under this framework beyond the extent of the contracting between the NHI scheme and providers.

### 5 4 2 Collection of funds

The Policy Document recognises that various factors can influence health expenditure, including economic growth.<sup>116</sup> An increase in revenue for health requires a reallocation of resources or an overall increase in public revenue raised for or allocated to health care.<sup>117</sup> Kutzin contends that the overall level of taxes primarily determines the resources available to State allocation and expenditure.<sup>118</sup> The Policy

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<sup>113</sup> Para 340.

<sup>114</sup> J Kutzin "A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements" (2001) 56 *Health Policy* 171 172.

<sup>115</sup> 173.

<sup>116</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 204.

<sup>117</sup> J Kutzin "A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements" (2001) 56 *Health Policy* 171 175.

<sup>118</sup> 175.

Document contemplates taxation as a means to collect funds for the NHI scheme.<sup>119</sup> Although significant changes are not necessarily required to fund the NHI scheme through taxation,<sup>120</sup> the principles of tax design must be balanced to implement “a sustainable, efficient and equitable NHI system.”<sup>121</sup> The principles of tax design recognised by the Policy Document are equity, efficiency, simplicity, transparency and certainty. These are to be considered in assessing the possibility of funding the NHI scheme through taxation.

The funding for health services through tax could be increased through direct taxation, such as personal income tax or corporate tax.<sup>122</sup> Indirect taxation could collect funds through value-added tax (“VAT”), fuel levies or the introduction of an NHI levy.<sup>123</sup> Additionally, the Policy Document also considers payroll taxation and a premium collection as funding possibilities.<sup>124</sup> This study submits that impact of the financing mechanism cannot be regressive or perpetuate inequalities in access to health care. Payroll taxation would limit access to health care to the formal employment sector. A VAT increase would be regressive as the tax burden of a product would form a larger share of a poor person’s budget than a rich person’s. Direct taxation poses less risk for regressive impact. The Policy Document argues that a “personal income tax surcharge would be administratively feasible in South Africa as it would be based on a well-established system.”<sup>125</sup> It does not, however, elaborate on how it is feasible or why it is considered well-established.

In developing the policy and potentially collecting funds through taxation, the tax base must be considered. A broad tax base results in lower tax rates and greater solidarity while a narrow tax base demands higher taxes to collect the same amount of revenue from a smaller pool of the population. South Africa has a narrow tax base. According to the National Treasury, only 13 993 926 people are registered for personal

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<sup>119</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 paras 214-215.

<sup>120</sup> Para 213.

<sup>121</sup> Paras 217.

<sup>122</sup> Para 225.

<sup>123</sup> Paras 220-222.

<sup>124</sup> Para 228.

<sup>125</sup> Para 290.

income tax for 2017.<sup>126</sup> The revenue for health care will ultimately come from a small percentage of the population. This can be balanced with indirect taxation methods to increase the degree of solidarity. Rudiger argues that by “[p]romoting needs-based, equitable taxation as a rights-based instrument for achieving universal health care... [it] opens up an economic and social rights perspective on health policy.”<sup>127</sup> To address the unequal access to and quality of health care, a progressive financing system is desirable for two reasons.<sup>128</sup> Firstly because of the large income inequality, and second because, as argued in a study by Ataguba and McIntyre, over 60% of South Africans would prefer a progressive financing system.<sup>129</sup>

The government subsidises health care for its employees and through tax credits for the medical aid schemes. These subsidies, amounting to an estimated R36 billion, will provide another source of revenue for the NHI scheme as they will be reallocated to the NHI Fund.<sup>130</sup> Other options for collecting funds include compulsory health insurance payments or social insurance taxes.<sup>131</sup> The latter two options are arguably more suited to socio-economic settings where there is not much informal employment, unlike South Africa.<sup>132</sup>

As evidenced by the State subsidies, the main issue is reallocating the resources to funding health care in an equitable manner. South Africa spends 8.9% of its Gross Domestic Product (“GDP”) on health care, far exceeding the 5% recommended by WHO.<sup>133</sup> A reallocation of the resources can potentially benefit the whole population

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<sup>126</sup> National Treasury *Budget Review 2017* (22 February 2017).

<sup>127</sup> A Rudiger “Health Rights and the Political Economy of Universal Health Care: Designing Equitable Financing” (2016) 18 *Health and Human Rights Journal* 67 73.

<sup>128</sup> J E Ataguba & D McIntyre “The Incidence of Health Financing in South Africa: Findings from a Recent Data Set” (2017) *Health Economics, Policy and Law* 1 17.

<sup>129</sup> 18

<sup>130</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 269.

<sup>131</sup> J Kutzin “A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements” (2000) 56 *Health Policy* 171 176.

<sup>132</sup> 176; Statistics South Africa *Work and Labour Force* < <http://www.statssa.gov.za/?cat=31>> (accessed 10 May 2017).

<sup>133</sup> World Health Organisation *World Health Statistics* (2015) <<http://www.who.int/countries/zaf/eg/>> (accessed 2 June 2016).

as opposed to the small percentage that is currently privately insured and benefiting from the subsidies and tax credits.

#### 5 4 3 Pooling of funds under the National Health Insurance scheme

The accumulation of prepaid revenue on behalf of a population is referred to as pooling.<sup>134</sup> Fragmentation limits cross-subsidisation and WHO discourages fragmented funding pools.<sup>135</sup> Financial risk can be effectively managed if it is shared by a greater number of people.<sup>136</sup> The NHI fund will pool resources and purchase health care services on behalf of the population.<sup>137</sup> The Policy Document argues that this will “reduce fragmentation” and “maximise income and risk cross-subsidisation”.<sup>138</sup> If all the people in a given pool are ill and require benefits, then there is little-to-no cross-subsidisation and therefore fewer resources available per capita. The private health insurance business limits these instances through techniques such as tiered rating, where specific costs are set directly in relation to the expected costs or durational rating, where a renewal cost of the contract is subject to increase.<sup>139</sup> The pool of the NHI scheme is the entire population, allowing for cross-subsidisation between the old and the young, the rich and the poor and the sick and the healthy.<sup>140</sup>

Another concern regarding pooling is the administration costs involved. The Policy Document creates a framework for keeping administration costs to a minimum and ensuring accountability.<sup>141</sup> The private sector operating alongside the NHI scheme will

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<sup>134</sup> J Kutzin “A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements” (2000) 56 *Health Policy* 171 176.

<sup>135</sup> World Health Organisation *World Health Report: Health Systems Financing: The Path to Universal Coverage* (2010) Geneva 77.

<sup>136</sup> 47.

<sup>137</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 252.

<sup>138</sup> Para 252.

<sup>139</sup> J Kutzin “A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements” (2000) 56 *Health Policy* 171 178.

<sup>140</sup> See chapter three part 4 4.

<sup>141</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 253.

however still need to be regulated, and this is to be taken into account when considering the overall administration costs involved.

#### 5 4 4 Purchasing of services under the National Health Insurance scheme

The resources accumulated by the NHI Fund will be used to purchase health care services on behalf of the population. A purchaser can be active or passive. Active purchasing describes a situation where purchasers strategically link their purchasing decisions to the performance of providers.<sup>142</sup> Purchasing can be active through financial incentives, referral systems or standard treatment guidelines.<sup>143</sup> The Policy Document contends that the NHI Fund will be an active purchaser.<sup>144</sup> The NHI Fund will not operate on a fee-for-service basis.<sup>145</sup> Fee-for-service purchasing operates where providers are reimbursed for services rendered, regardless of the outcome or impact on the patients' health. The Policy Document recognises fee-for-service purchasing as an impediment to quality health care.<sup>146</sup> The NHI Fund, as an active purchaser, will operate on performance-based payments for health care services.<sup>147</sup>

The Policy Document provides that it "will pay providers in a way that creates appropriate incentives for efficiency and the provision of quality and accessible care."<sup>148</sup> It proposes a capitation payment system which is an arrangement where providers are paid a set amount per patient per amount of time.<sup>149</sup> This seeks to provide service providers with an incentive to consider the cost of treatment.<sup>150</sup> The Policy Document states that as the capitation payment system is more outcome based than fee-for-service payment, it will encourage providers to consider not only the cost

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<sup>142</sup> J Kutzin "A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements" (2000) 56 *Health Policy* 171 183.

<sup>143</sup> 183.

<sup>144</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 275.

<sup>145</sup> Para 295.

<sup>146</sup> Para 187.

<sup>147</sup> Para 288.

<sup>148</sup> Para 286.

<sup>149</sup> Para 290.

<sup>150</sup> Para 293.

of treatments but also the effectiveness thereof.<sup>151</sup> A key issue will be how the capitation rate is determined.<sup>152</sup> These payment methods will be introduced gradually.<sup>153</sup>

The market structure is an important consideration in the purchasing of services and the pursuit of cost-effectiveness as it is argued that a competitive market will result in more affordable services.<sup>154</sup> A competitive market is presumed to lower costs and to avoid market monopolies that result in high costs. However, Kutzin argues that “[a] competitive insurance market is *not* a pre-requisite for active purchasing.”<sup>155</sup> There are concerns about the non-competitive nature of the NHI scheme as the NHI Fund will be the sole purchaser. Kutzin’s argument is thus significant in defending this characteristic of the NHI scheme. The NHI scheme will consist of a single-payer structure with the NHI Fund being the single purchaser.<sup>156</sup>

There is concern about a lack of competition and that this monopoly held by the NHI fund will result in high costs or maladministration.<sup>157</sup> Kutzin argues that a single-payer can take advantage of economies of scale in purchasing and thereby save costs without hindering the efficiency of the service provision.<sup>158</sup> Multiple-payers can result in diluted incentives, while a single-payer will provide consistent incentives. Furthermore, the administration costs of regulating multiple payers are high and can detract resources. The current multiple payers consist of the 83 medical aid schemes,<sup>159</sup> the State, and individuals’ out-of-pocket payments. The costs of regulating the private health insurance business and multiple payers of medical aid schemes detracts funding which could be spent differently.

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<sup>151</sup> Para 293.

<sup>152</sup> Para 290.

<sup>153</sup> Para 291.

<sup>154</sup> J Kutzin “A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements” (2000) 56 *Health Policy* 171 181.

<sup>155</sup> 184, original emphasis.

<sup>156</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 278.

<sup>157</sup> See chapter five part 5 1.

<sup>158</sup> J Kutzin “A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements” (2000) 56 *Health Policy* 171 186.

<sup>159</sup> Council for Medical Schemes: Annual Report 2014/2015 *15 Years on the Pulse* (2015).

The Policy Document defends the single-payer system:

“Acting as a single-payer and single purchaser, the NHI Fund will be able to reap the efficiency benefits of monopsony purchasing power and economies of scale, and ensure that incentive structures for healthcare providers are integrated and coherent.”<sup>160</sup>

This coincides with Kutzin’s premise that active purchasing does not require a competitive market and therefore refutes objections to the anti-competitive structure of a single-payer system.<sup>161</sup> Currently, the private health care sector is being investigated by the Competition Commission. The Competition Commission is concerned over the high prices and drastic increases in private health care. The Competition Commission is of the view that features of the private sector prevent and restrict competition.<sup>162</sup> This suggests that competition does not necessarily ensure efficiency and it is costly to regulate multiple purchasers. The lack of competition may, in fact, benefit the population as the NHI scheme’s objection is not to make profits, but to realise the right of access to health care.

## 5 5 Issues raised by the National Health Insurance scheme

### 5 5 1 Implementation costs of the National Health Insurance scheme

The financing of the NHI scheme has provoked objections, arguing that the tax base of South Africa is too narrow to support the NHI scheme.<sup>163</sup> South African Private Practitioners Forum (“SAPPF”) argue that the NHI scheme’s proposed financing structures will result in 12.8% of the population paying for the country’s health through personal income tax.<sup>164</sup> Similarly, the South African Institute of Race Relations raise

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<sup>160</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 276.

