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The ethico-legal position of state-funded healthcare for foreign nationals in South Africa

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Submitted to the Faculty of Health Sciences, University of Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree Masters of Science in Medicine in Bioethics and Health Law (by research).

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Qualifications: PhD

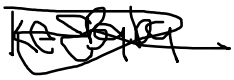
Submitted:14 June 2023

DECLARATION

I, Babalwa Zintle Bekebu (student number:1044202), am a student registered for MSc (Med) Bioethics and Health Law in the year 2023.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
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- I have followed the required conventions in referencing the thoughts and ideas of others.
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Signature: 

Babalwa Zintle Bekebu

Date: 14 June 2023

DEDICATION

In my culture, giving thanks is a symbol of respect and unity. Giving recognition to those who have paved the path for us is not only important for the provision of abundant blessings, but also for one's progression in life and the livelihood of the next generations to come. I feel a deep sense of belonging when I think of my ancestors and my supportive parents who birthed me. I had no idea I would achieve such a milestone in life, but God made it possible. Therefore, I am forever grateful to Him.

To my wonderful mother, Nomazulu Kulu, and my grandmother, Nontobeko Nozewu (fondly known to my brother and me as Yakhulu), thank you for standing by me throughout my studies. Thank you, Dlangamandla and Qwathikazi. You have been an anchor and a pillar of strength to me. I am glad I saw this through with the help of your prayers.

My father, Kostile Bekebu, was patient and supportive: I am grateful for you, Mqadi. Your support held me up throughout my Master's pursuit. My brother, Babalo Bekebu, thank you Mqadi. Your warm words of comfort helped me get to the finish line. And to my supportive friends, thank you for the pep talks whenever I felt like giving up.

I am proud of myself. Many have spoken about how incredibly challenging it is to write a dissertation to completion while juggling real life and work. Nothing could have prepared me for the tribulations I experienced throughout my pursuit of this degree. I am proud that I stayed the course. To more!

ACKNOWLEDGEMENTS

I would like to express my gratitude towards my supervisor, Dr Ewuoso, who dedicated long hours to guiding my research project. Thank you for providing your intellectual support.

I would also like to thank the following Departments for their support during my studies:

- The Steve Biko Centre for Bioethics
- The Wits Research Office
- National Research Foundation (NRF)
- The Postgraduate Merit Award (PMA) from The Postgraduate Office
- HWSETA

ABSTRACT

As South Africa ages into its democracy, the exclusion of foreign nationals (particularly those from other African countries) from state-funded services, such as healthcare, has become a key concern. Foreign nationals face significant barriers to state-funded or public healthcare access, including xenophobic behaviours and treatment from healthcare providers and provincial directives recommending up-front payment in contradiction to National Department of Health directives. Thus, limiting their access to public healthcare as most are charged exorbitant fees, mistreated, and fear deportation.

Above all, the public healthcare crisis in the country remains a key reason for the exclusion of foreigners from accessing state-funded healthcare. Policies and legislature regarding foreign nationals' access to state-funded healthcare exist, but there is a lack of implementation at the ground level. Furthermore, existing accounts in literature fail to account for the ethical need and obligation that the State has in providing state-funded healthcare to foreign nationals.

In this dissertation, I argue that the State has an ethical and legal obligation to provide state-funded healthcare to foreign nationals despite the South African public healthcare crisis. The objectives are to defend the claim that the exclusion of foreign nationals from state-funded healthcare would be in contradiction of the African Communitarian ethic of *Ubuntu*; it would be unlawful and unjust. I also support their entitlement to socio-economic rights, particularly the right to access state-funded healthcare, on the basis that foreign nationals make valuable socio-economic contributions to the country, therefore, should not be excluded from state-funded healthcare services.

This study is mostly analytically normative, involving a review of existing literature, drawing on ethical principles and the legislature to defend a thesis regarding why the State has an ethico-legal obligation to provide state-funded healthcare to foreign nationals. The analytical review showed that healthcare is not only a political or economic issue but a medical ethics issue. Consideration of ethical theories such as Utilitarianism, Kantian Ethics, African Communitarian ethic of *Ubuntu,* and Principlism show that even in a public healthcare crisis in South Africa, the exclusion of foreign nationals is not ethically justified. It is not in the interest of the common good and undermines human rights. According to the Constitution and existing South African legislature, it is also unlawful and unjust.

Thus, even in the most extreme state of the public healthcare system, the State still has an ethical and legal obligation to fulfil to all people in the land as per the South African Constitution of 1996. One life's value compared to another remains equal, and citizenship ought not to be a discriminating factor.

Word Count: 424

Keywords:

Right to Health, Foreign Nationals' Healthcare, *Ubuntu*, South African Public Healthcare Crisis, Rationing in Healthcare, Distributive Justice.

ACRONYMS

ACHPR	African Charter on Human and Peoples' Rights
ACMS	African Centre for Migration & Society
ADR	Age Dependency Ratio
ART	Antiretroviral Therapy
BOR	Bill of Rights
CCMT	Comprehensive HIV /AIDS Care, Management, and Treatment
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSOs	Civil Society Organizations
COVID-19	Coronavirus Disease Of 2019
DOH	Department of Health
DRC	Democratic Republic of Congo
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICCPR	International Covenant on Civil & Political Rights
ICEAFRD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic Social & Cultural Rights
ICERD	International Convention on the Elimination of All forms of Racial Discrimination
MDR-TB	Multi Drug-Resistant TB
MEC	Member of the Executive Council
NDOH	National Department of Health
NDP	National Development Program
NGO	Non-Governmental Organisation

NHA	National Health Act, 2003 (Act No. 61 of 2003)
NHI	National Health Insurance (Bill)
OAU	Organization of African Unity
SA	South Africa
SADC	Southern African Development Community
SAHRC	South African Human Rights Commission
SANAC	South African National AIDS Council
TAC	Treatment Action Campaign
UDHR	Universal Declaration of Human Rights of 1948
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
VAT	Value-Added Tax
XDR-TB	Extensively Drug-Resistant TB
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

1.1 Background

The healthcare system in South Africa (SA) comprises of two sectors: the private and the public sector. About 20% of the approximated 60 million population has access to world-class care offered in the private sector through medical aid schemes, while 80% depends on the public sector (World Health Organisation, 2010; Statistics South Africa, 2022). The government allocated R205.4 billion to the health sector for the 2018/19 budget expenditure, which was expected to increase by 7.8% per annum (Department of National Treasury, 2018). In the 2020/21 fiscal year budget, the healthcare budget increased to R248.8 billion; in the 2022/23 fiscal year budget, it has been increased to R259 billion (Department of National Treasury, 2021, 2022).

This makes the health sector budget allocation the third most significant State expenditure (after education and social development). It can be estimated that the total expenditure allocated to the health sector is around 20.3 % of the allocated R1.01 trillion 2018/19 social services pocket, 20.6 % of R1.21 trillion of the 2020/21 social services pocket and 20% of R1.3 trillion 2022/23 social services pocket (Department of National Treasury, 2018, 2021, 2022).

Despite the South African government's financial investment efforts, critics and analysts nationally and globally have described the South African healthcare system as facing a crisis as it fails to meet its delivery goals (Brits, 2016). The Ranking of the World's Health Systems, done by the World Health Organisation (WHO), ranked SA at 175th out of 191

countries on the list with an estimation of 0.86 doctors per 1000 people (WHO, 2000)[1]. This means that the public has drastically limited access to doctors per clinic visit or when hospitalised[2]. The public healthcare system is undoubtedly overburdened and in disrepair in many parts of the country. This is primarily due to poor management by the Department of Health (DOH), which has resulted in the gross shortage of essential medical equipment, healthcare professionals, supply of medicines, etc., in most public healthcare facilities such as clinics and hospitals (Brits, 2016).

Some have used the poor state of the healthcare system to justify the exclusion of foreigners from state-funded healthcare access. We can track back the most recent sentiments of the exclusion of foreign nationals from accessing public healthcare to the former Minister of Health, Dr Aaron Motsoaledi. In previous press conferences, the former Minister made unfounded claims that attributed the poor state of the public healthcare system to it catering to foreign nationals (mainly directed to those from other African countries) (van Dyk, 2018). He essentially said that the accommodation of foreign nationals compromised the public healthcare system's efficiency and posed a health risk to South African citizens (van Dyk, 2018).

Similarly, in a more recent occurrence in August 2022, a video of the MEC of Health in Limpopo, Dr Phophi Ramathuba, went viral. In the viral video, the MEC addressed a sickly

[1] The WHO published its first-ever analysis of world health systems wherein 191of its member states' (of which SA is part of) health systems were compared using five performance measures. The results were published on 21 June 2000 in *The World Health Report 2000 – Health systems: Improving performance**. Even though WHO releases reports yearly, these tend to focus on health trends and stats of that year. This report is of significance relevance as it has provided NGO's, international organizations, global policymakers and others with data and guidance to establish appropriate health policy and funding decisions.

[2] More recently, Dr. Joe Phaahla, the country's Minister of Health, revealed the 2022 doctor-to-patient ratio is 1:3 198 - 0.31 doctors per 1 000 patients - at a recent parliamentary Q&A session. 2019 saw a doctor to patient ratio of 0.79, this shows that the number of doctors per 1000 patients is on a decrease (BusinessTech, 2022).

Zimbabwean-origin patient admitted to a public hospital in Limpopo. The patient in question had allegedly crossed the border into Limpopo seeking healthcare treatment (van den Heever, 2022). In interviews post the incident, she attributed the public healthcare crisis to the South African porous borders that grant people from neighbouring countries undue access to the country. These public claims by State officials and politicians (often published or said to win over voters and public favour) contribute to the struggle and discrimination foreign nationals face in accessing public services such as healthcare.

Expectedly, the perpetuation of such misleading claims from public leaders exacerbates foreign nationals' plight in achieving a standard quality of life through accessing socio-economic rights. Not only does it contribute to dangerous stereotypes, but it also facilitates a space for discrimination within our communities and public healthcare facilities. Henceforth, we see that the promotion and protection of foreign nationals' socio-economic rights have been overlooked in post-apartheid SA. Considering that there are only approximately 2.8 million foreign nationals in SA, according to a report commissioned by Statistics SA in the Census in 2011, the claims that they are responsible for the poor state of the South African public healthcare system are untrue (StatsSA, 2011). This estimation includes documented and undocumented foreign nationals. This amount constitutes 5% of the South African population of 60 million people.

Additionally, it was estimated that in 2017, the Gauteng DOH only spent approximately R160 million on providing state-funded healthcare to foreign nationals (from countries like Zimbabwe, Nigeria, Malawi, etc.) out of the R40.2 billion budget allocation it had received for the year (Mahlangu, 2017). This means that it had only spent approximately 0.4% on

foreign nationals. Although it is money not spent on SA citizens, it hardly constitutes an overburdening of SA's public healthcare system.

