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Access to Health Care in South Africa:

An Ethical and Human Rights Obligation

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Abstract:

Access to health care is a constitutionally recognized right, under section 27 of the South African Constitution. Fifteen years post the first democratic election in South Africa the realization of this right is the focus of this research report. In 1997 the South African Human Rights Commission (SAHRC), a statutory body assigned to evaluate the realization of access to health care, held a public enquiry into the matter. The report was released in early 2009. The public health care system was found to be in a 'lamentable state'. South Africa faces a number of challenges that complicate the progressive realization of access to health care . For example, the country is currently in recession; the HIV / AIDS statistics is among the highest in the world placing a huge burden on public health; South Africa has the highest income inequality globally and the gap between public and private health care, with regards to affordability and quality of service remains a great concern. A way of addressing this problem is to engage ethical principles such as beneficence, non-maleficence, autonomy and (distributive) justice. Each of these in application can argue a case for the moral obligation to initiate a more effective national health care system. Rawls[1] (1999) emphasized the centrality of justice in consideration of the bio-medical principles.

[1] Rawls, J. 1999. *A Theory of Justice.* Revised edition. Cambridge, Mass.: Harvard University Press., 1971. Oxford: Clarendon Press, 1972.

The principle of justice and its derivative, distributive justice, is of importance when making a moral argument for equal access to health care for all. Farmer and Campos (2004:28) rightly asks[2]: "What does it mean, for both bioethics and human rights, when a person living in poverty is able to vote, is protected from torture or from imprisonment without due process, but dies of untreated AIDS? What does it mean when a person with renal failure experiences no abuse of his or her civil and political rights, but dies without ever having been offered access to dialysis, to say nothing of transplant?" There is a need for ethicists to become more involved in arguments pertaining to the inequalities in distribution of social goods.

Legislation and case law in South Africa also affirm the right to access health care services and have as their grounding normative ethical tenets. The recommendations made by the SAHRC, together with the planned national health insurance aimed at addressing the gap between public and private health care, can only become a reality through successful implementation of a monitored process based on ethical principles. There is a need for a practical implementation of current ethico-legal and human rights principles through every phase of the health care system to serve as monitors to ensure the success of this guaranteed right that so few people have genuinely seen realized. The findings of the SAHRC, together with the response from the Department of Health, serve as a basis for planning towards successful

[2] Farmer, P. and Campos, N.G. 2004. Rethinking Medical Ethics: A view from below. In: *Developing World Bioethics*, **4** (1), 17-41

implementation of an equitable health service system that is of an excellent standard. To aid in this process an ethical framework could be of use to assess the policies formed along the way as well as the practical implementation thereof. This research report is an analysis of current literature and data available on access to health care in South Africa in light of human rights and ethical arguments for its provision. The aim is to reflect on the realization of greater access to health care since 1994, identifying current hampering factors in achieving this and proposing a broad set of guidelines that can be applied to the reform process already underway in South African health care.

Introduction:

Fifteen years of democracy for South Africa has brought with it many new possibilities for this rainbow nation. The southernmost country on the continent of Africa saw the birth of its first Constitution to affirm the rights of *everyone* and not just a minority of the population of the country as was the case prior to 1994.[3] The final Constitution (1996) reflects on the International Covenant of Economic, Social and Cultural Rights (ICESCR), of which South Africa is also a signatory, although it has yet to be ratified.[4] According to Ngwena (2001/2:26-44), the political transition at that time, with the African National Congress (ANC) elected the ruling party, set the stage for the country to affirm a commitment to address the past and make the necessary legislative changes to start providing not only democracy but also access to health care for all.

The country now being a "teenager" on the road to democracy is at a very critical stage of its development. The hurdles still to be leapt over include developing and implementing programmes to raise the overall standards of the country especially pertaining to education, health care and other public services. Still in an early state of development, the system is vulnerable to internal and external hampering factors. For example, the successful

[3] The Constitution of the Republic of South Africa, Act 108 of 1996

[4] Ngwena, C. 2001/2. The Recognition of access to Healthcare as a Human Right in South Africa: Is it enough? *Health and Human Rights,* **5** (1):26-44. (The fact that the document is not ratified means that there is no legal obligation or official acceptance of this document. This places a question on the commitment of government to actively enforce the provisions of this document.)

implementation of adequate access to health care is inhibited locally by poor infrastructure in many areas. 'Trial-and-error' system development, the shortage of medical statistics that include all citizens in the past and lack in expertise as well as unwillingness to recognize the seriousness of amongst others the HIV/AIDS epidemic by political leaders, all contribute to poor service delivery. An example of an external hampering factor, is the recent inflow of millions of refugees from neighbouring countries seeking a better life and utilizing an already struggling- to- cope medical system, thus adding even more numbers of people in need of treatment to an already shortcoming budget. With the rest of the world finding itself in die midst of a global recession, South Africa has also recently officially announced its own economic recession.

South Africa recently held its third post-apartheid election. Prior to this election, Dr Barbara Hogan was acting Minister of Health in 2008. Her successor then was Dr Molefi Sefularo (The current acting Minister is Dr A Motsoaledi).[5]

In the launch issue of "What's new Doc"[6] Barbara Hogan, then acting as Minister of Health, set out a plan of action to provide greater access to health care. She declared her top priorities 1) to fight HIV, TB and 2) to improve the

[5] See: www.doh.gov.za. Cited 22 June 2009. This website is run by the Department of Health and gives access to the public on the focus of the department to current medical issues.

[6] Van der Merwe, I. 2008. Hogan: Expect Change –and soon. In: *What's New Doc*, (1):1-3

quality of health services provided. An outlay of her plan to change the system included reforming the fragmented public health sector, (focusing on the service provided by the public sector), the filling of vacant health care professional posts in the public sector, reducing the amount of money spent privately for health services, and moving towards a National Health Insurance (NHI).

The responsibility of implementing the planned NHI, as well as other strategies to improve health care, now rests with the new acting Minister of Health. This is no small task. The ruling party (the ANC), set the goal of implementing a NHI within 5 years. This is a fraction of the time it took some first world countries to implement their own National Health Insurance. According to Discovery Health (2009:1-4),[7] Australia took 30 years, the United Kingdom 37, Switzerland 90 years and Germany 127 years to reach this goal. This does not necessarily suggest that a NHI is not the preferred route. In fact, statistics show that the gap between the rich and the poor and similarly the private versus public health care sector serves as an indicator of the great income disparities within South Africa. "South Africa has the highest income inequality in the world," says Prof Di McIntyre (2009) of the University of Cape Town's Health Economics Unit.[8]

Services rendered by the private sector in a comparative study done by Discovery Health Care (see footnote 7), received a worldwide sixth position at 78%, outranking countries such as the USA, Germany and Canada.

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[7] Van Zyl, J. 2009. National Health Insurance. In: *What's new Doc*? (4):1-4

[8] Van Zyl, J 2009. National Health Insurance. In: *What's new Doc*?. (4): 1-4. Professor McIntyre is also part of the task team assigned by the State to assist in the development of a strategy for the implementing a National Health Insurance.