<sup>161</sup> J Kutzin “A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements” (2000) 56 *Health Policy* 171 184.

<sup>162</sup> Competition Commission ‘Market Inquiry into the Private Healthcare Sector’ <<http://www.compcom.co.za/healthcare-inquiry/>> (Accessed 20 June 2016).

<sup>163</sup> South African Private Practitioners’ Forum *Submission on National Health Insurance Financing to the Davis tax Committee* (October 2016) para 25.

<sup>164</sup> Para 25.



concerns about the unforeseeable long-term costs that may be incurred.<sup>165</sup> They also contend that there are other ways to achieve universal health coverage.<sup>166</sup> Interestingly the South African Institute of Race Relations argues that the rising costs of private health care are as a result of government regulation and they disapprove of the enforcement of premium minimum benefits.<sup>167</sup>

The Free Market Foundation recommends deregulating medicines and medical aid schemes to increase access to health care.<sup>168</sup> They argue that if pharmaceutical entities and medical aid schemes were free to regulate themselves, then market forces would increase access.<sup>169</sup> Although it is possible for market forces and a competitive market structure to increase access and lower costs, the behaviour of the health care market in South Africa indicates that this would not necessarily be the case. The cost of private health care has increased beyond the inflation rate, despite being subject to regulation.<sup>170</sup> The enforcement of premium minimum benefits ensures that beneficiaries are entitled to a basic standard of coverage for the premiums paid. Without such regulation, a medical aid scheme could be structured to only cover, for example, 20% of any health care costs. This would defeat the purpose of medical aid schemes, which seek to improve access and remove financial risk.<sup>171</sup>

The cost of the NHI scheme has triggered speculation. The figures provided in the White Paper estimated that the cost of the NHI scheme would require a public health spending of 6.2% of the GDP by 2025/2026.<sup>172</sup> This is based on the economy growing at a rate of 3.5% annually. The Policy Document recognises the current economic

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<sup>165</sup> South African Institute for Race Relations NPC *Submission on National Health Insurance Financing to the Davis tax Committee* (October 2016) 23; this was before the downgrading of the credit ratings, which they had highlighted as an economic variable which would affect the costs and long-term sustainability of the NHI scheme.

<sup>166</sup> 25.

<sup>167</sup> 3.

<sup>168</sup> Free Market Foundation *Submission on National Health Insurance Financing to the Davis tax Committee* (October 2016) 10.

<sup>169</sup> 16.

<sup>170</sup> Competition Commission 'Market Inquiry into the Private Healthcare Sector' <<http://www.compcom.co.za/healthcare-inquiry/>> (accessed 20 June 2016).

<sup>171</sup> Preamble, Medical Schemes Act 131 of 1998.

<sup>172</sup> Econex *Comments on Select Aspects of the NHI White Paper* (June 2016) 2.

environment, where the 2016 GDP growth was only 0.3%.<sup>173</sup> Although more detailed on expected costs than the White Paper, the Policy Document states that the costs are uncertain and largely dependent on the improvements of the public sector and the regulation of the private sector.<sup>174</sup> The International Monetary Fund and the World Bank regard this prediction as optimistic and note that realistically the rate of growth in South Africa is closer to 1% per annum.<sup>175</sup> The Minister of Health, Dr Aaron Motsoaledi, recently provided that over 40 billion rands have already been spent on infrastructure under the first phase of NHI scheme implementation.<sup>176</sup>

The implementation of the NHI scheme requires not only a shift in the use of resources but also an increase in resources. The implementation costs of the NHI scheme will be considered in evaluating the NHI scheme's compliance with constitutional and international law obligations regarding resources.<sup>177</sup>

## 5 5 2 Health care quality in the public sector

The state of the public sector presents a challenge to the implementation of the NHI scheme. The 2015 report of the Office of Health Standards and Compliance found that on average, there has been a decline in the quality of government health care facilities since 2012.<sup>178</sup> Inspections consider six priority areas: the availability of medicines and supplies; cleanliness; patient safety; infection prevention and control; positive and caring attitude of staff; and patient waiting times.<sup>179</sup> A score of 80% is deemed as an acceptable level of quality. Quality is an integral component of the right to health care,

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<sup>173</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 196.

<sup>174</sup> Para 239.

<sup>175</sup> Econex *Comments on Select Aspects of the NHI White Paper* (June 2016) 3.

<sup>176</sup> C Presence "Motsoaledi: NHI is Coming, Whether you Like It or Not" *IOL* 16-05-2017 <[http://www.nhisa.co.za/C\\_NewsReports.asp](http://www.nhisa.co.za/C_NewsReports.asp)> (accessed 18 May 2017).

<sup>177</sup> See chapter six part 5.

<sup>178</sup> Office for Health Standards and Compliance *Annual Report 2015/16* 19. See chapter two part 4 2.

<sup>179</sup> 19.

as articulated in General Comment 14.<sup>180</sup> The national average of quality compliance is estimated to be 46%.<sup>181</sup>

In its submission on the White Paper, the non-governmental organisation, Section 27, expresses concern over the “dire state of the health system”.<sup>182</sup> Section 27 argues that the public health care system needs to address some fundamental problems before the NHI scheme can be effectively implemented. This includes the deficit in human and financial resources, inadequate infrastructure, and inefficient administration systems.<sup>183</sup> The South Africa Medical Association also emphasise the low standard of quality in the public sector and the need for improvement before implementation of the NHI scheme.<sup>184</sup> They also raise corruption as a concern and stress the importance of good governance if the public sector is to be strengthened.<sup>185</sup>

London<sup>186</sup> suggests that the White Paper implies that penalties could be imposed if people seek care outside of their districts.<sup>187</sup> He cautions that this could “aggravate inequality”.<sup>188</sup> The facilities in the poorest (and therefore also the most vulnerable) areas are most likely not to meet the quality standards to be accredited with the NHI Fund.<sup>189</sup> This risks entrenching disparities in the quality of health care. Explicit effort needs to be made to address the disparities in quality to prevent perpetuating

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<sup>180</sup> See chapter four part 3 4.

<sup>181</sup> Section 27 Submission on the White Paper <<http://www.nhisa.co.za/B-submissions.asp>> (accessed 10 June 2016) para 6.1; see chapter two part 4.

<sup>182</sup> Section 27 Submission on the White Paper <<http://www.nhisa.co.za/B-submissions.asp>> (accessed 10 June 2016) para 6.

<sup>183</sup> Para 8.

<sup>184</sup> South African Medical Association Submission on the White Paper <<http://www.nhisa.co.za/B-submissions.asp>> (accessed 10 June 2016) 29.

<sup>185</sup> 141-145, 186.

<sup>186</sup> Professor Leslie London is a public health specialist at the University of Cape Town.

<sup>187</sup> L London “Comments on the White Paper on a National Health Insurance for South Africa” *Report to the Foundation for Human Rights* (2016) <<http://www.nhisa.co.za/B-submissions.asp>> (accessed 10 June 2016) 24; Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 107.

<sup>188</sup> L London “Comments on the White Paper on a National Health Insurance for South Africa” *Report to the Foundation for Human Rights* (2016) <<http://www.nhisa.co.za/B-submissions.asp>> (accessed 10 June 2016) 29.

<sup>189</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 219.

inequalities. This will be further elaborated on in the following chapter by evaluating the NHI scheme's compliance with the obligations imposed by the right to health care.

### 5 5 3 Participation and engagement

There is concern over the lack of community and stakeholder participation in the development of the NHI scheme. Participation and engagement is a fundamental part of PHC. WHO recognises collaborative dialogue and stakeholder participation as key elements of PHC.<sup>190</sup> Additionally, as PHC is needs-based, engagement is necessarily needed to determine the health needs of the population.<sup>191</sup> The White Paper provides that PHC is the “heartbeat” of the NHI scheme.<sup>192</sup> Despite this, the White Paper only briefly mentions that Clinic Committees can facilitate community participation.<sup>193</sup> Participation and engagement should be informative, consultative, collaborative, empowering and should involve the community.<sup>194</sup> London contends that the referral system reflects a missed opportunity for community participation and that the NHI scheme fails to provide for participation at all levels of operation of the NHI scheme.<sup>195</sup> In this regard, he recommends that effective measures be taken to ensure participatory decision-making and engagement with vulnerable groups and all affected communities.<sup>196</sup> The Policy Document provides:

“Community involvement will be essential at all levels of the transformed systems to ensure that there is participatory governance, and accountability.”<sup>197</sup>

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<sup>190</sup> WHO *Primary Health Care* <[http://www.who.int/topics/primary\\_health\\_care/en](http://www.who.int/topics/primary_health_care/en)> (accessed 10 April 2017).

<sup>191</sup> See chapter four part 3 8 1.

<sup>192</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 158.

<sup>193</sup> Para 186.

<sup>194</sup> A Muller “Community Participation in Health” (2013) *Nursing Update* 26 28.

<sup>195</sup> L London “Comments on the White Paper on a National Health Insurance for South Africa” *Report to the Foundation for Human Rights* (2016) <<http://www.nhisa.co.za/B-submissions.asp>> (accessed 10 June 2016) 14.

<sup>196</sup> 14.

<sup>197</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 345.

The NHI scheme's compliance with obligations regarding participation and involvement will be evaluated in the following chapter.

#### 5 5 4 Impact of the National Health Insurance scheme on private rights and interests

In seeking to address the inequalities in access to and quality of health care, the implementation of the NHI scheme may affect private rights and interests.<sup>198</sup> Certain organisations argue that the right to freedom of association is subject to potential infringement as people will not be able to choose whether to contribute to the NHI fund.<sup>199</sup> The Independent Municipal and Allied Trade Union and the Free Market Foundation argue that the money spent in the private health care sector is voluntary and the NHI scheme will remove consumer choice.<sup>200</sup> They argue that the right to freedom of association includes the right to dissociate.<sup>201</sup> The Free Market Foundation and the SAPPF contend that health care should be treated in the same manner as housing and education and that the private sector should be left to market forces.<sup>202</sup> However the Free Market Foundation and the SAPPF neglect to consider the public law programmes regarding both, such as housing subsidy schemes and public education. The South African Medical Association contend that the compulsory membership imposed by the NHI scheme will not hinder the right to freedom of

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<sup>198</sup> M Pieterse *Can Rights Cure?* (2014) 141.

<sup>199</sup> S18 of the Constitution; Hospital Association of South Africa Submission on the White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 1; Independent Municipal and Allied Trade Union Submission on White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 1-2; Free Market Foundation Submission on the White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 34.

<sup>200</sup> S18 of the Constitution; Independent Municipal and Allied Trade Union Submission on White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 1-2; Free Market Foundation Submission on the White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 34.

<sup>201</sup> In *Law Society of the Transvaal v Tloubatla* 1999 4 SA 59 (D) the Court held that the right to freedom of association includes the right to dissociate.

<sup>202</sup> Free Market Foundation Submission on the White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 34; South African Private Practitioners Forum Submission on the White Paper <[http://www.nhisa.co.za/B\\_submissions.asp](http://www.nhisa.co.za/B_submissions.asp)> (accessed 10 June 2016) para 60.

association “as long as it does not prevent people from joining private medical aid schemes that will be able to cover complementary services.”<sup>203</sup>

The Free Market Foundation views health care as an ordinary market commodity and “believes it is neither necessary nor appropriate for the government to provide ‘free healthcare for all’”.<sup>204</sup> Similarly, Afribusiness argue that the State is not obliged to provide free health care to all as access does not mean the provision of free services.<sup>205</sup> Their argument based on the right to freedom of association and is premised on the view that health care is not a right and that the State does not incur obligations under section 27(1)(a) read with (2) of the Constitution. This interpretation is problematic and contradictory to the international interpretation of health care as a right and the Constitutional Court’s socio-economic rights jurisprudence. The NHI scheme explicitly seeks to facilitate the realisation of the right of access to health care. A constitutional challenge based on the right to freedom of association would be weak given the socio-economic jurisprudence and transformative mandate and text of the Constitution.