To further fuel the hostility foreign nationals face in accessing healthcare services, in August 2018, the Gauteng Provincial Department of Health issued a drafted set of guidelines for the administration of non-South African patients that appears to have instilled confusion among healthcare professionals (Khan, 2019). It advised that all foreign nationals would have to pay the total amount of medical fees at public healthcare facilities before receiving any medical treatment and, in that way, disregarding the National Health Department of Health Patient Classification Manual (which uses a Means-test to ascertain affordability for healthcare services for all patients paying out-of-pocket) (Khan, 2019). This circular was soon retracted, but it had already caused confusion in the public hospitals where the document had been sent (Khan, 2019).

One can even surmise that it added to the medical xenophobia rumoured within the South African public healthcare system and perpetuated Afrophobia (the discrimination of people based on their African origin and culture (RED Network, 2021)).

South African societies have a long history of discrimination and exclusionary practices characterised by xenophobic tendencies towards foreign nationals, hence such treatment is institutionalised even at our State facilities. Healthcare professionals are already said to be discriminative against foreign nationals and ill-treat them at public healthcare facilities simply because they are non-South African patients (Daily Maverick (Spotlight), 2021). A visible example is how Dr Ramathuba treated that foreign patient mentioned before. She undermined many of her ethical oaths and boundaries as a healthcare professional. As a high-ranking public official in a position of power and influence, her actions may have harmed this

patient, and many other patients admitted into public healthcare facilities across the country by affecting their mental state while they are in a state of vulnerability (sick) and by justifying discriminatory behaviour by healthcare staff.

Furthermore, because SA, since 1994, has been reported to have rampant attacks against foreign nationals in communities in Gauteng, Free State, Kwa-Zulu Natal, Western Cape, and Limpopo, these claims made by public leaders are harmful. These are dangerous political views as they incite violence and disturbance in communities between those who consider themselves SA citizens and foreign nationals (South African History Online, 2015). From these attacks, we can easily see the influence that political figures have on what citizens believe and the impacts of spreading misinformation which always threatens the safety of foreign nationals. The issue of migration between African countries has been politically contentious for many years in most developing and undeveloped countries. This is mainly because countries have had to deal with the dramatic wealth inequalities that exist and persist within and amongst African countries (Alfaro-Velcamp, 2017).

As a result of these dramatic wealth inequalities in the SADC region countries, also known as the Southern African Development Community, SA finds itself a host country to foreign nationals as they seek to improve their opportunities to live a better quality of life. The reasons foreign nationals migrate to SA mainly range from socio-economic to political (StatsSA, 2011). For example, economic migrants move to other countries to better their economic standard of living and that of their families (StatsSA, 2011). Some foreign nationals come as migrants who move to another country of residence irrespective of their reason for legal status or migration. Others are refugees who are vulnerable and have to flee

war or persecution to save their lives or preserve their freedom (StatsSA, 2011). They tend to have no protection from their countries (StatsSA, 2011).

Refugees are also known as asylum seekers. These are displaced persons from their country of decent and have applied to be refugees within the host country and await whether their stay will be granted or rejected by the host country. While others enter the country as illegal migrants, also known as undocumented migrants, meaning that they have relocated to that country illegally or stayed for prolonged periods without a permit from the Department of Home Affairs (StatsSA, 2011). Depending on one's status from the above-mentioned classifications, SA laws and the kind of socio-economic rights one is entitled to are applied differently.

Post-apartheid, the South African government has prioritised rehabilitating our impoverished communities through prioritising various service delivery programmes. The goal has been to uplift the 'previously' disadvantaged parts of our society and focus on the promotion of national interest. Although it is important for the government to have such priorities, but it has undeniably blurred the legal differentiations of the categorises of foreign nationals in the country to citizens. Thus, all foreign nationals are grouped as economic migrants who are here to sponge off State resources. The reader will note that the South African immigration laws differentiate between foreign nationals with temporary and permanent resident status. There is also a distinction in South African refugee law between foreign nationals with asylum-seeker status and those with refugee status. Although my argument will require different justifications for refugees, legal migrants, and illegal migrants, I use the term foreign nationals in this project to encompass all. I indicate how my justification will apply to each group in the body.

Many who immigrate to SA view it as a country with better access to healthcare services. Many countries in the African continent struggle to provide basic primary healthcare to their people as most are impoverished. For example, one country in the SADC region is Zimbabwe which ranks 155th out of 191 countries on the WHO health systems list and is estimated to have one doctor per 10 000 people (WHO, 2000). Similarly, other African countries, such as Nigeria, are ranked low at 187 out of 191 countries. They have a low ratio of 1 doctor per 2000 people and an infrastructure struggling to cope (WHO, 2000). Another example is Zambia, ranked out of 191 countries on the WHO Health Systems list, with a ratio of 1 doctor per 6000 patients (WHO, 2000).

Principally, there are other reasons why South Africans ought not to be unfriendly to foreign nationals. One includes a period in the South African apartheid past when many of her political leaders escaped to neighbouring countries, where they were welcomed. It is, therefore, shameful that a country that has received help from others can mistreat the same persons in this way. Equally worrying is that political leaders tend to use foreign nationals as scapegoats for their incompetence in service delivery to appeal for public favour or votes from the public. The South African government has failed in two ways. One has been ensuring that corruption does not go unpunished by successfully railing it so that service delivery is effective and efficient. Two, it has failed to provide a framework to regulate cross-border flows and deal with the compensation of funds spent on foreign nationals by billing their countries of origin.

However, the issue with billing these other countries comes back to the South African public sector's disappointing lack of policy documents and coherent data to scale the extent of this

problem in contrast to the noise made about foreign nationals over-exhausting our public healthcare facilities and resources. The effects of using foreign nationals as scapegoats go beyond social discrimination. However, they extend to threatening the universal right to health (in literature and law) and access to healthcare services of foreign nationals in SA. For this reason, the social discrimination of foreign nationals in SA is a medical ethics issue. This dissertation aims to ethically argue that it is morally unjustifiable for the South African government to deny foreign nationals from accessing state-funded healthcare services. To argue this, I will consider the disjuncture in law, specifically of Section 27(1) of the 1996 Constitution of the Republic of South Africa; Section 27(g) of the Refugees Act 130 of 1998; Section 4(3) of the National Health Act 61 of 2003 together with other statutes of the country, policies, and regulations regarding foreign nationals' access to state-funded healthcare. I will also use African ethical considerations that describe what community means to Africans and why we ought to showcase *Ubuntu* to foreign nationals as means of solidarity and harmonious living.

Furthermore, this research paper will describe the discrimination and stigmatisation of foreign nationals as social and ethical issues that must be addressed. These social and ethical issues mirror the general problems about the comprehensive provision of healthcare and economic and social healthcare rights. As mentioned before, foreign nationals have faced significant barriers to healthcare access, including xenophobic behaviours and treatments of healthcare providers, provincial directives recommending up-front payment in contradiction to NDOH directives, thus, limiting their access to public healthcare as most are charged exorbitant fees, mistreated, and fear deportation at the public healthcare facilities.

Additionally, I discuss the importance of the stakeholders' (in the case of healthcare access: all citizens and foreign nationals) solicited input and education in the fair distribution of state-funded healthcare resources. To do this, I will mostly combine Afro-communitarian considerations with critical theories like Utilitarianism and Kantian ethics of deontology to demonstrate how the State has an obligation to provide state-funded healthcare to foreign nationals despite the public healthcare crisis in SA.

This paper will also recommend the need for clear guidelines that can influence policy to prioritise the rationing of State medical resources. In the case of the commonly existing instance in the SA public healthcare system where there is limited availability of medical resources, a regulatory framework stipulating resource distribution based on rational, ethical, democratic, and legitimate priority guidelines is essential.

1.2 Literature Review

In this literature review, I analyse literature about the historical establishment of the healthcare right and when it was recognised as a right in itself, where it is enshrined, and how it is depicted in the legislature, both nationally and internationally. I then reflect on foreign nationals' rights to access South African public healthcare. I also briefly consider healthcare as a socio-economic right and look at literature about the moral perspective of the right being inclusive of foreign nationals using Afro-communitarianism ethical considerations. Including the moral perspective plays a crucial role in morally understanding this right and its importance as a socio-economic right for foreign nationals who migrate across borders in the African continent. Thus, I also elaborate on how it has been influenced by international standards of law instruments or policy that SA is signatory.

In a submitted dissertation by Catherine Githaiga which explores the historical declarations of the right to healthcare for refugees in SA titled *Keeping the Flame of Hope Alight: Refugees And Right To Access To Healthcare Services In South Africa*, she refers to an observation made by Bilchitz (2003) on the phrase 'right to health' (Githaiga, 2010). Bilchitz refers to it as a shallow phrase that could refer to two related but different basic rights: the basic healthcare right and the healthy environment right (Bilchitz, 2003). For something to be considered a right, it must be significant in society's progression toward some of the social or public goals it would like to achieve. However, the use of language or phrases about rights and legislature, such as that of the 'right to health', are not used often in the medical field, and the meaning is not fully grasped as it would be in the legal field.

This is despite various internationally recognised human rights agreements, including the WHO Constitution, acknowledging this right as the utmost obtainable health standard (Leary, 1994). This lack of familiarity with this phrase and the inability to interpret the 'right to health' term opens a gap for us in the medical law research field to shine a light on the weight of this right in formulating public healthcare policy. This dissertation, therefore, considers the 'right to health' from the contextual view of foreign nationals, African ethics/philosophy, and the international and national laws that pertain to it.

The right to health has only been significantly considered in the twentieth century (Robertson, 1994). This consideration was due to two events of historical significance that affected the conceptualisation of the right to health internationally: the crimes against

humanity of World War II, notably the injustices inflicted upon people of Jewish descent and other vulnerable persons by Nazi Germany. These events significantly contributed to WHO's Constitution of 1946, where the healthcare right was acknowledged. The WHO Constitution (Preamble) affirmed that:

> The enjoyment of the highest attainable health standard is one of every human's fundamental rights without distinction of race, religion, political belief, economic or social condition. (World Health Organization, 1992; Leary, 1994)

This statement succinctly advocates against discriminatory practices when it comes to achieving the highest attainable standard of health, which is very important in recognising the right to health. It caters to all people and foreign nationals in various countries. Now, the highest attainable standard of health can be liable to the resources and healthcare professionals the State has available at a given time. I understand this to consider the need for more resources some States face, primarily in undeveloped and developing countries.