The services rendered by the public sector scored 53%, with only six countries rendering a poorer service. The public/private service combined scored 58%. Statistics on the distribution of health resources show that the number of people who need to be treated by a single doctor in the private sector is far under a thousand. In contrast to this, the number of people who need treatment from a single doctor in the public sector is over seven thousand. The population ratio per pharmacist in the private sector compared to public sector is 1000:18000.[9]

Within the public health care system, the lack of resources is currently a reality in South Africa. This state of affairs is evident in news reports, case law and the perception of the public trying to access public health services. The concern is that if funds are already a problem in what way will the National Health Insurance succeed in providing a service that would be of an acceptable standard to all. If the plan is to lift the standard of the public service to the same level as is provided in private health care then this suggests that an additional 60,000 beds would be necessary. The government would also need to employ more nurses adding up to 320,000 and even more doctors of around 124, 000 – not to mention the allied medical and health care personnel needed.

The current expenditure by government on health care in the public sector adds up to under 5% of the country's Gross Domestic Product (GDP). On the other hand, the estimated cost of a National Health Insurance (compared to

[9] (Indirect) The findings by Atagaba and McIntyre. 2009. (Cited in Van Zyl, J. 2009. National Health Insurance. In: *What's new Doc?* (4) :1-4

private care provided) adds up to over 25% of our GDP (Atagaba and McIntyre 2009:1-4).[10] This is more than 70% of the total budget of the country.

An article [11] by Thom published in *The Star* in early 2009 told the story of a patient named Morris (not his real name) employed by the State to deliver the anti-retroviral treatments to various facilities in the Free State province. Ironically, when he was diagnosed with HIV, the province ran short of this (life-saving) medicine. The article gives account of three stories that all reflect on the harsh reality faced by thousands in similar circumstances. Another story is that of a patient that knew of his HIV status and with secondary complications that needed medical attention. He had extremely poor immunity, as reflected by his low CD 4 count, (which made him eligible for ARV's) but when it came down to it, this much needed medicine wasn't available and without addressing his immunity status, the operation he needed would be too risky. This situation became public knowledge early in November 2008. Dr Mvula Tshabalala, head of the HIV programme in the Free State, acknowledged a shortage in medicine as well as funds in the province to deliver the medicine. The Acting Minister of Health at that stage, Dr Barbara Hogan, arranged for additional funds of over R9 million to be transferred to the province. Independent organizations such as the Treatment Action Campaign as well as the South African Council of Churches voiced the problem to the manager of the executive committee of the Free State Health,

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[10] (Indirect) Discovery Health. 2009. (Cited in Van Zyl, J. 2009. National Health Insurance. In: *What's new Doc?* (4) :1-4

[11] Thom, A. 2009. Hovering at death's door. *The Star*. 11 Feb. (page uncertain)

Mr Sakhiwo Belot. The response from the Department (four months later) was that the financial shortage of the province did not permit for initiation of new patients on anti-retroviral treatment.

Both these stories and the statistics as shown confirm the acute awareness that the health care system in South Africa is in a crisis. These stories are repeated by various accounts throughout the country and the statistics remain the same. If one considers how long it took developed countries to turn their health services around, one realizes that South Africa cannot look to the Western countries to provide us with a model to use here successfully within the planned 5-year period. A new strategy – drawing from the ethical principles that some might perceive to be only theory – needs to be put in place and applied practically. Moreover, the focus should be on mobilizing people to understand the advantage of having a Constitution that provides for the right to access health care and by being aware of their human rights in order to campaign from within the health care sector as well as from outside, to contribute to the attainment of this goal.

Access to health care as an ethical obligation:

A preliminary report published in April 2009 by the South African Human Rights Commission (SAHRC) based on a public enquiry into the current health services provided, found it to be in a "lamentable state."[12] Currently the public health system serves almost ninety percent of the country's 47 million people. The report stated in its executive summary that it could not specify with certainty, whether the health services in South Africa were indeed "improving or getting worse or whether the Constitutional guaranteed right of the realization of access to healthcare was indeed becoming a reality." (Van der Heer, 2009: 6-9)[13] One of the reasons stated, is that this report was the first of its kind and there is no previous parameter to measure it against that would give an accurate picture of the access to health care in the past versus the present. The Human Rights Commission also commented on the fact that although the State acknowledges the right to health care as a human rights principle, there is no definition to explain what that entails and therefore accurate measurement of its realization is not possible. This is one of the shortfalls of an approach strictly based on human rights.[14] Gruskin and Daniels (2008: 1573) argue that a human rights approach is very effective in

[12] South Africa: Public healthcare "is lamentable". 20 April 2009. *IRIN NEWS*, (online) Available from:http://www.IRINnews.org Cited 22 June 2009.

[13] Van der Heer, A. SAHRC Public Inquiry into Access to Healthcare Service Available from: www.sahrc.org.za/sahrc_cms/downloads/Dept%20of%20Health.ppt Cited 20 June 2009. 6-9

[14] Gruskin, S. and Daniels, N. 2008. Justice and Human Rights: Priority setting and fair deliberative process. *American Journal of Public Health.* Washington: **98** (9), 1573-1582

identifying the factors, whether that be political, social or other that need to be addressed by government and highlights the responsibility the state has in achieving this. Human rights are however, less effective in addressing the decision-making process to follow on an established right, because of their inability to determine which group or claimant should receive priority above the other. Although human rights are fundamentally rooted in ethics, on their own they do not give enough clarity on how to decide on the precedence concerning the realization of different rights. This can be addressed by drawing from the strengths of both human rights and ethical principles such as distributive justice.

Health care is not only an economic or political issue. "Unequal access to health care is also an ethical issue," (Levine 2007: 14-19).[15] This issue was and still is a reality in numerous countries worldwide today. The USA, like South Africa does not have a National Health Insurance and millions of people depend upon the State to provide them with an adequate health service. This has led to many discussions from various parties to try to determine what the ethical obligations of a State really are regarding health care for all. A report released by the Hastings Center in 2007[16] included perceptions from the

[15] Levine, M.A., Wynia, M. K., Schyve M., et al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. *Hastings Center Report*. Sept-Oct: 14-19

[16] Levine, M.A., Wynia, M. K., Schyve M., et al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. *Hastings Center Report*. Sept-Oct: 14-19

public on whether or not they agree with the idea that society has a moral obligation to provide access to health care for all. In this report, sixty percent (60%) of the people who were interviewed, agreed that this was not solely a political or economic issue but also one of moral importance, while seventy two percent (72%) of the people agreed that there was an obligation to provide access to health care for everyone.

With talk of implementing a NHI in South Africa and millions of South Africans being unemployed or receiving a minimal income per month and therefore not able to contribute to health insurance, many questions need to be addressed such as: Is it fair to expect the rest of the country to contribute on their behalf? To offer the same level of care that is currently available in private health care on a public level, would cost an estimated R325 billion. It does therefore seem highly unlikely to offer patients the same level of care on a NHI plan, which some currently can afford to buy privately. Is it fair to presume that some can afford to buy “good” medical care, while the rest seem disadvantaged in terms of receiving good medical treatment and thus have a lesser chance of good health, which in turn could affect every area of their lives? On the other hand, one must also ask if it is ethical to force a person to contribute to another’s medical insurance. In a free society, can he not choose on who or what he would like to spend his money? These questions have no easy answers. The argumentative application of ethical

principles can however serve as a guide to come to a workable moral conclusion.

Biomedical ethics today often use a principle-based approach when confronted with questions related to medical care.[17] Principlism consists of four principles: beneficence, non-maleficence, autonomy and justice.

Beneficence – *to do good or to actively promote the good* – means that we should actively work towards the promotion of access to health care services for all. When applying beneficence to the question of whether a moral obligation to provide adequate access to health care exists, it implies that we should take care of individuals and society. Yet, in the context of a NHI under the current financial, personnel and other problems, to support it remains problematic because there is no guarantee that it will, in fact, even benefit those who are most in need.