It is also argued that the NHI scheme may impugn on the right to freedom of trade.<sup>206</sup> Although this right is subject to regulation, there is concern over the extent of the regulation.<sup>207</sup> With regard to this competing right, the *Affordable Medicines Trust v Minister of Health*<sup>208</sup> case is applicable. The case concerned a challenge against a licensing scheme which restricted the dispensing of medicines under the Medicines and Related Substances Control Act 101 of 1965. The applicants argued that these regulations infringed, *inter alia* on health care practitioners constitutional right to freely

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<sup>203</sup> South African Medical Association Submission on the White Paper <<http://www.nhisa.co.za/B-submissions.asp>> (accessed 10 June 2016) 29.

<sup>204</sup> Free Market Foundation *Submission on National Health Insurance Financing to the Davis tax Committee* (October 2016) 2.

<sup>205</sup> Afribusiness Submission on the White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 12.

<sup>206</sup> Helen Suzman Foundation Submission on the White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 7; Hospital Association of South Africa Submission on the White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 43.

<sup>207</sup> S22 of the Constitution.

<sup>208</sup> 2001 3 SA 1151 (CC).

choose their profession.<sup>209</sup> The Constitutional Court unanimously rejected the arguments based on the Bill of Rights. The case turned on the *ultra vires* challenge as an empowering statute did not authorise the regulatory power.<sup>210</sup> The Court did, however, consider section 22 of the Constitution and the extent to which limitations on the right may be justified. The Court determined that a section 36 justification would not be necessary where the choice of profession or ability to practice it was not affected.<sup>211</sup> The Court held:

“[I]f the regulation of the practice of the profession is rationally related to a legitimate government purpose and does not infringe on any rights in the Bill of Rights, it will fall within the parameters of section 22. Where the regulation of a practice, viewed objectively, is likely to impact negatively on the choice of a profession, such regulation will limit the right freely to choose a profession guaranteed by section 22, and must therefore meet the test under section 36(1). Similarly, where the regulation of practice though falling within the purview of section 22, but limits any of the rights in the Bill of Rights, it must meet the section 36(1) standard.”<sup>212</sup>

Addressing health inequities is arguably a legitimate government purpose. Therefore, unless the NHI scheme is found to infringe a right in the Bill of Rights, the regulation of the health care sector would fall within the parameters of section 22 and a constitutional challenge on this ground would have weak prospects given the evident need for health care reform to give effect to section 27 of the Constitution.

Recently, Congress of South Africa Trade Unions (“COSATU”) expressed concern over a comment made by the Minister of Health, Dr Aaron Motsoaledi.<sup>213</sup> The Minister of Health expressed the need to work together with the private sector, such as medical aids, in the transition into universal health coverage. COSATU argues that a multi-payer system based on income groups will perpetuate inequalities.<sup>214</sup> The NHI scheme does not abolish medical schemes immediately. It seeks to use them in the transition

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<sup>209</sup> S22 of the Constitution; 2001 3 SA 1151 (CC) para 2.

<sup>210</sup> 2001 3 SA 1151 (CC) para 73.

<sup>211</sup> Para 73.

<sup>212</sup> Para 73.

<sup>213</sup> L Dentilinger “Motsoaledi: NHI Not Being Sold to Private Medical Schemes” 17-05-2017 *EWN* < [http://www.nhisa.co.za/C\\_NewsReports.asp](http://www.nhisa.co.za/C_NewsReports.asp) > (accessed 18 May 2017).

<sup>214</sup> L Dentilinger “Motsoaledi: NHI Not Being Sold to Private Medical Schemes” 17-05-2017 *EWN* < [http://www.nhisa.co.za/C\\_NewsReports.asp](http://www.nhisa.co.za/C_NewsReports.asp) > (accessed 18 May 2017).

phases and then to adjust their role accordingly to complement not compete with the NHI scheme.

The SAPPF are concerned about the loss of potential profits of medical aid schemes. They emphasise that the State is under the obligation to first address the failures in the public sector before incorporating the private sector in its efforts to realise the right of access to health care.<sup>215</sup> Kirby argues that the NHI scheme may be infringing on the medical aid schemes' right to property as it will deprive them of potential profits.<sup>216</sup> Kirby is critical of the enforceability of the right to health care and argues that it is "an aspiration that may only find its meaning in science fiction as opposed to jurisprudence and practical implementation of healthcare delivery and services."<sup>217</sup> He, therefore, argues that the NHI scheme may infringe on medical aids' property rights by affecting their future profits.<sup>218</sup> The Hospital Association of South Africa and the SAPPF also raise property rights issues in this regard.<sup>219</sup> The Hospital Association of South Africa further argues that the NHI scheme falls short of the constitutional standard of reasonableness regarding section 27.<sup>220</sup> An argument based on property rights and the impact of the NHI is weak and contingent on potential future profits firstly being recognised as property, and secondly that the impact of the NHI scheme is not justifiable. This issue illustrates the concerns of the private sector over profits.

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<sup>215</sup> South African Private Practitioners Forum Submission on the White Paper <[http://www.nhisa.co.za/B\\_submissions.asp](http://www.nhisa.co.za/B_submissions.asp)> (accessed 10 June 2016) 40.

<sup>216</sup> N Kirby "Health for All?" (2016) *Legal Brief* <<http://werksmans.com/legal-briefs-view/health-for-all/>> (Accessed 2 July 2016).

<sup>217</sup> N Kirby "Access to Healthcare Services as a Human Right" (2010) 29 *Medicine and Law* 487 496.

<sup>218</sup> 496.

<sup>219</sup> Hospital Association of South Africa Submission on the White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 43; South African Private Practitioners Forum Submission on the White Paper <[http://www.nhisa.co.za/B\\_submissions.asp](http://www.nhisa.co.za/B_submissions.asp)> (accessed 10 June 2016) para 15.

<sup>220</sup> Hospital Association of South Africa Submission on the White Paper <[http://www.nhisa.co.za/B\\_submission.asp](http://www.nhisa.co.za/B_submission.asp)> (access 10 June 2016) 54.



Other views support the de-commodifying of health care in recognition of the persisting inequalities.<sup>221</sup> The Rural Health Partner Network welcomes the White Paper's recognition of rural populations as vulnerable but caution that:

"Without due consideration of factors such as geography, demographic characteristics, epidemiological profiles, high levels of socio-economic deprivation and inequities in the resourcing of care, the NHI will simply duplicate historical and structural neglect that continues to define much of rural health."<sup>222</sup>

Additionally, Pieterse argues that legislative and policy efforts should address factors such as geography due to the impact they have on the realisation of rights and fulfilment of constitutional obligations.<sup>223</sup>

The crux of the issues raised concern the extent of regulation and impact on the private health care sector and private health care resources. These concerns need to be balanced against the purpose of the NHI scheme: to realise the right of access to health care and address the inequalities in access to and quality of health care. The transformative mandate of the Constitution favours the NHI scheme and transformative reform of the health care sector.

## 5 6 Conclusion

This chapter examined the NHI scheme as provided for in the latest Policy Document. This analysis will serve as the basis for the evaluation of the NHI scheme's compliance with constitutional and international law obligations imposed by the right to health care. As the NHI scheme is a financing system, the financing of the proposed health care system reform is a crucial aspect of analysing the NHI scheme. The Policy Document provides for various financing mechanisms. A contentious issue is the implementation costs of the NHI scheme. There is much speculation on the cost and sustainability of the scheme. This chapter has argued that given the persisting

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<sup>221</sup> R Amollo "In Pursuit of Health Equity in South Africa" (2009) 10 *ESR Review* 14 16.

<sup>222</sup> Rural Health Partner Network Submission on the White Paper <[http://www.nhisa.co.za/B\\_submissions.asp](http://www.nhisa.co.za/B_submissions.asp)> (accessed 10 June 2016) 4.

<sup>223</sup> M Pieterse "Rights, Regulation and Bureaucratic Impact: The Impact of Human Rights Litigation on the Regulation of Informal Trade in Johannesburg" (2017) 20 *PER* 2 19.

inequalities in health care, South Africa cannot afford not to seek reform and move towards a universal health coverage system.

The extent to which the scheme may legitimately affect the rights and interests of private actors is closely related to the nature of the obligations imposed upon the State by the right of everyone to have access to health care services. The following chapter will use this analysis of the NHI scheme to evaluate the extent to which the NHI scheme complies with its constitutional and international law obligations imposed by the right to health care.

## **CHAPTER 6: EVALUATING COMPLIANCE OF THE NHI SCHEME WITH THE CONSTITUTIONAL AND INTERNATIONAL LAW OBLIGATIONS IMPOSED BY THE RIGHT TO HEALTH**

### **6 1 Introduction**

The National Health Insurance (“NHI”) scheme proposed for South Africa seeks to address the inequalities in access to and quality of health care. The need for health care system reform was articulated in chapter two. The proposed reform stems from the recognition of health care as a human right. Both the Constitution of the Republic of South Africa, 1996 (“the Constitution”), and international law recognise health care as a human right. The right to health care imposes constitutional and international law obligations on the State. These have been analysed in previous chapters.<sup>1</sup> This chapter will evaluate to what extent the NHI scheme, as analysed in chapter five, complies with constitutional and international law obligations imposed by the right to health care.

### **6 2 The obligation to respect, protect, promote and fulfil the right of access to health care**

#### **6 2 1 Introduction**

The obligations to respect, protect, promote and fulfil the right of access to health care is an overarching typology which informs the specific State obligations in terms of both the South African Constitution and international human rights law.<sup>2</sup> This section will consider the State obligations in this regard. The obligations regarding private entities and State obligations in the context of business activities will be considered below.<sup>3</sup>

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<sup>1</sup> See chapter three part 4 and chapter four part 4.

<sup>2</sup> See chapter three part 2 3 and chapter four part 4 2.

<sup>3</sup> See chapter six part 7.

## 6 2 2 The obligation to respect the right of access to health care

The obligation to respect the right to health care is a negative obligation requiring the State to refrain from interference with existing enjoyment of the right.<sup>4</sup> The NHI scheme seeks more equitable access to health care services. The health care system needs to be reformed in a way that does not impair or prevent access. The current system fails this obligation as access is impaired and prevented by the two-tier system.<sup>5</sup> The NHI scheme proposes that access be determined on a needs basis and not a person's ability to pay.<sup>6</sup> This reform will address the features of the current system that prevents and impairs access. Additionally, the reallocation of resources and increased access will result in a reduction in the concentration of resources in the private health care sector and a more equitable distribution of resources in the health care sector as a whole.<sup>7</sup> Consequently, the doctor-to-patient ratio in the private sector, which is estimated to be 92 doctors per 100 000 patients (compared to the 25 doctors per 100 000 patients in the public sector),<sup>8</sup> will be diluted through the increased access under the NHI scheme. While this affects those with the existing enjoyment of the right to health care in the private sector, it does not deprive those with resources of access to quality health care.<sup>9</sup> However, the impact is not necessarily in conflict with the overarching obligation to respect because retrogressive measures can be justified.<sup>10</sup> Retrogressive measures will be examined under the obligation to realise the right of access to health care progressively.<sup>11</sup>

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<sup>4</sup> See chapter three part 2 3, part 2 4 and part 3. See also chapter four part 4 2.

<sup>5</sup> See chapter two part 4.

<sup>6</sup> See chapter five part 2 1.

<sup>7</sup> See chapter five part 2.

<sup>8</sup> Econex *Identifying the Determinants of and Solutions to the Shortage of Doctors in South Africa: Is There a Role for the Private Sector in Medical Education?* (2015) 6.