Before 1946, their states recognised people's healthcare rights at the State's discretion (Fluss, 1997; Chapman, 2002). Despite the conceptualisation of State responsibilities towards the health of its people, the acknowledgement and support of these rights to healthcare only occurred in the 1970s (Oliver and Atmore, 1995). The primary reason for the delayed acknowledgement and support of healthcare rights was the recent independence of many African countries from the colonisation. As a result of colonisation, African States inherited weak economies. This meant that they faced many challenges in upholding their State responsibilities, including providing these socio-economic rights mentioned prior, including

the healthcare right and the ability of their people to benefit from basic healthcare (Oliver and Atmore, 1995).

The Butare Colloquium (1978) remains a historical reference for acknowledging the priority of human rights in African countries. The Butare Colloquium (1978) was a colloquium/seminar in Francophone Africa about Human Rights and Development in Butare, Rwanda 1978 (Ouguergouz, 2003). In this colloquium, a conclusion was reached that the scarcity of resources (primarily due to the failing and weak economies inherited by African countries from colonisation) could not be used as an excuse and an explanation for the failure to prioritise and respect human rights (Ouguergouz, 2003). Following the Butare Colloquium, the Dakar Colloquium (1978) was held. It was concluded there that political and civil rights were not to be categorised in the same realm as human rights, particularly the right to health. Thus they could not be reduced to being the same (Ouguergouz, 2003). This is because political and civil rights were a class of rights that spoke more towards one's freedoms and choices of opinion or expression as citizens of that country (that could also be limited or taken away) (Ouguergouz, 2003).

In contrast, human rights were global basic rights that all humans had just because they were human (Law Library Howard University School of Law, 2018). Therefore, it became necessary to respect rights about the socio-economic welfare of people because these rights fundamentally focus on principles of dignity, equality, and indiscrimination, which are basic principles of human rights (Leary, 1994).

Health protection and promotion are closely related to protecting and promoting human rights and human dignity (Mann *et al*., 2017). Human rights, socio-economic rights, and healthcare rights have been widely written about, but I use them as each other's derivatives. I would like the reader to maintain the understanding of human rights as basic rights that we are all entitled to just because we are humans, and socio-economic rights to be human rights that speak towards affording people particular basic needs that are necessary for them, as human beings, to live dignified lives. They include the right to education, healthcare including reproductive healthcare, housing, a living wage, decent working conditions and other social goods (Ahmed and Bulmer, 2020). This, therefore, means that the right to healthcare is a human right guaranteed under Section 27 of the Constitution and categorized as a socio-economic right as it speaks to our ability to live in dignity.

The two colloquia (The Butare and Dakar) were essential in establishing the African Charter on Human and Peoples' Rights (ACHPR), enacted by the Organization of African Unity (OAU) in 1981 and was passed into effect in October 1986 (Rubner, 2008). Again, the need to recognise this healthcare right as part of the rights involved in the promotion of the welfare of people socio-economically was not enacted from an interest of serving the medical field but rather to suffice the political and philosophical perspective as there was a preoccupation with colonialism and apartheid during that period (Rubner, 2008).

During that same period, Ronald Dworkin (1977), a philosopher and a jurist in America, further analysed the importance of socio-economic rights in his paper titled 'Taking rights seriously' (Dworkin, 1977). He found that when something was classified as a right, the right

took precedence over all other claims or commodities (Dworkin, 1977). Special meanings, statuses, and priorities can be deduced by classifying something as a right. Consequently, using the phrase 'right to health' within healthcare research, advocacy, policymaking, or in healthcare practice when researchers and healthcare practitioners face instances of ethical dilemmas signifies the fact that a state of good health or well-being with accessible healthcare is essential in society. The phrase 'right to health' or the classification of healthcare as a right affords it a priority in society. To this end, in SA, healthcare is listed as a basic right in the South African Constitution of 1996 in the Bill of Rights.

Henry Shue (1980), an American philosopher, describes 'basic rights' as fundamental rights deemed necessary to enjoy all the other rights (Shue, 1980). Liebenberg (2006: 5) states that for socio-economic rights to mean more than promises on paper, they are a valuable tool for giving people access to essential resources and social services they need for a decent standard of living (Liebenberg, 2006). Considering the period in which the papers mentioned prior were written, especially in the African context where colonisation had been a substantial part of our history and liberated countries had inherited struggling economies, it is clear that at the time, there was a need to emphasise the need for socio-economic rights which included the right to healthcare, housing, education, etc., in order to rebuild our societies and establish our key values. There was a need, especially, to emphasise the importance of healthcare rights. This need is still apparent in the 21st century as the providence of socio-economic rights is still being used frivolously either as bait to gain public favour in politics or capitalist corporations in many of our African States.

In SA, legislation has enabled people to access basic services consistent with human dignity (Hassim, Heywood and Berger, 2007). The South African Constitution, the highest legislative document in the land, has included both rights (health and human dignity) under the Bill of Rights (BOR) (The Constitution of the Republic of South Africa, 1996). The Constitution, since its inception, has been commonly referred to as the most modernised and inclusive Constitution in modern society. For instance, the fact that the BOR was also included in the 1993 provincial Constitution and the current Constitution (1996) provides an obvious rights-based agenda, as referred to by Hassim et al. in their book on Health and Democracy (Hassim, Heywood and Berger, 2007).

SA has also become a signatory to many international legally binding human rights treaties due to its progressive legislation (such as its Constitution). These include the 1951 Convention and even the 1967 Protocol (Weiss, 1954). Catherine Githaiga refers to a paper by P. Weiss titled *The international protection of Refugees* in her dissertation wherein he highlighted how these instruments mentioned were the two most important instruments that specifically protected refugee rights under international law during that time (Weiss, 1954; Githaiga, 2010). This was very important in cementing the right to health in historical legislation and treaties, especially for refugees, as that facilitated their standard of living in foreign countries. This was also important for foreign nationals who, in future, would seek those same rights in foreign countries.

International provisions regarding the right to health or healthcare have expressed an unbiased approach to distributing health services or healthcare access (Robertson, 1994).

However, historical literature on access to healthcare for foreign nationals indicates that international human rights had limited to no inclusion of refugees' healthcare right for decades. For instance, when the main international law instruments were established to protect foreign nationals, there were long periods or gaps where their socio-economic rights were not considered. I noted this from observing when some laws, acts, and agreements were enacted and when countries became signatories to those laws, acts, and agreements. For instance, SA only became signatory in 1993 to the Convention relating to the Status of Refugees[3] (1951) under the United Nations High Commissioner for Refugees (UNHCR)[4] (Leary, 1994). That was a significant display of the country's respect and prioritisation of refugee human rights (Leary, 1994).

This delay undermined the humanity of refugees and displaced persons. Also, it is important to mention the racial inadequacies in this delay. Most refugees are poor and Black people migrating to countries with better economic stabilities and opportunities than their own African countries, which were ridden with war and colonisation in those times. The fact that people are foreign nationals in a country is not an invitation to strip their humanity away, and their basic human rights. International human rights law instruments have since revised their exclusionary ways of the past. They have since included refugees and foreign nationals in catering basic human rights, which means they are entitled to those rights. So have the South African human rights laws, despite the inconsistencies of the Constitution with certain State acts and policies, which will be discussed in later chapters.

[3] UN General Assembly. (1951). Convention relating to the Status of Refugees. Treaty Series, vol. 189, pp. 137.
[4] The UNHCR is a United Nations global organisation that functions to protect the rights of refugees and displaced persons everywhere in the world (UNHCR, 1950).

Upon a closer look at the WHO Constitution and the kind of written language used, one can appreciate the importance of the shallow phrase 'right to health' referred to in prior paragraphs. It embodies fair treatment of all regardless of the kind of religion one subscribes to, one's racial background, socio-economic status and political beliefs (World Health Organization, 1992). Within healthcare, equality is an essential principle in providing a functional service. The government has prioritised it in SA through the various discrimination agreements to which it is a signatory.

For instance, in 1994, SA became signatory to a wide range of international human rights treaties, such as the International Covenant on Economic Social and Cultural Rights (ICESCR)[5] (1966) which aims to promote and protect the rights of poor people who tend to have no access to basic human rights, the International Covenant on Civil and Political Rights (ICCPR)[6] (1966) which is an international human rights treaty that promotes and protects rights such as freedom from inhumane treatments, and the International Convention on the Elimination of All Forms of Racial Discrimination (ICEAFRD)[7] (1965) which is a convention that works to eliminate all kinds of racial discrimination (Leary, 1994). Most relevant to this research is Article 5(e)(iv) enshrined in the ICEAFRD, which states that:

[5] UN General Assembly. (1966). International Covenant on Economic, Social, and Cultural Rights. Treaty Series, vol 999, pp. 171.

[6]UN General Assembly. (1966). International Covenant on Civil and Political Rights. Treaty Series, 999, pp. 171.

[7] UN General Assembly. (1965). International Convention on the Elimination of All Forms of Racial Discrimination. Treaty Series, vol 660, pp. 195.

> [State] parties undertake to prohibit and eliminate racial discrimination in the enjoyment of the right to public health, medical care, social security, and social services. (International Convention on the Eimination of All Forms of Racial Discrimination, 1965 as qouted by Leary, 1994)

As the United Nations (UN) and the African Union recognise SA as a member, it has committed to upholding the standards outlined in these international human rights instruments by ratifying and being a signatory of numerous UN human rights conventions, such as the ones mentioned above (*Claiming Human Rights: Guide to International Procedures Available in Cases of Human Rights Violations in Africa*, 2008). These ratifications are legally binding international obligations which means that as a State, it has an obligation to protect people from any discriminatory treatment they might experience. The reader will notice that the language used does not make particular reference to citizens or foreign nationals, meaning that the overall sentiment is that the State must protect all people in its land from experiencing such treatment.

SA also underwrote the Convention on the Elimination of All Forms of Discrimination against Women in 1995 (CEDAW)[8] (1979) (Leary, 1994). This is a significant human rights agreement in advancing of human rights laws for women globally. Another important piece

[8] UN General Assembly. (1979). Convention on the Elimination of All Forms of Discrimination Against Women, Treaty Series, vol. 1249, pp. 13.

to this research to be taken away from this document is Article 2 (l)(f) of the CEDAW in, which provides that:

> [State] parties shall take all appropriate measures to eliminate discrimination against women in the enjoyment of the right to protection of health and safety in working conditions, including the safeguarding of the function of reproduction. (Convention on the Elimination of All Forms of Discrimination against Women, 1979 as qouted by Leary, 1994)

This Article, particularly, aims to protect women from discriminatory treatment when they access the right to health. When States become signatories to these documents, they accept an obligation to address and acknowledge any inequalities or discriminatory treatments against women and girls; take action against such as the State; pledge to carry out certain actions and pledge not to partake in certain actions; and to be accountable at the national and international level. The reader will note that CEDAW is also not particular about whether the States' obligation is towards its citizens or foreign nationals. So they are to protect all women and girls in their land without such specification.