Non- maleficence – *the obligation not to harm ; to not cause unnecessary harm* – can be used to provide an argument for or against a National Health Insurance as one could argue that the principle of not to harm can be applied to not taking money from the 'unwilling' rich and giving it to the poor.[18]

At the same time, the obligation generated from the principle could be used to argue that by not supporting a NHI, disadvantaged people continue to be marginalized as they remain on the periphery of access to health care.

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[17]Van Bogaert, D.K. 2007. Principlism. *Introduction to Bioethics: A reader.* Course Code FAMH 7015: 90-93

[18] Soman, E. Moral Obligation for society to provide healthcare. Accessed June 20, 2009. Available at http://www.socyberty.com/Issues/Moral-obligation-for-Society-to-Provide-Health-Care.121350/4.

The principle of respect for persons, or autonomy could be applied here from a Kantian perspective. Autonomy has its origin from Kant's Categorical imperative (Knapp Van Bogaert 2007:51-60)[19]. Kant believed in the moral validity of the 'respect principle' because of its universal applicability. Although Kant originally intended his moral theory to be viewed as moral obligations, they served as the basis for the development of Human Rights during the French Revolution[20]. The requirements of the Rights of Man are in turn: equality and fraternity (we are all members of a moral community and autonomy (or respect for persons). If we follow this moral law of respect for persons, accept that we are all members of a moral community and therefore cannot distance ourselves from the inequalities that the community is struggling with, then we have an obligation to support a NHI because it includes a framework for all persons to have access to health care.

The fourth principle (and arguably the one bearing the most weight in this moral problem), is that of justice and its derivative, namely distributive justice. Rawls[21] (1993) is famous for his works on the moral importance of justice. "Principles of distributive justice are normative principles designed to guide

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[19] Van Bogaert, D.K. 2007. General approach to Deontology. *Introduction to Bioethics: A reader.* Course Code FAMH 7015: 51-60
Kant is famous for his rule-based (deontological) moral theory which states that one should act only on the maxim whereby you can at the same time will that it should become a universal law.

[20] Van Bogaert, D.K. 2007. Principlism. *Introduction to Bioethics: A reader.* Course Code FAMH 7015: 90-93. Kant's Categorical Imperative lead to the Declaration of the Rights of Man during the French Revolution in 1789, the Nuremburg Code in 1947 as well as the Universal Declaration of Human Rights in 1948.

[21] Rawls, J. 1999. *A Theory of Justice.* Revised edition. Cambridge, Mass.: Harvard University Press., 1971. Oxford: Clarendon Press, 1972.
John Rawls lived 1921-2002. The original book was published in 1971, with various revisions following, including 1993 and 1999. His overriding aim was to "provide the most appropriate moral basis for a democratic society"

the allocation of the benefits and burdens of economic activity[22]." The justice principle serves as a basis for various moral theories on distributive justice: some argue for Strict Egalitarianism, others follow what is known as the Difference Principle[23] (Rawls, 1971) while some contend for Resource Based Principles [24](Dworkin, 1981: 185-246).

Strict or Radical Egalitarianism is the notion that all people should have a similar level of services and material goods. This Distributive Justice Principle justifies itself according to the idea of equal respect for all persons and that the simplest way of giving due respect to all is by equality in terms of services and goods[25]. The practical application of Strict Egalitarianism however has various shortfalls. It is difficult to specify and quantify a level. If distributive justice is applied in this way continually, all people will have to be controlled in terms of their 'goods' whether that be possessions, money, services or opportunities as one could be better or worse off later on, depending what he does with the goods. The most common criticism is however focused on the Welfare Principle: that everyone can be better off materially if incomes are not strictly equal.

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[22] Grendler, P. 2007. Stanford Dictionary. Second edition. Definition of distributive justice (online) Available from: http://plato.stanford.edu/entries/justice-distributive/ [cited 20 Aug 2009

[23] Freeman, S. 1998, 2002. Rawls, John. In: E. Craig (Ed.), *Routledge Encyclopedia of Philosophy.* London: Routledge. Retrieved July 23, 2007, from http://0-www.rep.routledge.com.innopac.wits.ac.za:80/aritcle/S091SECT1

[24] Dworkin, R. 1981. What is Equality? Part 1: Equality of Resources*. Philosophy and Public Affairs.* (**10)**: 185-246

[25] Nielsen, K. 1979. Radical Egalitarian Justice: Justice as Equality. *Social Theory and Practice* **(5)**:209-226

Rawls (Indirect: Freeman 1998, 2002?) believed that a democratic society could make the best decisions regarding the principles it would follow in regulating political, business and social matters when the members involved in the decision-process were "free"."[26] This is only possible when the people involved, abstract all knowledge regarding their personal circumstances e.g. their position in society, possessions and talents as well as their knowledge of the circumstances of others. For the sake of the argument, people are placed under a 'veil of ignorance'. There is still knowledge surrounding general physical, economic and social theories. In this scenario, the individuals involved are strictly equal. Rawls argues that justice is what would be agreed upon between free persons from a position of absolute equality. He proposed two principles of justice:

1. Every person has an equal claim to a fully adequate scheme of equal basic rights and liberties, which scheme is compatible with the same scheme for all; and in this scheme the equal political liberties and only those liberties, are to be guaranteed their fair value.
2. Social and economic inequalities are to satisfy two conditions: (a) They are to be attached to positions and offices open to all under conditions of fair equality of opportunity; and (b) they are designed to greatly benefit the least advantaged members of society. (Rawls, 1993:5-6)[27]

[26] Freeman, S. 1998, 2002. Rawls, John. In: E. Craig (Ed.), *Routledge Encyclopedia of Philosophy.* London: Routledge. Retrieved July 23, 2007, from http://0-www.rep.routledge.com.innopac.wits.ac.za:80/aritcle/S091SECT1

[27] Rawls, J. 1999. *A Theory of Justice.* Revised edition. Cambridge, Mass.: Harvard University Press., 1971. Oxford: Clarendon Press, 1972.

Rawls gives priority to principle 1 over principle 2. Principle 1 and 2(b) are principles of distributive justice and 2(a) equal distribution of opportunities. Health care as a moral right is best supported in terms of equality in opportunity and access (Shelton, 1978:165-171).[28] Justice demands the equitable distribution of health care opportunities.

Ronald Green (1976: 111-124) in his application of John Rawls' Theory of Justice contends that 'contract reasoning gives independent rational support to the assertion common today, that health care is a basic right of all persons regardless of income.'[29] If one accepts that health care to all is a moral right then the next question that comes to mind is what level of health care would be morally acceptable? Green comes to the following conclusions on health care policy after analyzing Rawls' theory on social justice:

1) Those who believe in the contract theory of justice would contend for the most extensive health care services possible in society.
2) Health care availability based on income is ruled out by the theory
3) Basic health care services should receive priority above more expensive treatments and should be put in place as soon as possible to all members of society
4) Health care as provided in a free market should not be cast away. Political intervention is however important to ensure progressive rates.

If we apply the above four comments to the scenario of access to health care in South Africa, then one can deduct the following to be moral:

[28] Shelton, R. L. 1978. Human rights and distributive justice in health care delivery. *Journal of medical ethics**. (4)**: 165-171*
[29] Green, R. 1976. Health care and justice in contract theory perspective. *Ethics and Health Policy*: 111-124.