<sup>9</sup> It is also important to consider that not all private practitioners will contract with the NHI scheme. It is likely that there will be a number of private sector health care professionals who continue to practice entirely in the private sphere, and those with the means and desire to do so can access health care services in this manner.

<sup>10</sup> See chapter three part 2 3 1 and chapter four part 4 2.

<sup>11</sup> See chapter six part 4 2.

### 6 2 3 The obligation to protect the right of access to health care

The obligation to protect requires the State to protect people from third party interference with rights.<sup>12</sup> A fundamental objective of the NHI scheme is to protect people from financial risk when seeking access to health care.<sup>13</sup> The NHI scheme seeks to remove barriers to access, such as, for example, financial barriers. This seeks to comply with the obligation to ensure a legal framework that enables access and prevents interference with access. The exponentially rising costs of health care in the private sector hinders the accessibility and availability of the right to health care.<sup>14</sup> The State is obliged to address this hindrance, through adopting legislative and other measures. The NHI scheme, therefore, purports to protect the right to health care by establishing such a framework. How the NHI scheme may protect the right through regulatory measures will be evaluated in below in respect of private entities and business activities.<sup>15</sup>

### 6 2 4 The obligation to promote and fulfil the right of access to health care

The obligation to promote and fulfil the right of access to health care is also a positive obligation and requires the NHI scheme to make provision for both direct and progressive fulfilment. The State is obliged to create the necessary conditions enabling access to health care.<sup>16</sup> The State is also obliged to provide services when people are unable to realise the right through their own means.<sup>17</sup> This includes social security measures, and the National Health Insurance Policy Document<sup>18</sup> (“Policy Document”) recognises this aspect of access to health care.<sup>19</sup> The current conditions of high costs in the private sector and inadequate quality of the public sector hinder access to health

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<sup>12</sup> See chapter three part 2 3 2 and chapter four part 4 2.

<sup>13</sup> See chapter five part 2 3.

<sup>14</sup> See chapter two part 4 1.

<sup>15</sup> See chapter six part 7.

<sup>16</sup> See chapter three part 2 3 3 and part 2 3 4 and chapter four part 4 2.

<sup>17</sup> See chapter three part 2 3 3 and part 2 3 4 and chapter four part 4 2.

<sup>18</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017.

<sup>19</sup> See chapter five part 2 1.

care. Compliance with this obligation is subject to the State's capability and the resources available.<sup>20</sup>

The NHI scheme's re-engineering of primary health care ("PHC") seeks to promote health and prevent disease.<sup>21</sup> The Integrated School Health Programme ("ISHP") contributes to fulfilling this obligation in the context of children's right to basic health care as it reflects prioritisation of children and tends to their specific developmental needs.<sup>22</sup> The Committee holds that the obligation to fulfil the right to health care entails the existence of a health insurance system available to all.<sup>23</sup> The State is obliged to create a health care system through which all people can realise their right to health care. Where people are unable to realise their right within the system, the State is obliged to provide the necessary means to do so.

The NHI scheme seeks to establish a health care system in which people are enabled to access health care services through increased physical accessibility and in the absence of financial risk. This will be done by purchasing health care services for all through contracting with public and private service providers.<sup>24</sup> Where people are still unable to access health care services, the State is obliged to take further action. The NHI scheme makes provision for such instances by, for example, paying attention to children's specific needs (such as learning barriers)<sup>25</sup> and to rural populations who do not have physical access to health care services.<sup>26</sup> The NHI scheme's compliance with the obligations imposed by children's right to basic health care will be evaluated in subsequent sections of this chapter.

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<sup>20</sup> See chapter three part 2 3 3 and part 2 3 4 and chapter four part 4 2.

<sup>21</sup> Department of Health *National Health Insurance Policy Document GN R627 in GG 40955 of 30-06-2017* para 143.

<sup>22</sup> Para 145; see chapter five part 3 3.

<sup>23</sup> See chapter four part 3 4 and part 4 2.

<sup>24</sup> See chapter five part 3 4.

<sup>25</sup> Department of Health *National Health Insurance Policy Document GN R627 in GG 40955 of 30-06-2017* para 145; see chapter five part 3.

<sup>26</sup> The Municipal Ward-Based Primary Health Care Outreach Teams under the Policy Document's PHC streams provide for home visits. This creates direct access for people who do not have physical access to health care services, especially in spatially populated rural areas, Department of Health *National Health Insurance Policy Document GN R627 in GG 40955 of 30-06-2017* para 144; see chapter five part 3.

## 6 2 5 Conclusion on tripartite obligations imposed on the State

The NHI scheme promotes efficient service delivery through structural changes and performance-based incentives for service providers to ensure positive health outcomes. Improved service delivery will promote health care <sup>27</sup> The efforts of the State to facilitate the realisation of the right of access to health care through the NHI scheme consists of various regulatory measures and policy actions. Having evaluated the NHI scheme in the light of these overarching obligations, the next section will evaluate the NHI scheme's compliance with the specific obligations to take reasonable measures to realise the right of access to health care.

## 6 3 The obligation to take reasonable legislative and other measures

### 6 3 1 The adoption of legislative measures

The important role of legislation in facilitating the realisation of the right of access to health care is recognised both internationally and in South African constitutional law.<sup>28</sup> The NHI scheme envisions an overhaul of the current health care system. The Policy Document is the current policy paper which guides the legislative and budgetary process of implementing the NHI scheme. It provides for future legislative amendments to be made to, *inter alia*, the National Health Act 61 of 2003 and the Medical Schemes Act 131 of 1998.<sup>29</sup> It provides for the operational functioning of the NHI scheme as a financing system to achieve universal health coverage.

Furthermore, the Policy Document emphasises the role of PHC.<sup>30</sup> The focus on PHC and the provision of PHC services arguably attempt to realise what is considered by the Committee as a component of the minimum core of the right to healthcare. Although South African Courts have rejected the minimum core standard,<sup>31</sup> this emphasis on PHC reflects what it is that the State is seeking to achieve through

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<sup>27</sup> See chapter five part 2 2.

<sup>28</sup> See chapter three part 4 2 and chapter four part 4 3 and part 4 6.

<sup>29</sup> See chapter five part 2 4.

<sup>30</sup> See chapter five part 3 3 2.

<sup>31</sup> See chapter three part 4 1.

legislative and other measures. Therefore, the NHI scheme is at least reasonable in its attempt to provide access to PHC services to all legislatively. The NHI scheme's focus on PHC also reflects the international understanding of universal health coverage in that equal access to PHC services is fundamental to achieving universal coverage.<sup>32</sup>

Regarding "other measures", the Office for Health Standards and Compliance was introduced in 2013 and seeks to enforce quality standards.<sup>33</sup> This measure forms part of an institutional framework to ensure the delivery and realisation of quality health care. The NHI scheme, although still developing and subject to changes, has initiated the creation of a legislative framework to address the unequal access to and quality of health care in South Africa. Moreover, the measures taken, legislative and otherwise, are required under section 27(2) of the Constitution to be reasonable. Therefore, it must be considered whether the NHI scheme complies with the criteria of reasonableness developed both by the South African Constitutional Court and international human rights institutions.

### 6 3 2 Evaluating the reasonableness of the measures adopted

As analysed in chapter three, the Constitutional Court has adopted a standard of reasonableness by which to review measures taken to realise socio-economic rights.<sup>34</sup> This section will evaluate the NHI scheme considering the factors of reasonableness to determine if the NHI scheme is a reasonable measure for facilitating the realisation of the right of access to health care.

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<sup>32</sup> United Nations General Assembly Resolution on Global Health and Foreign Policy (6 December 2012) A/67/L.36. This resolution recognises provision of PHC services as a mechanism to achieve universal health coverage.

<sup>33</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 paras 149-150.

<sup>34</sup> See chapter three part 4 2.



### 6 3 2 1 *Facilitating the realisation of the right of access to health care*

An explicit objective of the NHI scheme articulated in the Policy Document is to facilitate the realisation of the right of access to health care.<sup>35</sup> The Policy Document recognises the inequalities in access to and quality of health care and how these inequalities hinder the realisation and enjoyment of the right.<sup>36</sup> The NHI scheme seeks to facilitate the realisation of the right through reforming the health care system and addressing the inequalities in access to and quality of health care.

According to the Committee's interpretation of the right to health care, the four essential elements are accessibility, affordability, acceptability and quality.<sup>37</sup> The Committee holds that accessibility includes non-discrimination, physical accessibility, economic accessibility and information accessibility.<sup>38</sup> Given that the Constitution provides for the right of access to health care understanding what access entails is fundamental to facilitating the realisation thereof. The NHI scheme is a system of universal coverage and extends to all legal residents in South Africa on a non-discriminatory manner based on health care needs.<sup>39</sup> Through the PHC streams, the NHI scheme seeks to improve physical accessibility to health care services. Because of the needs-based approach and the cross-subsidisation through the pooling of resources, the NHI scheme also increases financial access by removing the financial risk in seeking access to health care. Information accessibility is fundamental to the development of the NHI scheme. This aspect requires stakeholder involvement and engagement. The NHI scheme must ensure that information on the developments and functioning of the NHI scheme be made known to all.

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<sup>35</sup> See chapter five part 2 3.

<sup>36</sup> See chapter five part 2 1.

<sup>37</sup> See chapter four part 3 4.

<sup>38</sup> See chapter four part 3 4.

<sup>39</sup> Arguably, non-needs-based approaches (such as the current system where access to health care is largely determined by a person's ability to pay) discriminate on the ground of socio-economic circumstances in conflict with s9 of the Constitution, Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 1.

### 6 3 2 2 *Reasonable in conception and implementation*

The NHI scheme has arguably been reasonably conceived as the idea has developed over many years and conforms to the international goal of universal health coverage.<sup>40</sup> The current NHI scheme has developed from the Green Paper<sup>41</sup> to the White Paper on a National Health Insurance<sup>42</sup> (“White Paper”) to the latest Policy Document.<sup>43</sup> There are many positive aspects of the approach to implementing the NHI scheme. The Policy Document considers how the economic environment has changed since the Green Paper’s release.<sup>44</sup> It is submitted that this illustrates reasonableness as the development of the NHI scheme takes changing circumstances into account.

The phased implementation allows for the NHI scheme to be continuously reviewed and revised. The pilot districts introduced in 2012 allow for problems arising from implementation to be addressed prior to national implementation. The pilot districts were introduced to test the PHC streams and the referral system.<sup>45</sup> They are monitored to determine whether these structural changes increase access.<sup>46</sup> Deployed in the most vulnerable districts across the nine provinces and explicitly seeking to address the high maternal and child mortality rates, the pilot districts reflect the NHI scheme’s prioritisation of the vulnerable. The pilot districts allow for the theoretical formulation of the NHI scheme to be tested practically. From the pilot districts, it can be determined what needs to change and what is effective in increasing access and improving the quality of care. This constant review and evidence-based feedback provide a strong argument for the NHI scheme being reasonable in its conception and implementation.

Furthermore, the focus placed on PHC by the NHI scheme reflects the internationally recognised role of PHC in the pursuit of universal coverage.<sup>47</sup> Universal

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<sup>40</sup> See chapter four part 3 8 2.

<sup>41</sup> Department of Health *Green Paper on National Health Insurance in South Africa* (2012).

<sup>42</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15.

<sup>43</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017.

<sup>44</sup> See chapter five part 5 1.

<sup>45</sup> See chapter five part 2 5.

<sup>46</sup> See chapter five part 2 5.

<sup>47</sup> See chapter five part 3 3 2 and chapter four part 3 8.

health coverage is recognised as a means of realising the right to health. As PHC is an integral aspect in the pursuit of achieving universal health coverage as it provides a normative foundation of what should be provided. Therefore, the NHI scheme's focus on PHC is appropriate (and reasonable) in the light of it seeking to realise the right of access to health care through a series of carefully planned and phased interventions.