Furthermore, in 1969, the ratification of the 1951 Conventions and the African Charter on Human and People's Rights of 1981 (ACHPR) occurred. From this important document, Article 16 of the African Charter on Human and Peoples' Rights is the most relevant to this research as it states that:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.

2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. (African Charter On Human And Peoples' Rights, 1981 as qouted by Leary, 1994)

Following all these agreements that SA has been signatory to, a significant show of the respect and prioritisation of refugee human rights occurred in 1993 as the South African government underwrote an agreement memorandum with the UNHCR granting refugees access into the country (Leary, 1994).

To further show SA's involvement in acknowledging the rights of foreign nationals, after the collapse of apartheid, the newly elected democratic South African leadership abolished the Aliens Control Act of 1991 from the apartheid era. It then enacted the Refugees Act (Crush and Williams, 2001). The Alien Control Act was declared unconstitutional. It was one of the most undignified acts enacted by the apartheid regime as it legitimised favouring white people over other races and racist (as well as antisemitic) sentiments (Hicks, 1999). The Refugees Act is now referred to as the Refugees Act No.130 and was enacted by Parliament on 20 November 1998 but came into effect in 2000 (Crush and Williams, 2001). An amendment was published to the Act in 2008. This amendment is called the Refugees Amendment Act (No 33 of 2008) (Crush and Williams, 2001). The government has passed more than 200 laws on foreign nationals (Crush and Williams, 2001).

These acts are significant because they largely contributed to moving towards the fair treatment of foreign nationals in SA. The enactment of these acts allowed for the Constitutional recognition of the rights of refugees and foreign nationals in terms of their migration statuses and the kind of rights they were entitled to in the country. It legitimised their rights in the country. As a result, after the apartheid regime, there was an increased influx of foreign nationals from neighbouring countries into the country. Even though these acts have been enacted to protect and promote the rights of foreign nationals, there is still rife abuse of their rights. Furthermore, the South African government still lags in reassessing key legislation on foreign nationals. This resulted in the Parliament enacting the new Immigration Act No.130 of 2002 only in 2002 (Crush and Williams, 2001).

Notice that I have justified how foreigners have a right to health so far. Thus far, the argument has not demonstrated that they have a right to *state*-funded health. To defend the latter, it is essential to highlight the progressive thinking in the conception of the rights of foreign nationals. The SA context is one of the existing crises of jarring disparities in the type and level of healthcare different socio-economic classes of the population (which is related to ethnicity and racial background) benefit from, especially in countries that are considered as low-middle income, with huge disparities in wealth such as SA (Omotoso and Koch, 2018). The enactment of Section 27 of the South African Constitution's Bill of Rights (1996) aims to correct this disparity by expanding the conception of the human right to health to include state-funded ones. The section articulates that:

> Everyone has the right to access healthcare services, including reproductive healthcare; sufficient food and water; and social security, including, if they cannot support themselves and their dependents, appropriate social assistance. The State must

> take reasonable legislative and other measures within its available resources to progressively realise each of these rights. No one may be refused emergency medical treatment. (The Constitution of the Republic of South Africa, 1996)

The text's use of 'everyone' is notably ambiguous concerning who 'everyone' absolutely includes and excludes. It is not unusual for a right stated in a BOR to be expressed superficially (Leary, 1994). On the surface, it can be understood that the 'right to health' presupposes that the government or any other custodian organisation or individuals must ensure the health status of all is guaranteed. The interpretation of this right in this manner is not viable, and the phrase is not necessarily taken to mean that in law about human rights. The phrase 'right to health' is sometimes used as a short-hand or shallow phrase when we refer to human rights and refers to a more detailed description of international treaties and basic human rights principles (Leary, 1994).

Article 25(1), expressed in the 1948 Universal Declaration of Human Rights (UDHR), reads:

> 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 the right to security in the event of...sickness, disability... (The United Nations General Assembly, 1948 as qouted by Leary, 1994)

The text used by the UDHR also uses 'everyone' as an inclusive universal term.

The South African government's Refugees Act and its related policies promote refugee integration and self-resilience (South African Refugees Act: Act No. 130, 1998). Their health becomes essential to their successful social coalition in South African communities. Even the South African Constitution under Section 27 of the BOR affirms the 'right to health' as "…access to healthcare for all, and everyone has a right to emergency medical treatment" (The Constitution of the Republic of South Africa, 1996). In addition, legally recognised refugees, like non-citizens (those with valid permits, for example), are entitled to emergency medical care under the Refugee Law (South African Refugees Act: Act No. 130, 1998). But, during the implementation of these rights, foreign nationals tend to be excluded (Daily Maverick (Spotlight), 2021). The 'all' within the Constitution is a key determinant in interpreting the right, and it is inclusive.

The use of inclusive language is not limited to the South African Constitution and African States Declarations only. For instance, the American Declaration of the Rights and Duties of Man, adopted by American States, is a declaration on the basic rights of individuals. It contains the use of language similar to that in the Constitution:

> Every person has the right to preserve his health through sanitary and social measures relating to food, clothing, housing, and medical care, to the extent permitted by public and community resources. (American Declaration of the Rights and Duties of Man, 1948)

The Declaration of Alma-Ata of WHO and UNICEF, which was accepted at the International Conference on Primary Healthcare that occurred in 1978, seemed to include the same language as well:

> The Conference strongly reaffirms that health, a complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right. The attainment of the highest possible level of health is the most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector. (Declaration of Alma-Ata, 1978)

The preceding paragraphs clearly show that the Constitution aligns with the language used in the international legislature meant to be inclusive. However, this is disconnected from practical implementation. An intersectional approach to healthcare access benefits society. The exclusion of foreign nationals from accessing healthcare, including state-funded interventions for epidemics of diseases that spread at accelerated rates, such as infectious diseases like HIV/AIDS or even COVID vaccines, remains a significant and fatal setback in the pursuit of achieving overall health goals of the country and the African continent.

Therefore, an intersectional approach to healthcare is an indicator and an insurer of a decent and dignified life regardless of nationality (Taylor, 1992). It is progressive and necessary to protect and further the interests of the public good and decrease any threats to public healthcare. This positively influences the population's activity within the economy, thus

increasing productivity and efficiency. Accordingly, the State is responsible for the 'progressive realisation' of the healthcare right.

Zia (Quoted in Harrel-Bond, 1986:155) observed that:

> Once a person—a human being—becomes a [foreign national], it's as if he has joined a different race or some lower social class. You discuss [foreign nationals'] rights as if human rights, which are more comprehensive and significant, do not exist. We've lost sight of the fact that each person is meant to be the final beneficiary of any advancement. (Harrell-Bond, 1986)

From a moral point of view, foreign nationals, by their intrinsic value of just being human beings, are entitled by birth right to certain basic rights (not limited to worth or dignity). According to the principles of the UNDHR, these rights are inclusive of healthcare right. Similarly, under international and national laws, the government is obligated to promote, safeguard and enforce human rights. This also includes those that pertain to foreign nationals. Under the Vienna World Conference of Human Rights (1993), it is written that:

> Governments' first duty is to uphold their commitment to protecting and promoting human rights. When healthcare systems are trustworthy and operating, they serve as development markers that denote positive health results and signal efficient interaction with important State services. (Vienna Declaration and Programme of Action, 1993 as qouted by Ager and Strang, 2008)

As most foreign nationals who require access to healthcare services in SA depend on state-funded healthcare, any laws that the government passes on certain elements relating to healthcare, for example, how they are treated at facilities, are the responsibility of leaders and managers within the healthcare field. The active involvement of healthcare management in transmitting any legislature concerning healthcare, in some cases more so the healthcare of foreign nationals in SA, is paramount in understanding and interpreting healthcare laws and policies. This promotes equal and fair access to public healthcare facilities through healthcare professionals, facilitating the ethical distribution of healthcare services.

Equally, the 'right to health' should not be interpreted as that people can abuse or even demand healthcare services where those services are limited or non-existent. The right to health speaks to the fact that no one may be denied healthcare access unfairly. The State does not have to realise this healthcare right immediately and to its full scope, but only to achieve the *full realisation* of the right progressively as stated in the BOR (The Constitution of the Republic of South Africa, 1996; Leary, 1994)

This explains the use of progressive obligation, gradual realisation, or due process per those rights as seen in the Constitution. Although monitoring committees have been established to interpret and apply these provisions, such committees were only established recently. In the Pan American Health Organization's 'The Right to Health in America', Professor Ruth Roemer pointed out that:

> A constitutional right to healthcare typically has a mostly symbolic purpose. It outlines the government's intention to safeguard its citizens' health. To guarantee entitlement to healthcare, a national policy statement alone is insufficient; the right

> must be established by particular statutes, programs, and services. Yet, stating a person's right to healthcare in a Constitution serves to notify the populace that doing so is the government's official policy and is mirrored in the fundamental law of the state. (Roemer, 1989)

The sentiments shared by Professor Ruth Roemer reflect a fair and just society where the right to health is protected and fairly distributed amongst societies. Although domestic and international migration policies and laws exist about the healthcare of foreign nationals, notice that these existing accounts in the literature fail to account for the ethical need and obligation that the State has in providing access to healthcare – including state-funded healthcare – for foreign nationals. Rather, overwhelming historical legal considerations of the right to health for foreign nationals exist in literature than ethical considerations for the right to health for foreign nationals in the South African context.

There is significant discourse among bioethicists globally on the right to access to healthcare for foreign nationals in both the global South and the global North. Underwhelmingly, most of the literature about the right to access to healthcare for foreign nationals in the South African context has been centred at mostly using law or policy considerations and referring vaguely to ethical implications of this right. The focus is also quite empirical and narrowed towards specific ailments and treatments such as foreign nationals' access to ART (antiretroviral treatment therapy) as published by researchers like Jo Vearey and Marlise Richter on behalf of the Migrant Health Forum in a report to the NDOH (Klingler, 2018).

Further, in international and international human rights laws, where refugees were incorporated, these laws run parallel (separated in practice). There was no link between what

international law prescribed and what international human rights law prescribed. The greater emphasis on refugees in international law made it seem like they are excluded from international human rights law as if foreign nationals are less human. As mentioned before, the need to recognise rights is for the socio-economic welfare of all. The recognition of the right to health, more significantly, is essential as it was not recognised from a genuine interest in serving the medical field and maintaining societal well-being but rather to aid the political and philosophical progression during the periods when colonialism and apartheid were still rife (Rubner, 2008).

Moreover, the existing inconsistencies in law, policy, and implementation raise another issue with access to healthcare for foreign nationals. As mentioned, SA has signed many treaties and has established Acts like the Refugees Act, Asylum Seeker's Act, and the Immigration Act. This was done to include foreign nationals in socio-economic rights to ensure their social amalgamation. Still, the highest law of the land, the Constitution, does not use language consistent with those acts in their specificity. Although, it is assumed that all Acts of law issued by the South African parliament are governed under the Constitution.