1) Justice demands that society should provide access to health care for all its members to the best means possible. Therefore, government should develop strategies to provide greater access to health care.
2) The right to have access to health care is not rooted in one's ability to pay for it. Health service provision should be established in such a way that the least advantaged benefits first; for e.g. build clinics in rural areas with poor access before starting to upgrade other service provision areas.
3) The reality is that government cannot afford to provide health care to all at the same level that is offered privately. Therefore, focus should go to providing basic health care for all.
4) The current private health care market should not be seen as a threat to the right to health care for all. Better systems can however be developed to form private-public partnerships and to regulate private health care costs.

The statistics from the Hastings Center show that many believe that the less fortunate should be helped to the extent that equal opportunity is created in order that the one's who then rise above the rest of the community with regards to social goods, really have a "fair playing field". Levine (2007:14-19)[30] argues that in order for the principle of distributive justice to be applied to its full meaning, other social resources should also get the attention that it deserves. This implies that if we pour all our resources into health care alone

[30] Levine, M.A., Wynia, M. K., Schyve M., et al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. *Hastings Center Report*. Sept-Oct: 14-19

hoping that it would ensure equality, we will soon realize that it is not feasible. A person having access to anti-retroviral therapy without the proper sanitation, shelter and nutrients necessary to promote his health, is not really better off. Thus, it is also unjust to let the great need for better medical care take up all the available resources and then in turn have a compound injustice effect on the poor access to the care that we were trying to address in the first place. For this reason, government should also give adequate attention to other social goods such as housing, sanitation, education and environmental protection.

The extent to which healthcare for all should be supplied could thus be limited. This is dependent upon factors such as available resources and other circumstances relevant to the South African setting. Many politicians and political parties acknowledge this moral duty (access to healthcare) today. In fact, it was a common phrase used during campaigning before the election. Once we have established the ethical obligation of the state towards health care, one has to consider a human rights and legal perspective. I will give an outline of the current Legislation and other relevant documents and analyze the current policies on access to health care. Thereafter I would like to make some suggestions in terms of an ethical framework to aid in the current reformation of health care.

Access to health care as a legally qualified right:

The Constitution serves as the *lex fundamentalis* (highest law) in the country. Parliament may serve as the highest body of legislation within the context of the system of the supreme Constitution and government, but any Act, legislation, or government body, which also includes Parliament, which opposes the Constitution, will be invalid.

The provisions of the Constitution of 1996 are very broad and therefore subject to interpretation and to limitation in terms of section 36 of the Constitution. In order to assist with the interpretation of the Constitution (section 39) legislation, common law, customary law and case law must be referred to.

Section 27 of the Constitution[1] affirms the right of every person to have (1a) "access to healthcare services, including reproductive health care," it also provides (2) for the state to provide for the progressive realization of these rights, within the country's available resources, whether by legislation and/or other measures. The focus of Section 27 of the Constitution is to assert the equality of humanity and thus complements Section 9, also known as the equality clause.[31] The purpose of Section 27 is to guarantee everyone formal and substantive equality when seeking health services in South Africa. Formal equality is the notion that everyone should be treated equally, while

[31] The Constitution of the Republic of South Africa, Act 108 of 1996.
See also Ngwena, C. 2001/2. The recognition of Access to Healthcare in South Africa: is it enough? In: *Health and Human rights*. **5** (1): 26-44

substantive equality tries to compensate or eradicate the 'social standard' that hinders equality. Ethnicity, sex and HIV status (e.g. of formal equality) should not be a hindrance to access medical services in the country. Section 27 also tries to level the playing field when it comes to substantive equality such as a person's income or area of residence when it comes to the access of healthcare services. The State not only has a negative duty not to interfere with another person's right to have access to health care services provided to him, but it also has the responsibility of providing such a service everyone living in South Africa.

The South African Human Rights Commission has a legislative mandate to promote, protect and fulfil human rights.[32] This constitutional body held public hearings to evaluate the realization of the right of access to health care services. The findings during these hearings are very valuable as they could serve as a platform not only for evaluating the realization of this constitutionally recognized right, but also as a tool to help bring government and other bodies to responsibility in planning and implementing strategies to improve the realization of this.

The Covenant on Economic, Social and Cultural Rights, of which South Africa is a signatory, also places an obligation on the State to provide for at least the minimum of the enunciated rights.[33] The above, together with other legislation

[32] South African Human Rights Commission Act, 54 of 1994, Section 9.

[33] See General Comment No. 3. The nature of States parties' obligations (Fifth session, 1990) U.N. Doc. E/1991/23, annex 111 at 86 (1990), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/I/Rev.6 at 14 (2003) ("General Comment No.3 of the CESCR")

such as the National Health Act 61 of 2003, the Children's Act 33 of 2005 and the Choice on Termination of Pregnancy Act 92 of 1996, enforce the right to certain health care services and specifically protect the rights of vulnerable groups.

The National Health Act[34] gives recognition to the past inequality of the health services provided and tries to assist in establishing a *uniform health system.* The Act also underwrites the Bill of Rights and gives recognition to section 27 of the Constitution. The goal is to integrate the different aspects of the country's health system as to achieve a better health system in South Africa. Chapter 1 expresses the focus of the act and states –

"The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation by-

a) establishing a national health system which-
    i) encompasses public and private providers of health services;
    ii) and provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford."

The same goal is expressed in the *White Paper for the Transformation of the Health System in South Africa, 1997*.[35] This paper states as its goal to unite

[34] National Health Act No.61, 2003

[35] (Indirect) Hassim, Heywood, Berger. 2008. Health and Democracy – A Guide to human rights, health law and policy in post apartheid South Africa: The private health care sector. *Introduction to Health Law*. 285

the public and private health care activities with all the different branches that stem from it and to deliver the best possible service available from these resources to the public. There is also a focus on achieving more fair distribution of these skills and services between not only public and private sectors, but also the different settings from city to rural areas in South Africa.

The Medical Schemes Act[36] has also undergone transformation in trying to provide greater access to more South Africans. The first Medical Schemes Act 72 of 1967 was legislated to serve as guardian of the interests of the white medical service seeker and was strict to specify what appropriate remuneration would be for a patient. The Act of '67 also described the minimum benefits and prohibited against excluding health users on the sole basis of their having a high risk of already having a poor medical status – this is known as risk rating. This however changed with subsequent legislation in the late eighties and became legal. In 1994, the law changed concerning the minimum benefits that all clients of a scheme should enjoy.

From then to now the Medical Schemes Act has been adopted to suit the larger South African community with the opening of medical aids to all citizens. The Medical Schemes Act no 131 of 1998 does not allow *risk rating* but allows *community rating.* This entails that a Medical Scheme distinguishes on the basis a person's income and the number of dependants but not to profile a person according to his risk of having disease. The Act

[36] Medical Schemes Act (MSA) no. 131 of 1998

also protects the members by prescribing the minimum benefits regardless of the amount paid for or the cover agreed on.

The Act also recognizes the intricacies of a family today and allows the member to specify as a dependant not only a wife or husband, but also a partner and not only direct children, but also other dependants. There is room for the Medical Scheme to *discriminate fairly* by allowing the Scheme to exclude cover for the first 3 months of belonging to it, or 1 year in the case of never having been a member of one before and by allowing older members to belong to the aid by paying higher premiums than regularly offered.