### 6 3 2 3 Availability of human and financial resources

Reasonableness requires financial and human resources to be made available.<sup>48</sup> As the NHI scheme is a financing system, the Policy Document focuses on the collection of funds, pooling of funds and purchasing of services as examined in chapter five. The Policy Document also provides for human resources to be made available. There is contention over the financial resources available and the feasibility of the NHI scheme. Critics question whether the NHI scheme is affordable, sustainable or financially feasible in the current unstable economic climate.<sup>49</sup> As articulated in *Government of the Republic of South Africa v Grootboom*<sup>50</sup> (“*Grootboom*”), an evaluation of reasonableness does not ask what would be the *most* reasonable measure.<sup>51</sup> Thus in evaluating the reasonableness of the NHI scheme, the question is not what would the most reasonable way be to finance and sustain the NHI scheme. If financial and human resources are made available for implementation and provided that the other requirements for reasonableness are satisfied, then the measure will satisfy the requirement of reasonableness.

The Policy Document seeks to increase human resources through enrolling more students in medical studies.<sup>52</sup> Regarding the affordability of the NHI scheme and the concerns raised about this, the State is obliged to make health care affordable (as a component of the right and to ensure economic accessibility) and also to make

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<sup>48</sup> See chapter three part 4 2.

<sup>49</sup> See chapter five part 5 for more issues raised regarding the affordability and sustainability of the NHI scheme.

<sup>50</sup> 2001 1 SA 46 (CC).

<sup>51</sup> See chapter three part 4 2 1 and part 4 2 2.

<sup>52</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 paras 176-179. See also paras 8, 59 and 61 on how human resources will be realigned to implement the NHI scheme.

resources available for the realisation of the right. Thus, if the NHI scheme is argued to be unaffordable or financially unsustainable, then the State is obliged to make resources available to afford it and sustain it. An argument based on the financial feasibility of the NHI scheme cannot justify not pursuing health care system reform. The NHI scheme does, however, need to provide specific detail on how financial resources will be made available in this regard. It currently only provides for the reallocation of State subsidies to medical aids and suggests that an increase in payroll tax and income tax would be a feasible way of financing the NHI scheme.<sup>53</sup>

Both the budgeting and expenditure of the State should reflect the right to health care as a priority for socio-economic transformation.<sup>54</sup> The obligation to realise the right within available resources will be elaborated on in subsequent sections.<sup>55</sup> As a requirement of reasonableness, the NHI scheme does make provision for the financial and human resources necessary for implementation. However, the Policy Document does still lack detail on the aspect of financing which renders the NHI scheme vulnerable to challenges in this regard.

#### 6 3 2 4 *Short, medium and long-term needs*

The phased implementation of the NHI scheme allows for short, medium and long-term needs to be addressed. The first phase focuses on strengthening the public health care sector to ensure that the facilities, resources and management can provide a strong foundation for the reform. The second phase consists of a reallocation of resources and governance, as well as the start of legislative amendments necessary for the implementation. The third phase finalises the financing of the NHI scheme and undertakes the legislative amendments to ensure that the legislative framework is coherent.<sup>56</sup>

The phased implementation coincides with the prioritisation of the vulnerable and the obligation to make immediate provision for those in need. The pilot districts were

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<sup>53</sup> Para 242.

<sup>54</sup> A Nolan, R O'Connel & C Harvey (eds) *Human Rights and Public Finance: Budgets and the Promotion of Economic and Social Rights* (2013) 22.

<sup>55</sup> See chapter six part 5.

<sup>56</sup> See chapter five part 2 4.

designated per vulnerability, with the most vulnerable districts across the provinces being used as pilot districts. Moreover, the re-engineering of PHC encourages preventative care. Long-term, preventative care will yield improvements in the health status of the population. The continuous process of removing barriers to access to health care illustrate medium-term development. Therefore, the NHI does make provision for short, medium and long-term needs.

#### *6 3 2 5 Inclusive of population groups and responsive to emergencies and the needs of the vulnerable*

The NHI scheme seeks to provide health care on a needs-basis. This is fundamental in ensuring that the inequalities in access to and quality of health care are addressed. Under the NHI scheme access to and quality of health care services will no longer be determined by a person's ability to pay.<sup>57</sup> This coincides with the NHI scheme's recognition of health care as a socio-economic right and not an ordinary market commodity.<sup>58</sup> The NHI scheme recognises children, orphans, the elderly, persons with disabilities, women and rural communities as vulnerable and prioritises their needs in the implementation of the NHI scheme.<sup>59</sup> The White Paper makes explicit provision for children and rural populations as vulnerable groups.

In chapter three, an argument is made for children to be recognised as a vulnerable group in need of special consideration and provision regarding health care.<sup>60</sup> The NHI scheme does make special provision for children's health care needs. The re-engineered streams of PHC facilitate access to health care services necessary for children's development. Children's right to *basic* health care under section 28(1)(c) of the Constitution is interpreted to mean health care services necessary for adequate development.<sup>61</sup> Therefore, the specific development-based provision made for children under the NHI scheme is consistent with this requirement of reasonableness

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<sup>57</sup> See chapter five part 2 1.

<sup>58</sup> See chapter five part 2 1.

<sup>59</sup> See chapter five part 3 2.

<sup>60</sup> See chapter three part 2 2 and part 5.

<sup>61</sup> See chapter three part 2 2.

regarding children as a vulnerable group. Compliance with obligations regarding children's right to basic health care will further be evaluated below.

The Policy Document recognises those living in rural areas as vulnerable groups due to their lack of access to health care services. The re-engineering of PHC addresses this barrier by enhancing physical and financial access to health care services. The Municipal Ward-Based Primary Health Care Outreach Teams ("Outreach Teams") are each responsible for a given number of households within a district.<sup>62</sup> Home visits are conducted to address health needs. Given the progress made with this initiative in the pilot districts, an additional 20 000 Outreach Teams will be deployed in municipal wards where poverty is prevalent.<sup>63</sup> This will aid in alleviating barriers to access to health care for the poor and vulnerable.

However, despite the explicit prioritisation of vulnerable groups and the extensive efforts made regarding children and rural populations, the Policy Document makes very little provision for mental health care services.<sup>64</sup> Mental health care is mentioned under the ISHP, in that the ISHP seeks to improve the physical and mental health of children.<sup>65</sup> Under "Treatment Guidelines", the White Paper provided that over time the Essential Drug List of the NHI scheme will eventually expand to cover, "where desirable", other services such as dental care and mental health care services.<sup>66</sup> This was problematic as mental health care is overlooked as a significant burden on the health of the population. Mental illness is the third biggest contributor to the burden of disease in South Africa.<sup>67</sup> The South African Society of Psychiatrists raised concern

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<sup>62</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 144.

<sup>63</sup> Para 168.

<sup>64</sup> See C Ngwena "Deconstructing the Definition of 'Disability' under the Employment Equity Act: Social Deconstruction" (2006) 22 *SAJHR* 613-646; and C Ngwena "Deconstructing the Definition of 'Disability' under the Employment Equity Act: Legal Deconstruction" (2007) 23 *SAJHR* 116-156.

<sup>65</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 145.

<sup>66</sup> Para 341.

<sup>67</sup> C Lund et al "Public Sector Mental Health Systems in South Africa: Inter-Provincial Comparisons and Policy Implications" (2010) 45 *Social Psychiatry Psychiatric Epidemiology* 393 394.

about the lack of psychiatric care at community and district hospital level.<sup>68</sup> They highlight the relationship between mental illness and the burden of disease in South Africa and argue that mental health is “crucial in reducing the overall burden of disease.”<sup>69</sup> The South African Society of Psychiatrists recommends that the NHI scheme establishes Community Mental Health Teams to operate at district hospital level.<sup>70</sup> The latest Policy Document addressed this concern and provides:

“Mental healthcare services will be fully integrated into PHC with a view to increasing prevention, screening, care, treatment and rehabilitation including community mental health services.”<sup>71</sup>

Given the vulnerability of mentally ill patients, special provision should be made in order to comply with this aspect of the obligation to take reasonable measures.

The NHI scheme also addresses the right to emergency medical services in terms of section 27(3) of the Constitution.<sup>72</sup> The Policy Document makes provision for increased access to emergency medical services.<sup>73</sup> An interesting feature of emergency medical services under the NHI scheme, which illustrates collaboration between the private and public sectors, is the following statement:

“[A]ll medical emergency vehicles will be of a standard colour regardless of whether they are publicly or privately operated and there will be a single national emergency number to serve both public and private operators to improve services and effective response to the needs of the population.”<sup>74</sup>

Efforts to improve access to emergency care recognises the discrepancy between the unqualified provision in section 27(3) and the reality of availability and accessibility to emergency medical services. The obligation of reasonableness requires the NHI

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<sup>68</sup> South African Society of Psychiatrists Submission on the White Paper <<http://www.nhisa.co.za/B-submissions.asp>> (accessed 10 June 2016) 2.

<sup>69</sup> 1.

<sup>70</sup> 2.

<sup>71</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 108.

<sup>72</sup> Paras 155, 139.

<sup>73</sup> Paras 155-158.

<sup>74</sup> Para 283.

scheme to be responsive to emergencies. *Soobramoney* illustrates the limited scope of section 27(3) where the Court interpreted this section narrowly to mean that where medical treatment is necessary and available, it must not be denied.<sup>75</sup> This study argues that the denial of treatment illustrated by the story of the domestic worker in chapter one implies that in reality, “available” also implies that the treatment must be financially available to the patient (either through state funding or private medical aid). The NHI scheme does not, however, address issues pertaining to the systemic failure to provide access to emergency health care services such as this.

### 6 3 2 6 *Balance and flexibility*

The phased implementation of the NHI scheme allows for balance and flexibility. The lessons learned from the pilot districts are applied and influence the further development of the NHI scheme. This creates a degree of flexibility in the development and implementation of the policy. The NHI scheme is to be fully implemented over 14 years. The Policy Document is cognisant of the fact that the socio-economic circumstances implicating implementation may change over this period. Thus, the constant review allows for change and adaptation. The NHI scheme will therefore not face the criticism of rigidity that the national HIV/AIDS policy faced in *Minister of Health v Treatment Action Campaign*<sup>76</sup> (“TAC”).<sup>77</sup>

This consideration of constant review and revision of the NHI scheme is distinguishable from the narrow application of reasonableness in *Mazibuko v City of Johannesburg*<sup>78</sup> (“Mazibuko”). In *Mazibuko* the Court held that the policy was reasonable as it was continuously being reviewed and revised.<sup>79</sup> The NHI scheme is constantly being reviewed and revised, but this alone does not exempt it from the other requirements of a reasonable programme. Chapter five examined the possibilities for the financing of the NHI scheme as provided by the Policy Document.<sup>80</sup> The NHI

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<sup>75</sup> 1998 1 SA 865 (CC) paras 14, 20; see also chapter two part 3 2.

<sup>76</sup> 2002 5 SA 721 (CC).

<sup>77</sup> See chapter three part 4 2 5.

<sup>78</sup> 2010 4 SA 1 (CC).

<sup>79</sup> See chapter three part 4 2 5.

<sup>80</sup> See chapter five part 5 1.



scheme still needs to provide detail on financing and management in a way that reflects flexibility. The absence of such detail is not sufficient for a measure to be considered balanced and flexible. The development of the NHI scheme must take this into consideration.

### 6 3 2 7 *Non-discrimination*

Accessibility is recognised as an essential element of the right to health.<sup>81</sup> Non-discrimination is recognised as an aspect of accessibility.<sup>82</sup> The universal nature of the NHI scheme is inclusive of the population.<sup>83</sup> The current two-tier system has resulted in very exclusive access to health care (especially in the private sector) and poor quality of health care in the public sector.<sup>84</sup> The universality of the NHI scheme also reflects the non-discriminatory approach to providing access to health care.