Compared to these acts, the Constitution is more inclusive and does not mention legal status concerning the right to state-funded healthcare services. This has confused policy implementation nationally as the interpretation is subjective, with no clarifying guidelines. This is apparent, for instance, in newly enacted bills such as the National Health Insurance Bill, where there is a lack of provision for foreign nationals, and an emphasis is vaguely placed on their legal status (National Health Insurance Bill, 2019). Subsequent chapters explain these inconsistencies further.

1.3 Research Question

This dissertation interrogates whether the South African government is ethically obligated to provide state-funded healthcare to foreign nationals despite the public healthcare crisis.

1.4 Rationale of The Study

Socio-economic rights, specifically the 'right to health', have no borders, especially the right to healthcare[9]. There is a need to have clear ethical guidelines and policies within public hospitals to govern the fair distribution of healthcare resources, especially within the context of the public health crisis that SA currently faces. Despite the false narrative that foreign nationals come to SA to access healthcare, a study on Migration Dynamics done by Statistics SA revealed that most foreign nationals who migrated to South Africa were within the employable ages (most between 16-35 years) and came, instead, as economic migrants.

Economic migrants are considered foreign nationals who move from their country of origin to improve their economic status, primarily by finding employment opportunities in the host country (StatsSA, 2011). It was seldom that some came to access South African healthcare facilities; instead, the government has fallen to using foreign nationals as scapegoats for their inefficiencies in both service delivery and corruption which has resulted in tense relations between nationals and foreign nationals that we have seen as the periodical xenophobic attacks across the country.

[9] Socio-economic rights being borderless means that people from all over the world have the right to healthcare as an international human right as it is also declared and recognised in many statutes and charters globally. In the South African context, it is encompassed in our Constitution and other mentioned legislature. The right to healthcare can be accessed beyond immigration borders.

Furthermore, xenophobia remains a crucial concern in SA. This is expressed not only through the physical assault on foreign nationals but through these exclusionary practices and sentiments uttered and displayed by political leaders to the public. This study is also important for contributing to the knowledge that excluding foreign nationals from accessing state-funded healthcare is a form of xenophobia. Based on this, the study encourages a new understanding of global health issues, especially those that impact vulnerable populations such as foreign nationals.

1.5 Thesis Statement

In this dissertation, I combine Afro-communitarian philosophy with utilitarianism and Kantian ethics to argue that denying foreign nationals in South Africa from accessing state-funded healthcare is ethically unjustifiable despite the South African public healthcare crisis.

1.6 Research Aim

To articulate and defend the thesis in the previous section.

1.7 Objectives

1. To defend the claim that it would be a violation of the African principles of *Ubuntu* to exclude foreign nationals from the SA healthcare system in any context.

a) To defend the claim that the exclusion of foreign nationals from the provision of state-funded healthcare is unjust.

2. To argue that foreign nationals make valuable socio-economic contributions towards the SA, therefore, have a right to State services.

1.8 Research Methods

Study Design

This is a mostly analytically normative research study involving a review of existing literature, ethical principles, and legislature to formulate arguments on why foreign nationals ought not to be excluded from accessing state-funded healthcare.

Normative ethics generally focuses on how we account for our morality and explains how we ought to guide our moral actions or choices (Driver, 2009). Sugarman and Sulmancy, in their paper, 'Methods in Medical Ethics', describe normative ethics as a section within philosophy that provides an explanation or a guide of the most important basic principles that guide us on how we ought to live amongst each other (Sugarman and Sulmasy, 2010). In this study, I address one normative question: "is it ethically justifiable for the State to exclude foreign nationals from accessing state-funded healthcare?".

While my study is primarily normative, I will also analyse and appeal to legislation and policies that affect foreign nationals' access to South African public healthcare. I use national and international legislation to answer the central normative question in this project. The literature review was included to critically consider policy documents and legislation to determine if these policies and laws enacted were inclusive or exclusive to all or some of the population.

Some key international and national policy guidelines and legislations include,

- The Constitution of the Republic of South Africa of 1996
- Refugees Act of 1998, Immigration Act of 2008
- National Health Act of 2003
- Universal Declaration of Human Rights of 1948
- The African Charter of Human and Peoples' Rights

The documents mentioned above are some of the documents that have been very instrumental in informing some of the migration and immigration policies and practises of the country and protecting and promoting the socio-economic rights of foreign nationals.

Sources of Literature

Normative ethical papers are sourced from various journals for the project via desktop internet searches. A similar process is used to search for official international and national legal documents and policies published about access to public healthcare facilities for foreign nationals. These are mentioned in my references in-text as well as my references.

My approach consists of analysing relevant texts by including definitions of relevant terms and concepts, analysing past and present theoretical frameworks, and deriving normative principles from these theories to defend stated claims. I retrieved different types of research papers ranging from but not limited to research articles published in reputable journals, PubMed, and Google Scholar. Google Scholar is important in sourcing grey literature that could be unpublished in journals such as conference papers and abstracts.

The legislation is searched and found on government websites and various online library sources such as BMJ, BME, etc. I ensured that I focused on information that deals with regulations and policies on protocols of use of public healthcare and the type of access to public healthcare facilities that foreign nationals have. This is the basic criteria of inclusion for the sources of information.

Keywords used to search for relevant studies and information include:
Right to Health, Foreign Nationals' Healthcare, *Ubuntu*, South African Public Healthcare Crisis, Rationing in Healthcare, Distributive Justice.

1.9 Limitations of The Study

This study has limitations. Specifically, the project focuses on the morality of denying foreign nationals access to state-funded healthcare. Whilst I combine the African communitarian ethic of *Ubuntu* with other theories to interrogate this question, it is essential to note that *Ubuntu* is primarily a South African ethic.

Another limitation that affected the study is the lack of South African policy or data that speaks to the gross effect of foreign nationals on the public healthcare system. So, therefore, I relied on newspaper reports which are only sometimes reliable sources of research data and policy. Most papers also needed more depth in the ethical considerations, which are part and parcel of a functioning healthcare system. For instance, a lot of literature focuses primarily on the socio-legal and legal aspects of foreign nationals' right to health and superficially includes ethical perspectives. For example "*Don't send your sick here to be treated, our own people*

need it more": Immigrants' access to healthcare in South Africa by T. Alfaro-Velcamp (2017)) and *An Analysis of Foreigners' Right to Health Services as Enshrined in the South African Constitution* by A. Mavenika, K. Odeku, and K. Raligilia (2014).

1.10 Research Ethics

As this project involves no empirical research or human participants, no research ethics committee approval was needed. Instead a waiver was attained from the University of Witwatersrand Human Research Ethics Committee (Medical). Waiver Reference no.: W-CBP-230330-01

CHAPTER 2: ACCESS TO HEALTHCARE AS AN ETHICAL OBLIGATION ON THE STATE

2.1 Introduction

In the Introductory chapter, I contextually introduced the status quo of the South African public healthcare sector, considered literature about the healthcare right as a right ensuring socio-economic welfare, when it became a recognized right, where it is enshrined, and how it is depicted in the legislature, both nationally and internationally. I also considered literature about the moral perspective of the right being inclusive of foreign nationals after demonstrating how that right extends to those who cannot afford healthcare. This served to form an ethical understanding of the importance of what the healthcare right means as a right ensuring socio-economic welfare for all (including foreign nationals who migrate across borders in the African continent), how it is influenced by international standards of law instruments or policy, and how that has affected foreign nationals' rights to benefit from public healthcare services in the country.

In this chapter, I make use of Utilitarianism, Kantianism, the African Communitarian ethic of *Ubuntu,* and Principlism to defend the thesis statement that the government has an ethical responsibility to adequately avail state-funded healthcare to foreign nationals despite the South African public healthcare crisis.

In Jeremy Bentham's thinking, Utilitarianism prescribes that an act is exclusively morally correct when it brings about the most happiness for the most amount of people considered (Bentham, 1970). I argue that providing healthcare services to everyone in need would increase utility for the most significant number of those in need. This would also address a pressing question concerning healthcare services access by the vast majority. I further argue

that providing foreign nationals with healthcare funded by the State promotes utility in cases of disease control. In such cases, it would be in the state's best interest to limit the infection rate of disease by ensuring that those who have such conditions and can spread them receive immediate treatment. To this end, excluding foreign nationals from accessing state-funded healthcare threatens public healthcare, at least from the Utilitarian positionality.

Furthermore, I consider Kantian ethics, which refer to the deontological moral theory, prescribe that the morality of an act is based on how right or wrong an action is and is non-dependant on the repercussions of that action but on the fulfilment of our duties as persons (Rachels and Rachels, 2010). I argue that, under the Kantian theory of deontology, the State has an ethical obligation to provide state-funded healthcare to foreign nationals as it is the right thing to do. Kant also claims that human beings should be treated in a manner that shows respect for their unique moral status, and that means that they should be treated as persons (Rachels and Rachels, 2010).

One can surmise that he refers to not treating people as a means to an end but as an end in itself, not reducing people to only resources but also having some respect for their rights, autonomy, and whatever choices they make. An important aspect of not reducing people is honouring their rights and respecting their autonomy and decisions (Hodson, 1983). From this perspective, granting access to foreigners to work in SA without ensuring their socio-economic welfare – including fostering their right to health – amounts to using them as mere means. Foreigners have a right to socio-economic rights because they are persons. Depriving

one of the basic human rights to health would violate their rights and their humanity, which is unacceptable under Kantian ethics and morally wrong.

Under the African Communitarian ethic of *Ubuntu*, I argue that it would be a violation of the African thinking about personhood to exclude foreign nationals from the provision of healthcare in any context. As infamously written about in many African philosophical works of literature on *Ubuntu*, *a person is a person through other persons*, meaning that as human beings, we are all mutually dependent on each other (Oppenheim, 2012). Part of realizing one's personhood through others is by acting to advance their well-being. This includes ensuring that those who cannot afford the minimum healthcare can access such care when needed. The contrary will be a failure to showcase *Ubuntu*, for instance not sharing resources with others.

I also use three principles under Principlism's four principles: respect for autonomy, non-maleficence, justice, and beneficence. Under Principlism, excluding foreign nationals from state-funded healthcare is morally wrong and unjust. To thoroughly defend my stance that it would be unethical for the State to exclude foreign nationals in the provision of state-funded healthcare, I use the principles of beneficence and non-maleficence and exempt respect for autonomy as it is rooted in a worldview that considers the individual more than the community and dismally attempts to understand communal relationships of people within their nexus (Behrens, 2018). Furthermore, I argue that it is unjust to exclude foreign nationals from the provision of state-funded healthcare based on the principle of justice that prescribes that we ought to act fairly and treat people fairly.