A case law example that affirmed the responsibility of the State to regulate prices of medicine and related services to increase the access to health care is that of the MINISTER OF HEALTH v NEW CLICKS SOUTH AFRICA (PTY) LTD.[37] The case was heard in the Constitutional Court. The case centred on whether it was reasonable for the Minister of Health to legislate a single exit price for medicine under the Medicines and Related Substances Act 101 of 1965. The Court responded to this by stating that the question is not simply about whether the cost of the medicine is 'appropriate'. The economic and political factors pertaining to this in the South African setting is also of importance. The Court held that the State has a Constitutional obligation to make medicine more accessible to the public and that this would entail that the Minister of Health and government legislate for a controlled and

[37]MINISTER OF HEALTH AND ANOTHER NO v NEW CLICKS SOUTH AFRICA (PTY) AND ANOTERS (TREATMENT ACTION CAMPAIGN AND ANOTHER AS AMICI CURIAE) 2006 (2) SA 311 (CC)

transparent pricing of medicine to ensure its affordability and availability to the public.

The Patients' Rights Charter:[38] While found on the Department of Health's "legislation" website, it does not have any legal standing. However, as its principles are codified in law, the Patients Rights Charter is considered to have quasi-legal standing. The Charter consists of twelve rights that every health care user has, but also importantly of 10 responsibilities. The third right mentioned in the Patients' Rights Charter is to have *access to health care*. The Charter explains what this statement means by listing seven points:

1. Every patient has the right to be treated in the case of an emergency, regardless of having the finances to pay for this health care
2. The patient has the right to be part of his/her treatment process and should be informed on it, including the complications that could also arise from it
3. Vulnerable groups are of importance and must be catered for because they have special needs. This includes children of all ages, geriatrics, pregnant women, and people living with pain, disability or HIV/AIDS
4. In the case of sensitive subjects such as cancer, reproduction and HIV or AIDS, non-threatening and non-discriminatory counselling must also be offered to the health user.
5. Cases where the patient is dying the care offered must also include palliation that makes a difference and is cost-effective.

[38] Available at the official website of the Department of Health: http://www.doh.gov.za/docs/legislation/patiensright/chartere.html [accessed July 20, 2009]

6. Every health user must be treated with respect and care that strengthens his human dignity.
7. When informing the patients about their health or the services offered, they have a right to be explained to in their own language.

The first point mentioned in the Patients' Rights Charter comes out of section 27(3) of the Constitution[1] that states:' No one may be refused emergency medical treatment'.

The question is: What is emergency medical treatment?

There are some clear-cut scenarios that would definitely qualify as emergency treatment, but some may be less clear, especially because of the socio-economic circumstances, the high incidence of infectious diseases like HIV/AIDS that all put extra strain on the health resources available. The court had to rule on this in a case based on the patient's right to emergency medical treatment in the case of SOOBRAMONEY v MINISTER OF HEALTH, KWAZULU-NATAL.[39] The applicant was a diabetic, with other complicating diseases such as chronic renal failure, ischaemic heart disease and had been suffering from them for a number of years. He was in need of chronic renal dialysis, which would be life saving and if he did not receive it for the rest of his life, he was sure to die. He appealed to the court based on Section 27(3) of the Constitution, stating that this was within his human rights to receive the *emergency treatment* that would save him from certain death. This happened

[39] SOOBRAMONEY v MINISTER OF HEALTH, KWAZULU-NATAL 1998 (1) SA 430 (D)

in Addington Hospital, a state funded hospital, where there were specific conditions that had to be satisfied by a patient before they were allowed into the haemodialysis programme because of limited resources. Section 36(1) of the Constitution[1] limits the rights of one person in terms of application as a general rule to such an extent that it is still considered to be justifiable and reasonable in the community of open democracy. The court held that in this case the limits set when allowing a patient into the dialysis program was reasonable and just because it was based on good medical evidence. The court recognized that the patient would not be able to survive without the dialysis; however, this was also true for other patients who were applying at the same hospital for dialysis. The Court also said that it is not within the its scope to force the State to supply the necessary funds and resources for treatment as this decision was of political origin.

The response of the Court to the relevance of section 27(3) was that the focus of this should be that no one may *refuse to give emergency treatment* and that it is not an absolute right to receive emergency treatment. The Court held that such treatment must actually be available. The Court gave recognition to costs and the availability of treatment when Legislation in this regard is interpreted.

The Court also held that because of the nature of the patient's illness, it was not an 'unexpected' trauma that is generally understood as an emergency, but something that has been there for years and thus not something that was

intended when the Legislation was drawn up. The SOOBRAMONEY[40] case was the first in which the Constitutional Court had been asked to give an interpretation on the State's obligation to fulfil a person's socio-economic rights. The Court's ruling aligns with customary judicial thinking. Ngwena (2001/2:32-33), associate professor in the Faculty of Law, Vista University, questions whether the Court took the necessary consideration needed to evaluate the specific context of the South African citizen and the realization of the rights guaranteed in the Constitution of 1996[41]. The decision of the Court in allowing the hospital to specify guidelines for treatment and by doing this excluding Mr Soobramoney from dialysis, is not in question. It is reasonable for the Department of Health and the bodies functioning under them to allocate the resources available to them by prioritizing. The ruling in this case emphasizes that the most important determinant when trying to assure a socio-economic right from the State; is the availability of resources. Therefore, the decision of the Court not to give lifelong dialysis based on the lack of resources, justified under Section 27(2) and (3), is the correct response.

[40] SOOBRAMONEY v MINISTER OF HEALTH, KWAZULU-NATAL 1998 (1) SA 430 (D)

[41] The Constitution of the Republic of South Africa, Act 108 of 1996.
See also Ngwena, C. 2001/2. The recognition of Access to Healthcare in South Africa: is it enough? In: *Health and Human rights*. **5** (1): 32-33

However, the Court still has an obligation under the Constitution to ask the necessary questions about the finances available within the budget on local and broader level when it has to rule on the realization of the socio-economic rights. In-depth analysis must also be done on national level to ascertain whether the budget allocated to health is appropriate when the State's duty to fulfil these rights, is taken into consideration. These questions were not addressed in the SOOBRAMONEY case and could have helped to shed some light on the progressive attainment of health (and its accompanying rights) in South Africa.

Access to health care services (or lack thereof) was also the point of dispute in the following case law: MINISTER OF HEALTH AND OTHERS v TREATMENT ACTION CAMPAIGN AND OTHERS (NO 2) 2002 (5) SA 721 (CC). This Constitutional court case dealt with the question whether the State had an obligation to provide Nevirapine to women during birth to prevent the mother to child transmission of HIV. The Court ruled that the government was not fulfilling its Constitutional obligation to progressively realize the right to access to health care services, in accordance with Section 27(1) and (2), because it was limiting the sites of Nevirapine available in the public sector and this was within the available resources of the State and could be life saving to a child.

The right to have access to health services in relation to other socio-economic rights: Access to health services alone cannot provide health; nutrition, shelter and sanitation are vital to health. The right to access to health services mentioned in Section 27 (1a) is only that and the focus of this provision is not

to ensure the other factors necessary pertaining to health[42]. The other socio economic rights that are contributing factors to health are found in other sections of the Constitution including: the right to social security mentioned in Section 27(1c), the right to have access to enough food and water Section 27(1b) and the right to have access to adequate housing as written in Section 26(1) of the Final Constitution.

The right to have access to health facilities and care (as well as reproductive health treatment) and the right to enough water and food, as well as social security, are all mentioned under one section of the Constitution of 1996. This leads to the question whether these rights should be read in unison or whether each one should be seen as a separate right. The arrangement of these rights together sheds some light on the fact that one of these rights cannot be evaluated or realized in isolation from the other, as they are interdependent.