The Policy Document provides that all South Africans and legal residents will be covered by the NHI scheme. As examined in chapter three, in *Khosa v Minister of Social Development*<sup>85</sup> (“*Khosa*”) permanent residents were denied access to social security grants on the grounds of citizenship.<sup>86</sup> This was held to be unreasonable as it amounted to unfair discrimination and infringed on the right of access to social security which was provided to everyone.<sup>87</sup> The denial of access impaired on the applicants’ human dignity and therefore amounted to unfair discrimination.<sup>88</sup> A denial of access to health care would also impair human dignity. Although the Court confined the *Khosa* decision only to one category of non-citizens, permanent residents, it is possible that denial of access on the ground of citizenship could amount to unfair discrimination.<sup>89</sup> The NHI scheme needs to be cautious in setting parameters of coverage that may potentially exclude groups unfairly.

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<sup>81</sup> See chapter four part 3 4.

<sup>82</sup> See chapter four part 3 4.

<sup>83</sup> See chapter five part 3 2.

<sup>84</sup> See chapter two part 4 1.

<sup>85</sup> 2004 6 SA 505 (CC).

<sup>86</sup> See chapter three part 4 2 7.

<sup>87</sup> See chapter three part 4 2 7.

<sup>88</sup> See chapter three part 4 2 7.

<sup>89</sup> See chapter three part 4 2 7.

The White Paper provided that section 27(g) of the Refugees Act 130 of 1998 will cover health care for refugees.<sup>90</sup> Asylum seekers (if in possession of a valid permit issued by the Department of Home Affairs) will only have access to emergency medical care and “services for notifiable conditions of public health concern.”<sup>91</sup> The White Paper provided that NHI scheme will not cover temporary residents, foreign students or tourists, and these categories of people will be required to have their own medical insurance.<sup>92</sup>

In its submission on the White Paper, the Johannesburg Migrant Health Forum raises concerns over the coverage provided for migrants.<sup>93</sup> The Johannesburg Migrant Health Forum argues that the coverage provided for migrants in the White Paper may not be constitutional on the grounds of discrimination and retrogression.<sup>94</sup> The Johannesburg Migrant Health Forum submit that excluding migrants from NHI scheme coverage amounts to discrimination that conflicts with the precedent set in *Khosa*.<sup>95</sup> Furthermore, the coverage provided for in the White Paper amounts to less coverage or access than what is currently available to migrants. This retrogression needs to be justified. The White Paper lacked details on these issues. The latest Policy Document provides:

“Migrants are not a homogenous group and consist of refugees, asylum seekers and irregular migrants and will receive basic health care services in line with the Refugees Act and international conventions that South Africa is a signatory to.”<sup>96</sup>

Thus, there is still a lack of detail on the provision of health care services for migrants. The NHI scheme needs to elaborate on its exclusion of migrants to determine whether it is justifiable and in compliance with the obligation to take reasonable measures.

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<sup>90</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 121.

<sup>91</sup> Para 122.

<sup>92</sup> Para 123.

<sup>93</sup> Johannesburg Migrant Health Forum Submission on the White Paper <[http://www.nhisa.co.za/B\\_submissions.asp](http://www.nhisa.co.za/B_submissions.asp)> (accessed 10 June 2016).

<sup>94</sup> Paras 6-8.

<sup>95</sup> Paras 18, 28.

<sup>96</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 101.

In *Mazibuko* the measure did not consider that the financial burden on the poor is much greater.<sup>97</sup> However, the Court did not find the measure to be discriminatory. Currently, the financial burden of access to health care is greater on the poor. The percentage of disposable income spent on health care is much greater for the poor than the rich.<sup>98</sup> The NHI scheme seeks to remove the financial risk of seeking access to health care. The universality of the scheme allows for cross-subsidisation between the old and the young, the sick and the healthy and the rich and the poor.<sup>99</sup> Because of this needs-based approach, the NHI scheme is distinguishable from the argument made in *Mazibuko* that the prepaid meters are discriminatory. The NHI scheme does not impose financial burdens on the rich and poor alike. In fact, it seeks to remove financial burdens for all through the cross-subsidisation.<sup>100</sup> The funding for the NHI scheme seeks to be progressive, but this will further be examined below.

#### 6 3 2 8 *Measures must be comprehensive, co-ordinated and transparent*

For a measure to be comprehensive and co-ordinated it must be developed by all three spheres of government.<sup>101</sup> The design of the framework must enable the State to meet its obligations. The NHI scheme must, therefore, involve all three spheres of government in its development and implementation. As articulated in *TAC*, there must be effective communication of information “to all concerned.”<sup>102</sup> Thus, the NHI scheme framework must be made known to all. Information and understanding are fundamental to the functioning and success of the NHI scheme. To satisfy the comprehensive, co-ordinated and transparency aspect of the reasonableness requirement, the development of the NHI scheme will need to include collaboration between all three spheres of government and make its contents appropriately known.

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<sup>97</sup> See chapter 3 part 4 2.

<sup>98</sup> See chapter two part 4 1.

<sup>99</sup> See chapter five part 3 2.

<sup>100</sup> See *City Council of Pretoria v Walker* 1998 2 SA 363 (CC) para 62 where late Langa DP (as he then was) held that the relevant cross-subsidisation did not amount to unfair discrimination as it was based on “formal rather than substantive equality.”

<sup>101</sup> See chapter three part 4 2 4.

<sup>102</sup> 2002 5 SA 721 (CC) para 123.

### 6 3 2 9 *Participation and meaningful engagement*

Participation and engagement are regarded as integral to socio-economic rights under constitutional law and to the realisation of the right to health under international law.<sup>103</sup> As meaningful engagement is required at every stage of policy development, the development of the NHI scheme must make provision for meaningful engagement with stakeholders. As Chenwi articulates, meaningful engagement provides active participants rather than passive recipients.<sup>104</sup> The development and implementation of the NHI scheme need active participation for its needs-based approach. PHC and a needs-based approach to health care entail community participation and engagement.<sup>105</sup> Without meaningful engagement in this regard, it will be difficult to determine the needs of communities. The White Paper only provided that Clinic Committees can facilitate community participation.<sup>106</sup> The Policy Document provides:

“The success of NHI will requires building a responsive health care system that is people-centred. Community involvement will be essential at all levels of the transformed systems to ensure that there is participatory governance, and accountability.”<sup>107</sup>

Thus, despite recognising the importance of involving the community, there is no provision facilitating stakeholder engagement in the development and implementation of the NHI, apart from submissions made on the policies. These submissions alone do not constitute meaningful engagement. London recommends that the State should facilitate participatory decision-making and engagement with stakeholders and

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<sup>103</sup> See chapter three part 4 2 8 and chapter four part 3 8 1.

<sup>104</sup> C Chenwi “‘Meaningful Engagement’ in the Realisation of Socio-Economic Rights: The South African Experience” (2011) 26 *SAPL* 128 129. See also A E Yamin “Taking the Right to Health Seriously: Implications for Health Systems, Courts and Achieving Universal Health Coverage” (2017) 39 *Human Rights Quarterly* 341 356, 368.

<sup>105</sup> See chapter five part 3 3 2 and part 5 3.

<sup>106</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 186.

<sup>107</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 345.

communities.<sup>108</sup> The South African Society of Psychiatrists *inter alia*, have expressed willingness to participate in the development and implementation of the NHI scheme.<sup>109</sup>

Given the nationwide impact of the NHI scheme, engagement and participation are necessarily needed for effective implementation. The Minister of Health, Dr Aaron Motsoaledi, has stressed the need to work with the private sector, not against it, in facilitating the transition to the NHI scheme.<sup>110</sup> An intersectoral approach is necessary, calling for collaboration between, *inter alia*, the medical profession, the legal profession, academia, and government. The NHI scheme must make provision for such collaboration and facilitate engagement and participatory decision-making to comply with this aspect of reasonableness. Moreover, engagement and participation can aid effective development and implementation and also gain more support for the reformation, as this is only possible through better understanding.

## 6 4 The obligation to progressively realise the right of access to health care

### 6 4 1 Progressive realisation

The obligation to progressively realise the right of access to health care recognises resource constraints and the ever-changing circumstances in the country.<sup>111</sup> In agreement with Bilchitz, this study argues that progressive realisation should tend to urgent needs and seek to continuously improve the standard of provision of health care for all.<sup>112</sup> It is therefore argued that the NHI scheme's provision for the vulnerable,

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<sup>108</sup> L London "Comments on the White Paper on a National Health Insurance for South Africa" *Report to the Foundation for Human Rights* (2016) <[http://www.nhisa.co.za/B\\_submissions.asp](http://www.nhisa.co.za/B_submissions.asp)> (accessed 10 June 2016).

<sup>109</sup> South African Society of Psychiatrists Submission on the White Paper <[http://www.nhisa.co.za/B\\_submissions.asp](http://www.nhisa.co.za/B_submissions.asp)> (accessed 10 June 2016).

<sup>110</sup> C Presence "Motsoaledi: NHI is Coming, Whether You Like It or Not" *IOL* (16 May 2017) <[http://www.nhisa.co.za/C\\_NewsReports.asp](http://www.nhisa.co.za/C_NewsReports.asp)>. See also J Bornman "COSATU Furious over NHI being SA's Version of Obamacare" (16 May 2017) *Business Day* <<https://www.businesslive.co.za/bd/national/health/2017-05-16-cosatu-furious-over-nhi-being-sas-version-of-obamacare/>>.

<sup>111</sup> See chapter three part 4 3 1 and chapter four part 4 5.

<sup>112</sup> See chapter three part 4 3 1.

rural and children, coupled with the complete overhaul of the health care system, complies with this conception of progressive realisation. The Policy Document explicitly provides that the NHI scheme seeks to progressively realise the right to health by extending coverage to include the whole population.<sup>113</sup>

The NHI scheme commits also provides for immediate steps to be taken to address the needs of the most vulnerable and those in urgent need.<sup>114</sup> The phased implementation reflects an understanding that all aspects of the right cannot be realised immediately and that accumulation of resources takes time. Provision is also made for the most vulnerable through the PHC streams.<sup>115</sup> The ISHP focuses on children's health care needs and the Outreach Teams provide home visits to increase accessibility for rural populations. The NHI scheme arguably complies with the obligation to progressively realise the right of access to health care as it makes provision for meeting urgent needs and improve provision over time.<sup>116</sup>

#### 6 4 2 The presumption against retrogressive measures

The international understanding of progressive realisation adopted in South African socio-economic rights jurisprudence includes a presumption against retrogressive measures. If obliged to move continuously towards the fulfilment of a right, then the State necessarily cannot unjustifiably scale back on the existing enjoyment of the right. Retrogressive measures are not permissible unless sufficiently justified.<sup>117</sup>

Those currently enjoying access to quality private health care may be impacted by the NHI scheme. The NHI scheme will dilute the doctor-to-patient ratio in the private sector by contracting with private service providers and thereby increase access to the private sector and distributing resources more equally.<sup>118</sup> The number of medical aid schemes will be decreased as they will be regulated to provide "top-up" coverage.<sup>119</sup>

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<sup>113</sup> See chapter five part 2 3 and part 3 2.

<sup>114</sup> See chapter five part 2 4.

<sup>115</sup> See chapter five part 3 2.

<sup>116</sup> See chapter three part 4 3 1 and chapter four part 4 5.

<sup>117</sup> See chapter three part 4 3 2 and chapter four part 4 5.

<sup>118</sup> See chapter three part 4 3 2.

<sup>119</sup> See chapter five part 4 and part 5.