Lastly, under public health ethics, I argue that the State has an ethical obligation to provide state-funded healthcare to foreign nationals as it is in the best interest of public health. Public health ethics are relevant as they speak from a population-based/communal perspective rather than an individualistic one. They include the use of frameworks to reason in a just manner for the available ways in which public health can work in practice according to ethical principles, stakeholders' beliefs and values, and actual data derived from the sciences (Kass, 2001). For instance, in the case of the COVID-19 pandemic, which is a societal health threat, and to protect overall societal health, there is an ethical obligation upon the State to provide foreign nationals with state-funded healthcare. This includes vaccines and treatment of COVID-19 as a failure to accommodate the health interests, particularly of foreign nationals who cannot afford such healthcare, could compromise public health.

The provision of healthcare services to people is not only influenced by economic and political concerns but also moral concerns. Mark Levine et al. (2007) wrote about the fact that in many nations today, disproportionate healthcare access is still a problem and an ethical concern (Levine *et al.*, 2007). The introduction and development of the 2019 National Health Insurance (NHI) Bill in SA has sparked much controversy from various stakeholders to determine the state's ethical obligations with regard to the provision of healthcare for everyone, including foreigners. The public commentary around the NHI triggers a reminder of a report published by the Hastings Centre in 2007 in the United States of America, which reported on public perceptions on whether or not people agreed with the concept of a societal moral obligation for the provision of healthcare access for everyone (Levine *et al.*, 2007).

In this report, of those surveyed, about 60% conceded that it was not only of political or economic concern but also a moral concern. Meanwhile, 72% conceded that there was a societal moral obligation for the provision of healthcare for everyone (Levine *et al.*, 2007). This report shows that the general consensus of the public is that healthcare should not be dependent on nationality hence the use of words such as *all* and *everyone*. The inclusion of morality in this consideration signifies that healthcare access for everyone is a standard norm/moral value that we all share across the world as it contributes positively to our health status and socio-economic well-being. Healthcare should be accessible to all regardless of nationality. More importantly, it emphasises the understanding of the healthcare right as a basic right that all people should have access to- just because they are human beings.

In pondering on foreign nationals' consideration in the provision of state-funded healthcare services, factoring in the current state of the healthcare system in South Africa, a lot has to be questioned. For example, is it fair to expect the State to make extensional provisions within the healthcare budget to accommodate the explicit incorporation of foreign nationals in healthcare provisions? This is taking into consideration the State's expenditure per person per annum. The State allegedly spends an average of R 3,473 per annum per person for the approximated 45 million people in SA who do not have medical aid, as reported in the Health Budget Brief that South Africa sent to the United Nations International Children's Emergency Fund (UNICEF), now known as the United Nations Children's Fund (UNICEF, 2018).

I say allegedly because the true realisation of those benefits to each person is still left to be desired. In any case, the implications of explicitly including foreign nationals in state-funded healthcare would affect our country's expenditure. We would need to restructure our health sector budget affecting the rest of the fiscal year budget. In light of this, my main question poses both an economic and ethical dilemma.

On the other hand, it is also challenging to consider the practical financial implications of the explicit inclusion of foreign nationals. SA is implementing the proposed NHI Bill in which there has been a deliberate avoidance of mentioning foreign nationals in the Bill (White and Rispel, 2021). Would this inclusion worsen the collapse of the healthcare system by increasing spending, and would this be fair to South African citizens? There is no data to show the real impact the burden of foreign nationals have on the public healthcare sector. So, the apprehensions surrounding foreign nationals' access to state-funded healthcare are not based on facts or data.

Further, one must consider whether the current status quo is ethical. Currently, foreign nationals are faced with restrictive access to socio-economic rights due to non-compliance on at the face of care to the different Acts that stipulate foreign nationals' entitlements to rights, and the State's inconsistency in migration control and welfare stipulations (Kavuro, 2022). In a fair society that upholds human rights, the current status quo does not observe the rights of foreign nationals to access state-funded healthcare as the policy implementation is not strictly followed up within the Department of Health (DOH). This is why we see the resistance to access to healthcare and discrimination at public healthcare facilities. Answers to questions

like this are not easily concluded. However, the application of ethical principles in defending the just rationing of healthcare services can serve as a guide to reach viable moral conclusions.

2.2 Utilitarianism and Healthcare Provisions to Foreign Nationals

David Hume (1711-1776) proposed the moral theory of utilitarianism, which was substantively conceptualised by Jeremy Bentham (1748-1832) and followed through by one of his followers, John Stuart Mill (1806-1873) (Rachels and Rachels, 2010). Bentham[10] argued that morality is founded on the greatest utility principle (Rachels and Rachels, 2010). Bentham describes utility as the extent to which an act prevents harm and does good (Bentham, 1970). He explains that utilitarianism prescribes that an action is only seen as morally right if it results in the most good for the most amount of people considered (Bentham, 1970).

It is prevalent for the utilitarian theory to be used in medical ethics when dealing with the moral dilemmas that come with rationing of resources, and this is because a utilitarian approach in medical ethics is always society-centred; whenever there are medical ethics dilemmas, the outcomes must provide the highest level of benefit for the most amount of people involved (Mandal, Ponnambath and Parija, 2016). So, under utilitarianism, we must choose an act with consequences that lead to maximising happiness/good/welfare for

[10] Cited in Rachels, J and Rachels, S. (2010). The Elements of Moral Philosophy. Sixth Ed. New York: McGraw-Hill

everyone. The act of providing foreign nationals with state-funded healthcare is an act and a duty that maximises the average good for everyone.

Mack (2004:63-72), in his paper titled *Utilitarian Ethics in Healthcare*, writes about the four parts of the utilitarian theory that are considered in solving moral dilemmas in public healthcare: consequentialism, maximisation, aggregation, and welfare (Mack, 2004). Consequentialism states that whatever act or decision made must be critiqued upon based on its results, maximisation holds that the act must be of the most benefit to the most amount involved, and aggregation is a concept whereby the aggregated welfare is equal to the total amount of the welfare of an individual, and welfarism holds that the *goodness* of the allocation of resources can only be critiqued based on the levels of utility in that specific case (Mack, 2004).

Maximization concerns maximizing available resources. The emphasis is generally placed on the level of the population, while the basis for state-led public health interventions is implemented from a perspective that must be unbiased (Bellefleur and Keeling, 2016). In this situation, the population's health is the good that is maximized. Moreover, an analysis of risks versus advantages relating to the population's general health is investigated in the public health field. Crucial factors to consider are the efficiency and effectiveness of the interventions, actions and programs conducted in public health and are also essential considerations for the utilitarian. Therefore, utilitarianism and public health consider the results of that action (Levine *et al.*, 2007). Welfarism concerns the utility of allocation/distribution. It entails the idea that the *goodness* of the allocation of resources

ought to be evaluated based on the levels of utility in that specific case (Mack, 2004). As I have, in fact, demonstrated that it is in the best interest of public health to fund the healthcare of foreigners in the previous section, funding the healthcare of foreigners increases utility.

Furthermore, considering that the utilitarian principle is integral during public healthcare policy development, an interpretation of how the principle of utility is applied in moral dilemmas such as the one at hand is necessary. There are two ways of applying this, one being act utilitarianism and the other being rule utilitarianism. Bentham describes act utilitarianism as prescribing that an action is right if it brings about the most good for the most amount of people considered (Bentham, 1970). Whether that act is morally correct is considered on its own instance, which means that it can only be morally correct if there was no other act that could have been performed to produce higher utility (Bentham, 1970).

Whereas, Mill explains that rule utilitarianism prescribes that an action is morally right if it is consistent with the generally accepted norms that would bring about the most pleasure over pain for the most people In other words, an act is moral only if it is according to the rules of conduct that have been assured by the principle of utility as an act that will yield at least as much utility as any other rule that could be applied in that particular case (Mill, 1863).

In this instance, the question would be whether the provision of state-funded healthcare to foreign nationals, despite the public healthcare crisis in SA, would produce as much utility as any other rule that can be applied in that case. Will following this rule generally bring about a

situation wherein utility will be maximised? I contend that it would. Suppose foreign nationals have equal access to state-funded healthcare, that, firstly, improves their general standard of living- they are healthier as they have access to state-funded healthcare and, therefore, can contribute further to the economy by being fit to contributing members of their communities by being able to work and not be dependent on State resources to live.

Secondly, the State faces less of a liability of spending State funds on tertiary care and emergency care (which are reasonably far more costly) in the future when an ailment could have been prevented at an earlier stage, such as in primary healthcare. For instance, the general average cost per day per hospital admission in the public sector was calculated to be R1,543 in the most recent public sector data relating to the 2010/11 period [(Day, Gray and Budgell, 2011) as cited by (Ramjee, 2013: ii)]. Considering that the average length of stay in public hospitals is estimated to be 5.3 days, then the average hospital cost per admission in total was R8,775 [(Day, Gray and Budgell, 2011) as cited by (Ramjee, 2013: ii)]. This shows how costly it is for tertiary hospitals to treat ailments per patient per average stay in the hospital.

Furthermore, as it stands, tertiary hospitals in the country have a backlog of patients waiting for tertiary-level treatments such as surgery. For instance, the Chris Hani Baragwanath Hospital in Soweto, Johannesburg, has a surging waiting list for surgery of about 11 194, up from the previous year's 7288 (Molapo, 2022). Although I do not claim that *all* patients on the waiting list for tertiary care are foreign nationals, it is difficult to provide this estimate. It is also not my point that all patients will take advantage of state-funded healthcare, suppose

this is available. Some may exercise their freedom to decline care, which could degenerate into a more severe illness. The point I wish to convey here is that the demand and influx of patients reliant on tertiary care can partly be addressed through reliable healthcare access that allows for the early detection of conditions. This access ought to be afforded to everyone, including foreigners.

Also, it is common for healthcare professionals to use utilitarian thinking when faced with the rationing of resources and healthcare services. Utilitarian thinking, in this context, prescribes that whenever there is a choice between reserving healthcare for a small number based on scarcity of resources versus promoting equal efficacious methods of healthcare access, we must ensure that the welfare of patients is to a maximum and any other expenses and incurred risks of potential exclusion be kept to a minimum (Mack, 2004). Therefore, a decision that breaches this moral norm would be considered unethical, at least from this perspective.

Jeremy Bentham and John Stuart Mill, who are mentioned before, centred their interests on legal and social transformation (Driver, 2009). Bentham (1970: 1-8), in an *Introduction to the Principles of Morals and Legislation* (1781 ed.), asserted that both governments and people should act under the idea of utility (Bentham, 1970). In the same section, he also said that "actions are approved when they are meant to promote happiness or pleasure, and disapproved of when they tend to cause unhappiness, or pain" (Bentham, 1970). I take this to mean that the government, citizens, and foreign nationals have their part to play in utility, wherein achieving happiness is the ultimate objective and behaviours that result in suffering or misery are considered morally wrong.