In the case of GROOTBOOM AND OTHERS v, OOSTENBURG MUNICIPALITY AND OTHERS[43] the applicants wanted the High Court to rule in favour of their right to access to adequate housing as stated in Section 26 of the Constitution and the right of every child to basic shelter, Section 28. The applicants were homeless and Section 26 (1) says that everyone has a right to have a sufficient place to live in. However, Section 26 (2) mentions

[42] Bilchitz, D. 2008. Health. In: *Introduction to Health Law*: 72

[43] GROOTBOOM AND OTHERS v OOSTENBURG MUNCIPALITY AND OTHERS, 2000 (3) BCLR 277 (C)

that the State must take reasonable steps within its available resources and legislative measures to attain that this right is progressively realized. Section 28 of the Constitution centres around the rights of children and states in 28 (1c) that: “every child has the right to basic nutrition, shelter, basic health care services and social services.” This was not adhered to, as is the case with the rights in Section 26 (or 27), with the remark that the State must do this within their available resources. The decision of the Court was therefore that, whether or not the State had the capacity, the right to basic shelter for a child (s28) is an unqualified constitutional right and had to be met by the State immediately. They did not however succeed in terms of section 26. Their success was due to the provision of the Constitution that the right was not based on progressive realisation but that the intent was for the immediate provision of such a right in the Constitution. The Court also evaluated the attempt of the State to realise the right to adequate housing and found that there was a reasonable attempt with a structured plan within the scarce resources and great need for housing in South Africa. In both the case of SOOBRAMONEY and that of GROOTBOOM, the Court ruled against them because their rights were limited by resource constraints and the Constitutional provision that the State had a duty to realise these rights progressively. The State however has an obligation to have a reasonable and structured way of trying to meet more people’s needs, not only in terms of the number of people, but also in terms of the spectrum of people in South Africa and by doing so, fulfil the progressive realization of access to health (and other socio-economic rights such as housing).

The State's ability to implement sustainable health care for all:

The current legal framework, from the Constitution to legislation and case law, all provide opportunity for the people of South Africa to have health as the WHO defined it – not just merely the absence of disease– but a state of total well-being. The fact of the matter is that in many cases, this country also serves as an example that legislation alone does not uphold or guarantee the rights of South Africans. Public policy turned into practice is a vital step. The ability of the State to implement what the Constitution provides for is dependant upon resources, skills and other economic and political factors. The role of the South African Human Rights Commission in its Public Enquiry to access to health services was exactly that: to evaluate current implementation and make some recommendations. One can evaluate the State's current provision of access to health care on two levels: The first is equity, which is the availability of the access to health care for all in equitable fashion. The second is based on utility, the current functionality of the health care services in South Africa.

The SAHRC in its executive summary[44] recommended that a new White Paper had to be drawn up, or the current one adjusted to aid in the proposed National Health Insurance. Recommendations were made to extend the private-public partnerships. This may include, for example. opening more

[44] Van der Heer, A. SAHRC Public Inquiry into Access to Healthcare Service Available from: www.sahrc.org.za/sahrc_cms/downloads/Dept%20of%20Health.ppt Cited 20 June 2009. 6-9

private wards in public hospitals. The SAHRC also said the idea of a single National Health Insurance should be pursued continually.

Evaluation of the current infrastructure revealed problems of equitable access due to a lack of facilities, unclean buildings, and too many patients per service provided and dated technology. The primary health care services, which are suppose to function as the entry point for the person wanting to utilize health services, were found to be dysfunctional on management and implementation level. The shortage of medically trained staff is another identified problem in health care delivery. The findings were that of an understaffed delivery system, especially for the people living in rural areas. Vulnerable groups, such as children and refugees, were found to be exploited by the system rather than protected. Specific recommendations were also made regarding the integration of HIV/AIDS and TB programmes. The Department of Health (DOH) responded to the report of the SAHRC[11] by questioning the methods used to measure a system with a "general impression of an under-funded system struggling to cope with the demands made upon it" stating that this was just an impression of those interviewed and could not be seen as scientifically based data. The comment on heavy workloads by medical personnel as well as staff shortages was also questioned because of the "method" of determining this. The DOH addressed the shortage of infrastructure by referring back to the Hospital Revitalisation audit of 1996. The Department also mentioned that attempts to provide better infrastructure in terms of buildings were done by having completed seven

new hospitals and also having 46 other medical projects under construction as well as the conceptual approval of another 26 hospitals. Funds are however a problem. The SAHRC documented problems experienced concerning management on provincial and district levels. The DOH assured that this would be addressed, but also acknowledged difficulties in standardizing management. The Department is confident that their newly developed primary health care plan as well as the promise to increase staff members will resolve the issue.

The public inquiry has been successful in many ways: The country had its first independent audit of the services provided in health care. This opens the table for discussion. We have already had a response from the Department of Health showing structured thinking and addressing every problem area (at least in writing). The next step is however of vital importance: The implementation of the recommendations and the overseeing that it is done in an excellent manner that is sustainable.

Recommendation:

I would like to suggest that the current structures be kept as it is for now: this would include the task force appointed for the NHI recommendations as well as other stakeholders (including the DOH and NGO and private consultants) but that government and the task force apply an ethical framework. This could unify the above groups and private and public health irrespectively in purpose and by applying ethico-legal principles, to come up with a sustainable answer for achieving the goal of establishing a national health system. This would include filling the vacant posts in the public health service first, addressing issues such as what core minimum benefits consist off and addressing all other issues with open interactive discussions between relevant parties as well as public involvement to come to sustainable solutions that will ensure greater access to health care for all.

The Hastings Center[45] has set out a guide of core ethical values that they deem a 'must' to help guide health reform in the states. They give four practical principles that they believe if applied to a health system, could aid in creating better access to health care. These are derived from the - ethical values discussed:

Principle 1: The state should offer each citizen core health care benefits that address his/her basic medical needs. This is known as primary health

[45] Levine, M.A., Wynia, M. K., Schyve M., et al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. *Hastings Center Report*. Sept-Oct: 14-19

care/medical benefits (PMB's). In private medical care, a medical aid is forced under legislation to provide this. The department of health has however not defined PMB's for all areas: "primary health care" for women and children is free, but still it is not stated what primary health care entails. The findings of the South African Human Rights Commission on the services provided in primary health care were also not of acceptable standard. The interpretation of Rawls' justice theory by Green (1976:111-124)[46] emphasizes that distributive justice provides that *every* citizen should have his basic medical needs met.

Principle 2: The process of defining primary health care benefits should be ethical. This also includes the responsibility of assuring that the means of limiting the benefits should be based on an ethical framework to ensure that the decisions on coverage are based on fair principles after careful reflection on the issues of quality, cost and access.

Principle 3: The system must be sustainable. This is of great importance, especially in the resource restrained setting that South Africa is facing. Thus, it does not help to offer the best care or having too broad a scope of primary benefits offered to all and then finding it impossible to sustain later on. The State should also give attention to the development of other social contributors such as education, housing and sanitation.