Retrogressive measures are to be assessed in terms of their impact.<sup>120</sup> If there is a positive impact on the population as a whole and especially if there is a positive impact on the vulnerable, then this assessment should be favoured. If the NHI scheme is successfully implemented, access to and quality of health care will be improved for the majority of the population currently dependent on the public sector. This study argues that the State is therefore not required to justify the potential retrogressive impact on those with current access to the private sector. However, even if the impact of the NHI scheme is to be assessed in terms of those negatively affected, then the retrogression may still be justifiable. The vulnerability of those who currently experience inadequate access to and quality of health care, as well as the transformative nature of pursuing the realisation of socio-economic rights, would arguably justify the retrogression. Therefore, although the NHI scheme may be subject to objections of retrogression, the need to address the unequal access to and quality of health care favours assessment of the whole population, who will benefit from the NHI scheme.

## **6 5 The obligation to realise the right of access to health care within available resources**

To comply with the obligation to realise the right within available resources, the NHI scheme needs to make provision for accumulating resources, as well as their use and distribution in pursuing the realisation of access to health care for all. As the NHI is a financing system, it is particularly concerned with the accumulation and distribution of resources.<sup>121</sup> Using Kutzin's framework, the collection of resources, the pooling of resources and the distribution of resources under the NHI scheme was analysed.<sup>122</sup> The NHI scheme makes provision for the reallocation of resources to the NHI Fund as well as additional resources to be raised. This coincides with the South African socio-economic rights jurisprudence which expresses the need to look beyond the existing budget.<sup>123</sup> Liebenberg argues that a failure to look beyond the present resources

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<sup>120</sup> See chapter three part 4 3 2.

<sup>121</sup> See chapter five part 4.

<sup>122</sup> See chapter five part 4.

<sup>123</sup> See chapter three part 4 4.

available will hinder transformation and preserve inequalities.<sup>124</sup> The NHI scheme seeks to transform the health care system into a more equitable one and address the inequalities in access to and quality of health care. Therefore, the NHI scheme must look beyond the resources currently available to aid this transformation.

The pooling of resources and cross-subsidisation under the NHI scheme arguably provides for the resources to be used in a way which would benefit the “widest sections of the community” and address the inherited inequalities.<sup>125</sup> The purchasing of services amounts to the manner in which resources accumulated are distributed. Ssenyonjo emphasises that the obligation to use available resources, under international law, requires equitable distribution.<sup>126</sup> The needs-based approach to access to health care and the universal coverage provided under the NHI scheme reflects a potentially more equitable distribution of health care resources.<sup>127</sup>

Although the Policy Document provides extensively for the various options by which to raise resources, it is inconclusive as to how exactly this will be done. Submissions on the NHI scheme argue that the White Paper looked at resource availability too optimistically and that the proposed reform is unaffordable.<sup>128</sup> Arguing that there are not sufficient resources available to implement the NHI scheme or realise universal health coverage is contradictory to the constitutional and international law obligations imposed by the right to health care. The State is obliged to make resources available or to show that every effort has been made to do so. Implementation of the NHI scheme requires financial resources, equipment, facilities, medicines, information, technology and human resources. The NHI fund will accumulate and pool the financial resources to purchase health care services on behalf of the population. Additional financial resources will be made available through the reallocation of State subsidies

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<sup>124</sup> S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 211.

<sup>125</sup> *Azanian Peoples Organisation v President of the Republic of South Africa* 1996 4 SA 672 (CC) para 43.

<sup>126</sup> M Ssenyonjo “Reflection on State Obligations with Respect to Economic, Social and Cultural Rights in International Human Rights Law” (2011) 15 *The International Journal of Human Rights* 969 980; see chapter four part 4 4.

<sup>127</sup> See chapter five part 2 3.

<sup>128</sup> See chapter five part 5 1.



to medical aid schemes and a reallocation of tax credits granted to medical aids.<sup>129</sup> Furthermore, facilities and equipment will be upgraded. There has been and will continue to be an increase in the uptake of medical students and nurses to increase human resources for the implementation of the NHI scheme.<sup>130</sup> Another measure to increase human resources will involve the NHI scheme contracting with private providers, allowing for increased access.<sup>131</sup> The NHI scheme will make use of the existing district health system to deliver health care services. This could enable greater community involvement in addressing specific health care needs.<sup>132</sup>

Currently, under the two-tier health care system, the obligation to mobilise available public and private resources to realise the right to health is not being complied with. This is because of the unequal distribution of resources. The State is not using all available resources to realise the right of access to health care for *all*. The redistribution envisioned by the NHI scheme seeks to make use of the resources optimally to satisfy this obligation and to ensure more equitable access. It has been argued that resources are to be used imaginatively to bring relief to those burdened by the inherited inequalities of our past.<sup>133</sup> The private sector's concern over losing resources is trumped by the need to address the stark inequalities in access to and quality of health care. This study argues that available resources include private resources, at least when public resources have been exhausted.<sup>134</sup> Currently, the resources in the public sector are insufficient to realise the right of access to health care for all. Redistributing and using some private resources is therefore not only necessary but arguably also justified in seeking to realise the right of access to health care.

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<sup>129</sup> See chapter five part 4 2.

<sup>130</sup> See chapter five part 4 2.

<sup>131</sup> See chapter five part 4 4.

<sup>132</sup> A Fusheini & J Eyles "Achieving Universal Health Coverage in South Africa through a District Health System Approach: Conflicting Ideologies of Health Care Provision" (2016) 16 *BMC Health Services Research* 1 8. See also chapter five part 5 3.

<sup>133</sup> See chapter two part 2 and part 4 1. See also chapter three part 3 4 4.

<sup>134</sup> See chapter three part 4 4.

## 6 6 Obligations imposed by children's right to basic health care

Children's right to basic health care impose different obligations on the State. The responsibility placed on parents under both international law and the Constitution support the notion that parents are primarily responsible for the realisation of the right and that the State only incurs obligations when parents are unable to provide.<sup>135</sup> Fundamental to the specific provision of children's right to basic health care is the recognition of their vulnerability.<sup>136</sup> Reasonableness requires that special provision is made for the vulnerable, and if children are considered vulnerable, then they are deserving of prioritisation.<sup>137</sup> Whilst the nature of the obligations imposed by children's right to basic health care remains unclear, their vulnerability makes a strong argument for the prioritisation of their needs.

The NHI scheme recognises children as a vulnerable group.<sup>138</sup> The Policy Document also articulates the need for speech, audiology, oral health and psychological services for school-going children.<sup>139</sup> Addressing the health-related barriers to learning faced by children illustrates how the NHI scheme seeks to provide for children's needs. The re-engineering of PHC includes the ISHP. The ISHP provides preventative and curative services through schools. It focuses on screening services for learning barriers such as vision, hearing, cognitive and developmental impairments.<sup>140</sup> Each pilot district received 70 school mobiles to provide these services.<sup>141</sup> The White Paper contended that through the provision of these services in the pilot districts 201 770 learners experiencing health-related barriers to education were identified.<sup>142</sup> The oral health, hearing, speech and visual needs of these learners

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<sup>135</sup> See chapter three part 5 and chapter four part 5.

<sup>136</sup> See chapter three part 2 2, part 4 2 6 and part 5.

<sup>137</sup> See chapter three part 4 2 6.

<sup>138</sup> See chapter five part 3 2.

<sup>139</sup> See chapter five part 3 3.

<sup>140</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 145.

<sup>141</sup> See chapter five part 2 5.

<sup>142</sup> Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 171.

were addressed. a further benefit of the ISHP is that it provides access to areas which would not ordinarily enjoy physical access to health care services.<sup>143</sup>

Additionally, the Outreach Teams aid health promotion and development.<sup>144</sup> In the pilot districts, a high percentage of home visits by the Outreach teams provided child health care services.<sup>145</sup> This provides children with basic health care and does not limit access solely to children in school. The contracting of private practitioners for PHC services also increase the human resources available for addressing health-related barriers to learning and other child health care needs.<sup>146</sup>

The reform of the health care system should also enable parents to realise children's right to basic health care, especially by the removal of financial risks. The NHI scheme is also cognisant of the impact that health can have on other areas of children's development, such as education. The recognition of children's vulnerability requires for the prioritisation of their needs in order to be reasonable. The NHI scheme arguably does this.

## **6 7 Obligations imposed by the right to health care in the context of private entities and business activities**

The international law framework regarding socio-economic rights and private entities differs from the constitutional framework.<sup>147</sup> International law traditionally binds State parties to the covenants or charters whilst the Constitution provides for direct and indirect horizontal application of the Bill of Rights. The aim of this section is to evaluate to what extent the NHI scheme fulfils its constitutional and international law obligations imposed by the right to health in the context of private entities and business activities.

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<sup>143</sup> Department of Health *National Health Insurance Policy Document* GN R627 in GG 40955 of 30-06-2017 para 144.

<sup>144</sup> Para 144.

<sup>145</sup> 39.5% of the services provided by the Outreach Teams in the pilot districts were for child services, para 144; see also Department of Health *White Paper on National Health Insurance* GG 39506 of 11-12-15 para 169.

<sup>146</sup> See chapter five part 3 4 and part 4 4.

<sup>147</sup> See chapter three part 6 and chapter four part 6.

The NHI scheme has to ensure that the private sector does not hinder the realisation of the right to health care. The State is obliged to provide an environment which ensures that the private sector complies with the international law framework.<sup>148</sup> The NHI scheme purports to do this. It seeks to reform the health care system, consisting of a public and private sector, working together to achieve universal health coverage. The NHI scheme prioritises the right to health care over business interests in seeking to remove the financial risk associated with seeking access to health care. Furthermore, the NHI scheme also protects the right to health care by providing access on a needs-basis, as opposed to access being determined by a person's ability to pay. The regulation of the health care system imposed by the NHI scheme seeks to improve access to and quality of health care.<sup>149</sup> This is in line with the State's obligation under international law to protect the right to health care. Furthermore, the impact of the NHI scheme's redistribution of resources on the private sector can be justified as the State is complying with its obligation to fulfil the right to health care.

The Constitutional Court has emphasised that the nature of the right and the potential of interference by private parties are focal considerations in determining the extent to which obligations can be imposed on private entities.<sup>150</sup> *Daniels* and other jurisprudence<sup>151</sup> hold that in determining the obligations imposed on private entities, the potential of invasion by private entities needs to be considered.<sup>152</sup> Currently, in South Africa, there are many barriers to access health care. The high cost of private health care is barring access to the majority of the population. Additionally, the unequal distribution of resources, in favour of the private sector, also hinders access to and quality of health care. Thus, the realisation of the right is implicated by the private sector and letting the private sector function unregulated or not including it in the reform of the health care system, inequalities will only escalate further. The factors articulated in *Daniels* also ask: "would letting private persons off not negate the

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<sup>148</sup> See chapter four part 6.

<sup>149</sup> See A E Yamin "Taking the Right to Health Seriously: Implications for Health Systems, Courts and Achieving Universal Health Coverage" (2017) 39 *Human Rights Quarterly* 341 366.

<sup>150</sup> See chapter three part 6 5.

<sup>151</sup> See chapter three part 6 5.

<sup>152</sup> CCT 50/16 ZACC 13 (11 May 2017) para 39; see the analysis of *Daniels* in chapter three part 6 5.

essential content of the right?"<sup>153</sup> This study has argued that transformation of the health care system cannot happen in isolated from the private sector. This is not only because of the unequal distribution of resources but also because the right of access to health care is undermined by the stark inequalities perpetuated by the current health care system.<sup>154</sup> The NHI scheme envisions one health care system in which the public sector and private sector work together to achieve the realisation of the right through universal health coverage. To pursue the NHI scheme without any involvement of the private sector would limit resources available and would not allow the unequal distribution of resources to be addressed.