For example, there have been many reports of healthcare professionals' ill-treatment of foreign nationals at public healthcare facilities. I will look at two reported accounts that have made headlines in recent years as they caused public outrage. The first account is of *Araya Y*, reported in the Mail and Guardian, who was a Somali refugee woman based in Port Elizabeth and was pregnant. She had sought medical attention to give birth at a government district hospital in July 2010 but was abused by medical staff and denied (Mail and Guardian, 2012). The abuse came in discrimination and derogatory terms such as *kwerekwere* (a slur to mean foreign national). She was refused medical care even though she had labour pains. She ended up in a private hospital, leaving her in debt as she could not afford it.

Araya Y's story is not uncommon amongst foreign nationals living in SA and dependent on state-funded healthcare facilities, unfortunately. Araya Y sought assistance at an alternative hospital in private healthcare, where she delivered her baby safely (but left in debt). Unfortunately, not all people denied healthcare at public healthcare facilities in SA are as Araya Y in terms of her and her baby surviving that ordeal. Even though SA is working on the improvement of its healthcare system, it should ensure that foreign nationals are included. Despite the responsibility SA has towards the provision of healthcare to foreign nationals who live in the country, this poses a massive dilemma for the rationing of resources, service delivery and the administration thereof. This is especially the case for a system such as ours that presents with severe struggles in meeting the threshold of needs of its people. However, the intersectionality of the health exigencies of citizens and foreign nationals is inseparable. The repercussions for SA's or the government's failure to act adequately towards foreign nationals according to its legal commitments, regarding access to public healthcare facilities

and communities that are non-discriminatory and non-xenophobic, cannot be ignored. This incident ended in decreased utility. Even though it was an individual experience, the pain resonated amongst a larger group of foreign nationals as it painted a picture of how much their lives were worth. Many felt that the DOH disregarded their rights to healthcare. Therefore, according to the principles of utility, it was morally wrong.

Another similar account is that of a lady called *Francine Ngalula Kalala* (pseudo-name), who was from the Democratic Republic of Congo (DRC) and was in SA as an asylum seeker. In her story, she gave birth at the Johannesburg railroad station. Security guards rescued her when she was in labour as hundreds of bystanders looked on (Ncube, 2017). She had also been denied access to healthcare assistance by two State hospitals. The reason provided is that she presented a permit for asylum seekers (Ncube, 2017). Having delivered the baby at a station, more ill treatment was in-store for Kalala and her husband. They went to another hospital to seek assistance but were still denied access while their new-born child was short of oxygen-turning blue. Upon trying another hospital, they finally got assistance.

Although they could possibly sue the government for unfair treatment and discrimination, it still does not remove the fact that foreign nationals experience systemic abuse and neglect at public healthcare facilities. These range from neglect, assault, discrimination, and verbal abuse to financial exclusion as they are asked to pay exorbitant fees upfront (Ncube, 2017). A researcher doing her postdoctoral research at the African Centre for Migration and Society (ACMS) at Wits University, Dr Rebecca Walker, commented in an interview reported by The New Humanitarian in 2017 (online news webpage) that "[these cases] were not exceptional

case…migrant women accessing care routinely face discrimination and abuse within the public healthcare system" (Ncube, 2017).

These accounts show individual cases where the right to healthcare was not upheld at the point of care. This is a threat to policies that have been developed to assist in the improvement of healthcare access in the country, such as Batho Pele[11], and legal frameworks like the Constitution, Refugees Act, National Health Act, and many other legal instruments that have been adopted in South African law but are not practised and implemented in real life situations such as the accounts mentioned above. My point is that the non-implementation of these frameworks has a more significant negative consequence for foreign nationals, civilians, and the government. When everyone subscribes to the same conduct in similar instances, utility is increased for everyone in the long term. Suppose the State is required to act to increase utility. In that case, state-funded healthcare ought to be a minimum requirement in public healthcare for all.

Many scholars agree with the common intuition above. They include Royo-Bordonada and Roman-Maestre, 2015, Holland, 2007, and Rothstein, 2004 (Bellefleur and Keeling, 2016). Royo-Bordonada and Román-Maestre (2015: 1) asserted that "public health is in essence…utilitarian because it seeks to preserve the health status (something that contributes

[11] Batho Pele is a Sesotho phrase, that can be translated to ‘people first', was launched in 1997 as a public call to internally change the public service delivery and sectors using a ‘people first' approach with 11 highlighted principles. The launch of Batho Pele was because of the inherited public service system from apartheid that could not accommodate the larger majority of South Africans as it had a lack of patient-centred skills and attitudes to meet the progressive issues the country was facing (Department of Health, 2021).

to the well–being of persons) of the maximum number of individuals possible, ideally *the entire population"* (Royo-Bordonada and Román-Maestre, 2015). In light of this, I argue that under the utilitarian principle, the provision of state-funded healthcare provision to foreign nationals is a crucial public good.

Governments have always prioritised monitoring particular health threats that might potentially come about as a result of migrant populations coming into the country because of outbreaks of transmissible infectious diseases from the past that were of public health concern, and these include diseases like the plague and cholera (Gushulak, Weekers and MacPherson, 2009). These infectious diseases tend to be public healthcare threats as witnessed in recent histories, such as in the influenza A/H1N1 2009 pandemic, the Severe Acute Respiratory Syndrome (SARS, 2003) pandemic, and more recently, the COVID-19 pandemic, which has exerted immense pressure on the ailing South African healthcare system (Gushulak, Weekers and MacPherson, 2009).

What the preceding suggests is not that foreigners ought not to be cared for but rather that care ought to be made available for all. Precisely, the COVID-19 pandemic has shown how a *nationalist approach* to the distribution of vaccines and life-saving drug interventions in the Northern-rich states, or the Western-World can result in a negative ripple effect on the poorer parts of the world. Also, the virus's progression via high mutation rates (too much more advanced and deadly strains) has had devastating effects on states in the poor Southern areas of the world because of vaccine hoarding (Psaledakis, 2021). The global humanitarian interest was ignored in vaccine hoarding, which was unethical and economically

disadvantageous for all, allowing more people to be infected, including the already vaccinated. Under utilitarian principles, where an act is judged by its overall utility outcome for the highest amount of people involved, hoarding vaccines by Northern-rich countries is unethical and unjust.

Similar to the Northern-rich countries, during the distribution of vaccines in SA, the Minister of Health did not include foreign nationals (especially undocumented immigrants) in the vaccine roll-out (Vearey *et al.*, 2021). Multiple organisations and groups that advocate for the rights of foreign nationals have spoken out about this injustice. Not only is it a short-sighted decision, but it did not assist the State in limiting the disease's infection rate. It was also economically unfavourable as the cost of treating an individual, for instance, is representative of that of treating a community in the long run. The quicker herd immunity can be achieved, the more beneficial it will be for the economy and the health system. The exclusion of persons, based on furthering national interests, from vital public healthcare interventions is a public health threat that hardly results in the greatest utility, for example, in a pandemic. Decisions like this, whether motivated by national interest, carelessness, or malice, result in the loss of lives, which results in negative utility.

Although the utilitarian approach has proved helpful in justifying why state-funded healthcare needs to be accessible to foreigners, it still has its problems that we must consider. I will consider two issues that might arise relevant to this context. Firstly, the utilitarian principle seems too focused on the overall outcome for everyone and ignores individual rights and duties (Rachels and Rachels, 2010). It justifies the illusionary benefit that the

suffering of a few people for the benefit of many is morally correct. A question arises, should the individual rights of South Africans, in this case, be set aside so easily? Some might even add that patriotism and prioritizing national interests through putting South Africans first has nothing to do with Afrophobia/xenophobia. The inclusion of foreign nationals in an already collapsing healthcare system seems to bear a burden on the citizens regarding the perceived limits to the amount of healthcare access they are to receive and the inevitable increase of taxes to finance this.

However, on a closer look at the claim of patriotism and the prioritization of national interests, we see that it is a neoliberal repackaging of nationalism that is a form of fascism. Furthermore, considering this perceived burden, we see it does not exist. Firstly, the number of foreign nationals in the country is less than 5% of the population, so there is no real addition of many numbers, and the number of foreign nationals that are dependent on state-funded healthcare and do access state-funded healthcare is far less than that (StatsSA, 2011).

Rather, many travel to SA as economic migrants, meaning that many foreign nationals are young (between ages 15-34), have medical coverage, are healthy, contribute to the economy and hardly travel for access to healthcare (StatsSA, 2011). Secondly, many foreign nationals are scared to seek healthcare in SA due to the mistreatment and exorbitant fee charges they have experienced at the point of care and their fear of deportation (Siegfried, 2014). Therefore, there is no actual setting aside of rights or the abandoning interests of South Africans.

Another problem with the utilitarian approach is that the demand for impartiality is inconsistent with common morality. Treating everyone equally requires us to abandon our special relationships as compatriots, family or just friends. This is too demanding (Rachels and Rachels, 2010). Here, our special relationships are valued as no different as those with strangers we have never met. This is not an issue of relevance in relation to having access to healthcare for foreign nationals. Special relationships, in any way, would not be considered in healthcare rationing as it is.

While understanding that rationing occurs at both a macro-level (for instance, the allocation of funds) and micro-level (for instance, individual patients' resource allocations) and are also affected by each other, special relationships do not take priority in rationing (Scheunemann and White, 2011). Healthcare professionals look at a criterion that details: age, survival chances/severity of illness, and waiting time when rationing resources and healthcare services, which those criteria are rarely dependent on nationality or race (Scheunemann and White, 2011).

2.3 African Communitarian Ethic Of *Ubuntu* arguments that impose an ethical obligation upon the State to ensure that foreign nationals are provided with state-funded healthcare

In the previous section, I used utilitarian arguments to defend the claim that the State has an ethical obligation to provide state-funded healthcare to foreign nationals despite the South African public healthcare crisis. My overarching argument under the utilitarian principle was that the provision of state-funded healthcare to foreign nationals is in the best interest of everyone. This section argues that the African Communitarian Ethics of *Ubuntu* yields a

similar conclusion: state-funded healthcare should be accessible to foreign nationals. To defend this position, I draw on African thinking about community grounded in *Ubuntu* philosophy. Community is *uluntu* in Nguni languages which is loosely translated to people. In Africa, it generally means those who share life together and have common interests and ways of living. Although other cultures might have a slightly different definition, in African culture it means there is value in community, as one is born into a community they will always be a part of it (Venter, 2004). It is the bases of Communitarianism.