[46] Green, R. 1976. Health care and justice in contract theory perspective. *Ethics and Health Policy*: 111-124

The Hastings Center made the following recommendations concerning sustainability (I adapted it to the South African context):

a) The strategy developed should extrapolate the goals set in terms of the total costs of health and should focus on what should go to health care as a means of preventative health care and the calculated benefit of this in return if the societal burden of illness is alleviated in a way. An example of this in the current setting would be to ensure that anti-retroviral therapy is available to all who meet the criteria set for initiating treatment. This would not only ensure that the person involved is healthy for longer and able to work and contribute to his own care and be an active member of society, but also alleviate the burden on the medical system of seeking health care for all the secondary complications and diseases associated with HIV, such as TB, meningitis and Kaposi's sarcoma.

b) The available resources should be defined in order that the core benefit package is determined in an accurate manner. In the case of GROOTBOOM[47] the findings of the Constitutional Court were that this was a political matter to be determined by the State. The evaluation of resources would include looking at availability of nurses and doctors, buildings and health care delivery points as well as medicine, management skills, finances and all other contributors.

[47] SOOBRAMONEY v MINISTER OF HEALTH, KWAZULU-NATAL 1998 (1) SA 430 (D)

c) The health care system should not become static, but should be able to adjust to circumstances. Mari Hudson in her editor's letter in 'What's new Doc' says 2009 will be known as the watershed year for health in the country:[48] "Years from now 2009 will be viewed as the period between the health system that was and a completely new system. This year is marked with 'firsts' for the health care sector: The minister of health, Dr Aaron Motsoaledi admitted that the public health sector is in such a state due to years of underfunding of the health sector. Doctors went on strike for the first time to make their voices heard for better working conditions and remuneration. The National Health Insurance plans are on the way and it is expected that a new White Paper on Health will be released under the direction of Dr Olive Shisana, former Director General of Health. Dr Motsoaledi also confirmed more than once that the NHI would only follow after the public health sector had been upgraded".

d) The core health care benefits should be available to *all* and government should not exclude any group to save costs. Currently in South Africa, although children are provided to receive free primary health care benefits, this is only the case up to the age of fifteen. This distinction marginalizes an already vulnerable group.

[48] Hudson, M. 2009. Editor's letter: Watershed Year. In: *What's new Doc?* July, (5): 6

Principle 4: The health care system must assign responsibility with great clarity to each participant within the system and then hold them accountable. Five recommendations can be made regarding the practical implementation of this:

a) The responsibility of health should not become the sole task of the formal structure of the Department of Health or provincial government. It is their primary responsibility, but also the task of other organizations. In the past, non-governmental organizations such as the Treatment Action Campaign made great progress concerning access to health care for all in the country. The provision of access to health care is also of societal concern. Individual communities should take on the responsibility to address their specific health care needs wherever possible.

b) Strategies need to be developed to encourage health carers from students in training to, to nurses and doctors and then the greater establishments to use the resources made available to them to the best possible level of efficiency. This is of special importance in the case of health care in the public sector.

   The figure for expenditure per capita per year in the public sector on first glance is quoted to be R644. The amount spent per capita in the private sector is sixteen times more than that of public health adding up to an amount of R10 500. This is what has lead to many

demanding better access to health care for *all*.[49] A report compiled by the Hospital Task Group in 2008, titled *Examination of Factors Impacting on Private Hospitals* state that these figures are not accurate if the full picture is taken into consideration. The intention of this report was also to aid in the achievement of greater access to health care by reducing the cost and making it more affordable. The total cost of expenditure such as VAT, the cost of renting of buildings and other infrastructure, the acquisition of pharmaceuticals at a higher price than the public sector and so forth add up to narrow the gap per capita expenditure in the private versus the public sector. Another factor that is in favour of the State is the 'cheap labour' they obtain in getting students in training to deliver service for free, and then when initially qualified to work at a much lower rate than what the public sector can procure for. This led the Hospital Task Group to come to a figure of R6000 per capita per year in private versus R2000 per capita per year in public sectors. The argument here is not for the private sector per se, but rather that the public sector needs to be held more accountable for the money spent, as a better service with the same budget is most likely possible.

[49] Hudson, M. 2008. How high are private hospital costs really? In: *What's new Doc.* Dec, (1): 3

c) Health care development should not only focus on creating greater access to health care, but also on the quality of the care given. Various options should be sought to promote this. One option could be by means of regular evaluation of the different levels of care and then an incentive for good care provided.

d) The medical health system should undergo the necessary development to decrease the chances of misuse, under or overuse and waste of resources as well as fraud. Budget planning and expenditure on provincial level has been problematic. This has been evident from numerous reports, one of them being the shortage of anti-retro viral medicine in the Free State province.

e) Health care users must be educated concerning their responsibilities toward their own health as well as how and where to access the health care system. Your doctor or health care provider should be seen as your partner in health care, providing expert opinions and treatment, but not the primary person responsible for a person's health and well-being. The outcome of many chronic diseases is dependant upon the managing of risk factors by for example life style changes and the daily taking of prescribed treatment.

Conclusion:

South Africa has come a long way in providing greater access to health care. The country has a Constitution[50] that provides for the realization of the right to health care. The evaluation of the South African Human Rights Committee emphasized that legislation alone will not uphold a right. The public health sector is currently failing to provide adequate health care in terms of accessibility and utility to the majority of the country[51]. On the other end of the spectrum, private health care provides excellent care to a majority of the country (thus good utility, but poor accessibility).[52] Justice demands that a sustainable solution for good health care for all be sought. Green's[53] interpretation of Rawls' principles of justice together with the ethical framework from the Hastings Center[54] provide one workable solution to evaluate the process of working towards private-public partnerships, better health care and as a long term goal, a National Health Insurance.

[50] The Constitution of the Republic of South Africa, Act 108 of 1996

[51] Van der Heer, A. SAHRC Public Inquiry into Access to Healthcare Service Available from: www.sahrc.org.za/sahrc_cms/downloads/Dept%20of%20Health.ppt Cited 20 June 2009. 6-9

[52] Van Zyl, J. 2009. National Health Insurance. In: *What's new Doc*? (4):1-4

[53] Green, R. 1976. Health care and justice in contract theory perspective. *Ethics and Health Policy*: 111-124.

[54] Levine, M.A., Wynia, M. K., Schyve M., et al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. *Hastings Center Report*. Sept-Oct: 14-19

References:

1. Rawls, J. 1999. *A Theory of Justice.* Revised edition. Cambridge, Mass.: Harvard University Press., 1971. Oxford: Clarendon Press, 1972.

2. Farmer, P. and Campos N.G. 2004. Rethinking Medical Ethics: A view from below. In*: Developing World Bioethics*, 4 (1), 17-41

3. The Constitution of the Republic of South Africa, Act 108 of 1996

4. Ngwena, C. 2001/2. The Recognition of access to Healthcare as a Human Right in South Africa: Is it enough? *Health and Human Rights* 5 (1):26-44

5. See: www.doh.gov.za. Cited 22 June 2009. This website is run by the Department of Health and gives access to the public on the focus of the department to current medical issues.

6. Van der Merwe, I. 2008. Hogan: Expect Change –and soon. In*: What's New Doc* (1):1-3

7. Van Zyl, J. 2009. National Health Insurance. In*: What's new Doc?* (4):1-4

8. Van Zyl, J. 2009. National Health Insurance. In*: What's new Doc?* (4):1-4 Professor McIntyre is also part of the task team assigned by the State to assist in the strategy for a National Health Insurance.