Three key points can be taken from this analysis. Firstly, the private health care sector is subject to the changes that the NHI scheme will bring; It cannot be excluded from the transformation of the health care system. Secondly, the private health care sector must function in a way that facilitates the realisation of the right of access to health care. It cannot hinder access through exorbitant prices, exclusivity and hoarding of resources. Lastly, there is a need for the private sector to work together with the public sector to achieve universal health coverage in South Africa. These factors provide a strong argument for the regulation of the private sector as a means to address the inequalities in access to and quality of health care. The private sector is bound to the Bill of Rights, and the State is obliged to ensure and facilitate compliance.

There are a number of ways in which the NHI scheme will affect the private health care sector. As explained in chapter five, the NHI Fund will purchase services from private providers as well as the use of facilities and equipment. The redistribution of a substantial amount of financial resources from the private sector (the State subsidies and tax credits to medical aids) to the NHI Fund will necessarily impact on the resources and profits of the private sector. Private providers will have the opportunity to contract with the NHI Fund to provide services.<sup>155</sup>

The role of medical aids will change significantly under the NHI scheme. The NHI scheme differs from medical aids as it will cover all and the socio-economic status of a person will not influence their access to and quality of health care. The NHI Fund will

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<sup>153</sup> CCT 50/16 ZACC 13 (11 May 2017) para 39.

<sup>154</sup> See chapter two part 4 1.

<sup>155</sup> See chapter five part 4 4.

be a non-profit public entity. The number of medical aid schemes will decrease.<sup>156</sup> Their role will develop into providing complementary of top-up coverage for services not covered by the NHI scheme. This change will be instituted through legislative amendments.<sup>157</sup> Although concerns have been raised regarding the medical aid schemes loss of potential profits, it is justified for the State to regulate the health care system in such a way as to ensure more equitable access in recognition of health care as a right, and not a market commodity. The profits made by medical aid scheme administrators are arguably an available resource. Therefore, the obligation to realise the right within available resources coupled with the obligation to ensure that the private sector does not hinder access justifies the reallocation of resources and regulation in this regard. The high costs and exclusivity of the private sector warrant a more equitable distribution of resources to address inequalities in access to and quality of health care. Competition has failed to do so.<sup>158</sup>

## 6 8 Conclusion

This chapter has evaluated the extent to which the NHI scheme fulfils the constitutional and international law obligations imposed by the right of access to health care. The Policy Document is a step towards developing the NHI scheme into legislation. It has already influenced the budgetary processes. This chapter argues that the State's efforts regarding the development of the NHI scheme complies with the obligation to take legislative and other measures imposed by the right to health care. Section 27(2) of the Constitution also requires measures taken by the State to be reasonable. The evaluation of reasonableness highlights potential discriminatory issues regarding immigrants. The evaluation elaborates on aspects of the NHI scheme which are reasonable and which are vulnerable to challenges of unreasonableness.

Progressive realisation requires the removal of barriers, and the NHI scheme purports to do this. Progressive realisation includes a presumption against retrogressive measures unless justified. Although the NHI scheme may have a

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<sup>156</sup> See chapter five part 4.

<sup>157</sup> See chapter five part 2 4.

<sup>158</sup> See chapter five part 3 4 for Kutzin's argument on competitive markets and health care services.

retrogressive impact on some, this chapter argues that there is no need to justify these as the population as a whole will be better off under the NHI scheme. In the alternative, if the State was required to justify any retrogressive effects, these are argued to be justifiable in the context of the transformative constitution.

The NHI scheme as a financing system seeks to use the available resources in a more equitable manner to realise the right of access to health care. The arguments concerning the affordability of the NHI scheme are refuted by the obligation imposed on the State to make resources available for the realisation of the right of access to health care. This chapter also argues that available resources include private resources, therefore implicating the private sector in the health care system reform.

This chapter has also evaluated the obligations imposed by children's right to health care in a two-fold manner. Because of the obligation on parents to provide care and realise the rights of children, the State is obliged to ensure that the framework enables parents and caregivers to do so. Secondly, if parental care is lacking or inadequate, then the State is obliged to provide for children's health care needs. The NHI scheme proposes a framework which will enable parents and care givers to realise children's right to basic health care by increasing physical and financial access. Additionally, the NHI scheme makes specific provision for children's developmental health care needs. This study argues that the NHI scheme sufficiently complies with the obligations imposed by children's right to basic health care.

Lastly, this chapter evaluates the obligations imposed by the right to health care in the context of private entities and business activities. International law obliges the State to ensure that the private sector does not hinder the realisation of the right. Thus in protecting, respecting and fulfilling the right to health, the State is obliged to ensure that the private sector complies with the international law framework. The constitutional obligations differ as they can be imposed directly on private entities. This study argues that if the State is fulfilling its constitutional and international law obligations imposed by the right to health care, then the impact on and regulation of, the private sector is justified, especially given that the reform is in the best interests of the majority of the population.

## CHAPTER 7: CONCLUSION

### 7 1 The need for reform

This study began with the tragic story of the domestic worker who was denied access to emergency medical care at a private hospital because of her indigence.<sup>1</sup> This example is reflective of the barriers faced by the majority of the population in accessing health care services. Having analysed the constitutional and international law obligations imposed by the right of access to health care and the National Health Insurance (“NHI”) scheme, one cannot help but wonder if this woman would have had a different fate under a universal health coverage system, such as the NHI scheme.

Under the NHI scheme, the woman’s ability to pay would not determine her access to necessary health care services. The NHI scheme would fund the necessary treatment through contracting with the private hospital to treat her. This gives effect to a basic principle of human rights law that a person’s right of access to health care should not be contingent on their ability to pay.<sup>2</sup>

There is a patent need to reform the health care system and to address the inequalities of access and quality which the South African health care system has inherited from its past.<sup>3</sup> There is a disjuncture between the recognition of health care as a human right in the Constitution and the current reality in South Africa that a person’s ability to pay for health care services largely determines the extent to which they have access to quality health care.<sup>4</sup> The Minister of Health, Dr Aaron Motsoaledi describes the current health care system as:

“[A] flagrant disregard of our Constitution because the Constitution does not recognise economic status in the provision of health services. It is also a flagrant disregard of the Constitution because it makes healthcare a condition of service rather than a right.”<sup>5</sup>

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<sup>1</sup> See chapter one part 1 1.

<sup>2</sup> See chapter four part 3 4.

<sup>3</sup> See chapter two part 3 and part 4.

<sup>4</sup> See chapter two part 4 1.

<sup>5</sup> Dr Aaron Motsoaledi, Minister of Health Policy Debate on Health Budget Vote National Council of Provinces 16-05-2017 <<http://www.gov.za/speeches/minister-aaron-motsoaledi-health-budget-vote-201718-16-may-2017-0000>> (accessed 18 August 2017).



As emphasised throughout this study, there is a need to address the inequalities in access to and quality of health care inherited from South Africa's colonial and apartheid past. Constitutional provision of the right of access to health care provides a means through which to do so. It is in this context that the NHI scheme must be considered. It seeks to fulfil a constitutional right and address issues of equality and human dignity which lie at the heart of the Constitution of the Republic of South Africa, 1996 ("the Constitution").<sup>6</sup>

## **7 2 Constitutional and international obligations imposed by the right to health**

Compliance with constitutional and international law obligations imposed by the right to health should carry significant weight in arguing for the transformation of the health care system. This study has argued that the NHI scheme will provide a critical framework for realising the right to health care service in South Africa.<sup>7</sup> The NHI scheme complies with the criteria of reasonableness laid down in leading South African socio-economic rights jurisprudence. In particular, it serves as a co-ordinated and comprehensive programme for facilitating access to health care and eliminating the vast inequalities inherent in the current system.<sup>8</sup>

This study also argued that any potential retrogressive impact on the private health care sector could be justified as the reform of the health care system is to the benefit of the majority of the population, particularly the most disadvantaged and vulnerable.<sup>9</sup> A more equitable distribution of health care resources is desirable and necessary to address the structural problems of the health care, the underlying determinants of health, and the burden of disease in South Africa.<sup>10</sup> This study has argued that the constitutional goal of transformation should be reflected in the prioritisation of resources for realising socio-economic rights. As emphasised in this study, "available resources" are not limited to those budgeted for, and the Constitutional Court has shown that budgets can be scrutinised.<sup>11</sup> This refutes objections against the cost of

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<sup>6</sup> See chapter five part 2 3.

<sup>7</sup> See chapter six part 3.

<sup>8</sup> See chapter six part 3 2.

<sup>9</sup> See chapter six part 4 2.

<sup>10</sup> See chapter five part 2 2.

<sup>11</sup> See chapter six part 5.

the NHI scheme. The State has an obligation to make sufficient resources available for the realisation of the right of access to health care. The NHI scheme arguably does so. Furthermore, as the South African Constitution also imposes obligations on the private sector, and both constitutional and international law imposes obligations on the State to ensure that the private sector does not hinder access to health care, this study has argued that the private sector must be included in the health care system reform.

This study recognises that the NHI scheme is not without flaws or free from objections.<sup>12</sup> However, the evaluation argues that the continuous phased development of the NHI scheme allows for such concerns to be addressed. Furthermore, chapter two provides grounds on which to claim that South African cannot afford *not* to seek transformation of the health care sector. The current health care system is demonstrably perpetuating inequalities in access to and quality of health care.<sup>13</sup>

### **7 3 Considerations for further implementation and development of the NHI scheme**

Future developments and implementation of the NHI scheme by the Department of Health and the bodies established in this regard,<sup>14</sup> should address the vulnerable aspects of the NHI scheme which this study has highlighted, such as the provision of mental health care, prioritisation of vulnerable groups, emergency medical services and non-discrimination. Further development of the NHI scheme will also require clarity on resource accumulation and redistribution. Emphasis should be placed the argument that the NHI scheme's objective of a more equitable distribution of health care resources is harmonious with the transformative goals of the Constitution and the purpose of socio-economic rights.<sup>15</sup>

Further research is however required into the economics of reprioritising resources for the realisation of the right of access to health care, as well as other socio-economic rights due to their polycentric nature.<sup>16</sup> Implementation of the NHI scheme should

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<sup>12</sup> See chapter five part 5.

<sup>13</sup> See chapter two part 4.

<sup>14</sup> See chapter five part 2 4.

<sup>15</sup> See chapter two part 3 2.

<sup>16</sup> See chapter two part 3 2 for more on the interrelationship between socio-economic rights and the underlying determinants of health care.

facilitate participation and engagement between the private and public sector, the different levels of government, and communities to determine their needs as per primary health care.<sup>17</sup> As service delivery continues to occupy the forefront of social movements and political unrest in South Africa, the legislative framework giving effect to socio-economic rights is bound to attract more scrutiny for enabling State compliance with positive obligations.

#### **7 4 The value of universal health coverage**

The premise that universal health coverage is the “practical expression of the right to health” is supported by a statement made by the former director-general of the World Health Organisation, Dr Margaret Chan:

“[Universal health coverage], based on primary health care, serves the health goal well as a unifying concept, a platform for the integrated delivery of health services, and one of the most powerful social equalizers among all policy options. It is the ultimate expression of fairness. People who cannot pay for health care are not left to stay sick, get sicker, or die of a preventable or treatable condition.”<sup>18</sup>

Without reforming the South African health care system, the inequalities in access to and quality of health care will grow and continue to perpetuate past injustices. A rights-based approach to socio-economic transformation allows for constitutional values to permeate service delivery, such as in health care services. As a means to give effect to the right to health care through universal health coverage, the NHI scheme is a formidable effort at addressing the unequal access to and quality of health care.

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<sup>17</sup> See chapter four part 3 8 1.

<sup>18</sup> Dr Margaret Chan, former Director-General of the World Health Organisation “Universal Health Coverage: A Pro-Poor Pillar of Sustainable Development” *Global Leadership Address at the International Conference on Universal Health Coverage in the New Development Era* Tokyo, Japan 16-12-2015 <<http://www.who.int/dg/speeches/2015/universal-health-coverage/en/>> (accessed 15 August 2017).

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