9. (Indirect). The findings by Atagaba and McIntyre. 2009. (Cited in Van Zyl, J. 2009. National Health Insurance. In: *What's new Doc?* (4):1-4

10. (Indirect). Discovery Health. 2009. (Cited in Van Zyl, J. 2009. National Health Insurance. In: *What's new Doc?* (4):1-4

11. Thom, A. 2009. Hovering at death's door. *The Star.* 11 Feb. (page uncertain)

12. South Africa: Public healthcare "is lamentable". 20 April 2009. IRIN NEWS, (online) Available from:http://www.IRINnews.org Cited 22 June 2009.

13. Van der Heer, A. SAHRC Public Inquiry into Access to Healthcare Service Available from: www.sahrc.org.za/sahrc_cms/downloads/Dept%20of%20Health.ppt Cited 20 June 2009. 6-9

14. Gruskin, S. and Daniels, N. 2008. Justice and Human Rights: Priority setting and fair deliberative process. *American Journal of Public Health*. Washington: 98 (9), 1573-1582

15. Levine, M.A., Wynia, M.K., Schywe, M.J., et. al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. Hastings Center Report. Sept-Oct: 14-19

16. Levine, M.A., Wynia, M.K., Schywe, M.J., et. al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. Hastings Center Report. Sept-Oct: 14-19

17. Van Bogaert, D.K. 2007. *Principlism. Introduction to Bioethics: A reader. Course* Code FAMH 7015: 90-93

18. Soman, E. Moral Obligation for society to provide healthcare. Accessed June 20, 2009. Available at: http://www.socyberty.com/Issues/Moral-obligation-for-Society-to-Provide-Health-Care.121350/4.

19. Van Bogaert, D.K. 2007. *General approach to Deontology. Introduction to Bioethics: A reader.* Course Code FAMH 7015: 51-60

20. Van Bogaert, D.K. 2007. *Principlism. Introduction to Bioethics: A reader. Course* Code FAMH 7015: 90-93
Kant's Categorical Imperative lead to the Declaration of the Rights of Man during the French Revolution in 1789, the Nuremburg Code in 1947 as well as the Universal Declaration of Human Rights in 1948.

21. Rawls, J. 1999. *A Theory of Justice.* Revised edition. Cambridge, Mass.: Harvard University Press., 1971. Oxford: Clarendon Press, 1972.
John Rawls lived 1921-2002. The original book was published in 1971, with various revisions following, including 1993 and 1999. His overriding aim was to "provide the most appropriate moral basis for a democratic society"

22. Grendler, P. 2007.Stanford Dictionary. Second edition. Definition of distributive justice (online) Available from: http://plato.stanford.edu/entries/justice-distributive/ [cited 20 Aug 2009]

23. Freeman, S. (1998, 2002). Rawls, John. In E. Craig (Ed.), Routledge *Encyclopedia of Philosophy*. Second edtition..London: Routledge. Retrieved July 23, 2007, Available from: http://0-www.rep.routledge.com.innopac.wits.ac.za:80/aritcle/S091SECT1

24. Dworkin, R. 1981. What is Equality? Part 1: *Equality of Resources. Philosophy and Public Affairs*. (10): 185-246

25. Nielsen, K. 1979*. Radical Egalitarian Justice: Justice as Equality.*

Social Theory and Practice. (5):209-226

26. Freeman, S. (1998, 2002). Rawls, John. In E. Craig (Ed.), Routledge *Encyclopedia of Philosophy*. Second edtition..London: Routledge. Retrieved July 23, 2007, Available from: http://0-www.rep.routledge.com.innopac.wits.ac.za:80/aritcle/S091SECT1

27. Rawls, J. 1999. *A Theory of Justice.* Revised edition. Cambridge, Mass.: Harvard University Press., 1971. Oxford: Clarendon Press, 1972.

28. Shelton, R. L. 1978. Human rights and distributive justice in health care delivery. *Journal of medical ethics*. (4): 165-171

29. Green, R. 1976. *Health care and justice in contract theory perspective. Ethics and Health policy*. 111-124

30. Levine, M.A., Wynia, M.K., Schywe, M.J., et. al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. Hastings Center Report. Sept-Oct: 14-19

31. The Constitution of the Republic of South Africa, Act 108 of 1996. See also Ngwena, C. 2001/2. The recognition of Access to Healthcare in South Africa: is it enough? *Health and Human rights.* 5 (1): 26-44

32. South African Human Rights Commission Act, 54 of 1994, Section 9.

33. See General Comment No. 3. The nature of States parties' obligations (Fifth session, 1990) U.N. Doc. E/1991/23, annex 111 at 86 (1990), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/I/Rev.6 at 14 (2003) ("General Comment No.3 of the CESCR")

34. National Health Act No.61, 2003

35. (Indirect) Hassim, Heywood, Berger. 2008. Health and Democracy – A Guide to human rights, health law and policy in post apartheid South Africa: The private health care sector. Introduction to Health Law. 285.

36. Medical Schemes Act (MSA) of 1998

37. MINISTER OF HEALTH AND ANOTHER NO v NEW CLICKS SOUTH AFRICA (PTY) AND ANOTERS (TREATMENT ACTION CAMPAIGN AND ANOTHER AS AMICI CURIAE) 2006 (2) SA 311 (CC)

38. Available at the official website of the Department of Health: http://www.doh.gov.za/docs/legislation/patiensright/chartere.html [Accessed July 20, 2009]

39. SOOBRAMONEY v MINISTER OF HEALTH, KWAZULU-NATAL 1998 (1) SA 430 (D)

40. SOOBRAMONEY v MINISTER OF HEALTH, KWAZULU-NATAL 1998 (1) SA 430 (D)

41. The Constitution of the Republic of South Africa, Act 108 of 1996. See also Ngwena, C. 2001/2. The recognition of Access to Healthcare in South Africa: is it enough? *Health and Human rights.* 5 (1): 32-33

42. Bilchitz, D. 2008. Health. In *Introduction to Health Law*: 72

43. GROOTBOOM AND OTHERS v OOSTENBURG MUNCIPALITY AND OTHERS, 2000 (3) BCLR 277 (C)

44. Van der Heer, A. SAHRC Public Inquiry into Access to Healthcare Service Available from: www.sahrc.org.za/sahrc_cms/downloads/Dept%20of%20Health.ppt Cited 20 June 2009. 6-9

45. Levine, M.A., Wynia, M.K., Schywe, M.J., et. al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. Hastings Center Report. Sept-Oct: 14-19

46. Green, R. 1976. *Health care and justice in contract theory perspective. Ethics and Health policy*. 111-124

47. SOOBRAMONEY v MINISTER OF HEALTH, KWAZULU-NATAL 1998 (1) SA 430 (D)

48. Hudson, M. 2009. Editor's letter: Watershed Year. In: *What's new Doc?* July, (5):6

49. Hudson, M. 2008. How high are private hospital costs really? In: *What's new Doc.* Dec, (1): 3

50. The Constitution of the Republic of South Africa, Act 108 of 1996

51. Van der Heer, A. SAHRC Public Inquiry into Access to Healthcare Service Available from: www.sahrc.org.za/sahrc_cms/downloads/Dept%20of%20Health.ppt Cited 20 June 2009. 6-9

52. Van Zyl, J. 2009. National Health Insurance. In*: What's new Doc?* (4):1-4

53. Green, R. 1976. *Health care and justice in contract theory perspective. Ethics and Health policy*. 111-124

54. Levine, M.A., Wynia, M.K., Schywe, M.J., et. al. 2007. Improving Access to care: A Consensus Ethical framework to guide proposals for reform. Hastings Center Report. Sept-Oct: 14-19