Communitarianism is not unique to Africans. It (communitarianism) is a philosophical, moral theory that places importance on the relationship between individuals and the communities in which they live (Behrens, 2018). It involves the idea that communal relationships mould one's identity and personality, hence, it is less individualistic and more interdependent. From this perspective, right acts tend to honour people's ability to commune with others or harmonize (be able to live in harmony) and be harmonized with others[12] (Metz, 2021).

The difference between communitarianism and utilitarianism is that utilitarianism bases the moral principle on the maximization of happiness. In contrast, communitarianism emphasizes the morality of an act based on it catering to communal relationships. In this regard, the State has an obligation to provide foreign nationals with state-funded healthcare if this is essential for active participation in the communal relationship. In this regard, actions

[12] In philosophy and Metz writing, the term *to be harmonized with others* means to be able to form harmonious relationships with others and live together in "peace" and be in community with each other.

that *alienate* individuals will be immoral from the *Ubuntu* perspective. The preceding will not necessarily be the case under utilitarianism, supposing that the alienating act can increase overall happiness.

The communal relationship is a broad core thinking in African morality, particularly *Ubuntu* philosophy. The derivation of the term *Ubuntu* is from isiXhosa, isiZulu, isiNdebele and siSwati, languages spoken under the Bantu Nguni tribes situated in various regions of the country (Ncube, 2010). It is expressed in variations across African cultures. In Sotho languages, it is called *Botho* (Oppenheim, 2012). It is also commonly found at the crux of most traditional African cultures.

Ubuntu has many connotations. One view is that it is a way of living adopted in many sub-Saharan African communities. It embraces a spirit of solidarity, trust, accountability, comprehensive decision-making, genuine kindness/giving, reciprocity, and inclusivity (Oppenheim, 2012). Furthermore, it is described as the ability to have empathy, hospitality, dignity, and respect. *Ubuntu* has been commonly explained as *I am because we are umuntu ngumuntu ngabantu,* translated as *a person is a person through other persons* (Metz, 2021). It is a person's moral trait, meaning that the being or idea of a person is at the core of all facets of *Ubuntu*. Harmonious living is central to the idea of personhood in this philosophy. In my language, which is isiXhosa, harmony is known as *ukuphilisan*a, translated as living together.

Here, an act is morally justified if it honors communal relationships and immoral if it achieves a contrary effect (Metz, 2021). Therefore, the African communitarian ethic of

Ubuntu is about grasping how we are connected and the need to foster our lives together in the community (Metz, 2021). These are essential principles that describe various ethical issues that are on the macro level within resource rationing in public healthcare, especially when it comes to foreign nationals. In order to use its teachings as advisory in policy and law, it is essential to remember that *Ubuntu* is rooted in its people, culture and society and represents an African worldview that is difficult to define in the Western context, which some of our governments and systems are situated in (Ncube, 2010).

Steve Biko, as encapsulated in the African Philosophy Reader by Coetzee and Roux (1998), wrote:

> In Western Culture, a visitor to someone's house, except for friends, is always met with the question, "What can I do for you?" This attitude of seeing people not as themselves but as agents for some function either to one's disadvantage or advantage is foreign to us…We enjoy man for himself. We regard our living together not as an unfortunate mishap warranting endless competition among us but as deliberate act of God to make us a community of brothers and sisters jointly involved in the quest for a composite answer to the varied problems of life. Hence, in all we do we always place man first rather than the individualism which is the hallmark of the capitalist approach. (Coetzee and Roux, 1998: 27-28)

Biko speaks of how things are done in African homes, which extends to African culture. He explains how visitors are met with a sense of welcome that resonates with belonging rather

than a quest. He shows that in African culture, we believe in communal relationships. Communal relationships entail two facets:

(1) identity, which speaks to sharing a way of life.

(2) solidarity, which speaks to care for a good quality of life.

Under identity, we consider elements such as a sense of togetherness, being a member of a group/society, and coordination, which speaks to working together-participating in the community with equal trust and willingness (Metz, 2021). Under solidarity, we consider elements such as mutual aid, which speaks to going out of your way to help others by catering to their needs and sympathetic altruism, which speaks to sympathising and helping others for their sake (Metz, 2021).

These facets of communal relationships are at the core of being African. Taking the fact that we live with foreign nationals in our communities, and they are of African descent, I maintain that their exclusion from state-funded healthcare would violate the principles of *Ubuntu* since we thereby fail to provide mutual aid to others. In the African context, there is an understanding of caring for each other. As people living in community with each other, it cannot be that we can watch one of our brothers or sisters suffer and not provide aid, especially in the case of a basic right such as healthcare.

The way South African nationals treat foreign nationals is problematic. There has been a reported surge in post-apartheid SA of widespread xenophobic attacks and discrimination towards foreign nationals (Daily Maverick (Spotlight), 2021). We once relied on other

African countries in the past, so it is common decency to reciprocate the same to those who come to our country to seek an improved livelihood for themselves and their families. This will showcase *Ubuntu* to others who have helped us. In all moral theories, we recognise that you return the favour if someone washes your hands.

However, it is possible to understand why South Africans behave the way they do towards foreign nationals. The downside of Ubuntu is that it asks too much of us in that it requires, in order to showcase humanity, one to relate to others in positive ways (e.g., living in solidarity, i.e., providing aid and sympathetic altruism). When we do this, it is not always in our best interests. It might be disadvantageous or even harmful. Philosophically, one modification of thinking about Ubuntu is not to take on duties upon ourselves just to develop our personhood or exhibit genuine human-ness in how we treat/live with others. However, we should also think that we can be genuine human beings or develop personhood by how we treat ourselves. This means we ought to showcase to own-selves Ubuntu when we have to.

Unfortunately, capitalism has bred a lot of societal ills resulting in the decline of social morality for the sake of survival amongst many (Behrens, 2013). Predictably, shared sentiments of individualism and a decline in social morality are expected in SA, considering that it is rated as a country with high inequality disparities, with one of the highest Gini coefficient ratings (World Bank, 2021). Even though access to basic services, education and healthcare, and social grants provision have improved, majority of the country's population is impoverished (Behrens, 2013). Unemployment and inadequate housing leave communities vulnerable to despair and associated social problems such as substance abuse, crime, and

violence. Some believe that many of SA's current moral failures stem from corruption and the desire for power among the country's leadership, who cannot use poverty or deprivation to fail at service delivery. These societal failures have bred xenophobia amongst communities, especially those with many foreign nationals. These actions show a lack of community foreign to the traditional African way of life (Behrens, 2013).

It is vital for society to re-affirm its human dignity, which is one of the core principles of *Ubuntu*. The South African government must explicitly take a stance to address the challenges of poverty and social inequality in our communities, which have been exacerbated by the lockdown regulations within the country in the past year. This is important to foster radical social change to ensure that a better percentage of the population has a decent standard of living. As a moral theory, African communitarianism provides a solid basis for establishing policies for outbreak control concerning infectious diseases that effectively safeguard against threats to public health. Given that this approach is a socially rooted framework, it may be preferable for addressing social problems, including communicable diseases (Cheyette, 2011).

2.4 Kantianism and state-funded healthcare for foreign nationals

In the previous two sections, we looked at utilitarian arguments and the African communitarian ethic of *Ubuntu* on why the State has an ethical obligation to provide state-funded healthcare to foreign nationals. Utilitarianism and African communitarian ethics

of *Ubuntu* yield the same conclusion. The State ought to be concerned for the health and well-being of all the members in her territory. This is very important in public healthcare and ought to inform the policies and laws we develop for public health in South Africa.

The Kantian theory of deontology is like the utilitarian theory in that it is the dominant theory in the Global North, which is quite different to the African communitarian ethic of *Ubuntu* (which is rooted in African culture and principles). The Kantian theory of deontology focuses on the act. We ought to do what we have a duty to perform. This does not consider maximising good (Rachels and Rachels, 2010). Precisely, morality ought not to be about maximising the good. It is about following moral rules or performing our duties (Rachels and Rachels, 2010).

Rachels and Rachels write that Kantian theory of deontology prescribes that the morality of an act is based on the extent to which an act is right or wrong, and it does not consider the resulting consequences but rather considers their fulfilment of one's duties (Rachels and Rachels, 2010). It appeals to goodwill and appeals to our ability to reason as people. In Kantian deontology, there is a difference when referring to *humans* and *persons*. Humans are human beings who are biologically classified as Homo Sapiens, whereas Kant defines persons as humans who are rationally aware/possess rationality/ cognitive sense and can follow moral rules (Johnson and Cureton, 2022).

As a result, not all humans are persons, as some do not meet the cognitive performance/rationality criteria. Therefore, only persons deserve respect and dignity as they are considered rational beings and can respect moral rules meaning they can respect themselves and are ends in themselves. Therefore, all persons (by virtue of their rational ability) have the right to common respect and dignity. I contend that foreign nationals are persons in this case as they are rational beings who are capacitated to make decisions and follow moral rules.

Regarding the distribution of COVID-19 vaccines in SA, the Minister of Health made no means to include foreign nationals (especially undocumented migrants) in the vaccine roll-out at the beginning of 2021(Vearey *et al.*, 2021). This later changed in the year after non-profit organisations rallied together in advocating for documented and undocumented migrants to get the COVID-19 jab (Cassim, 2021). As mentioned before, the intended exclusion of these foreign nationals was unjust under utilitarianism as it was not in the best interest of everyone. It decreased the overall utility for everyone involved as COVID-19 is an infectious disease that has resulted in a pandemic and millions of deaths around the world. So, the exclusion of foreign nationals puts the lives of foreign nationals in danger and the rest of the lives of the citizens in the country. Furthermore, it is a public healthcare threat, as it has shown us in the last two years that it is capable of crippling our healthcare system. Under the Kantian theory of deontology, the act is unjust as it is simply not morally correct. It does not fulfil the state's duty of efficiently providing healthcare.

Rachels and Rachels (2010:130) wrote about how the deontological view asserts that some characteristics of acts (and maybe their consequences) determine whether they are morally correct or morally wrong (Rachels and Rachels, 2010). Kantian deontology is taken from what Kant referred to as the Categorical Imperative. This principle has various formulations: the first is the Formula of the Universal Law of Nature, the second is the Humanity Formula, and the third one is The Kingdom of Ends Formula (Johnson and Cureton, 2022). The first formulation prescribes that you are to act or commit actions in that maxim in which you can simultaneously want that it become a universal law (Johnson and Cureton, 2022).

The second formulation requires individuals to consider humanity as an end in and of itself, never as a means to an end, whether it be an act towards yourself or another person (Rachels and Rachels, 2010). It speaks on Kant's moral theory's core of respect for persons. You are to act in ways that avoid simply utilizing people to meet one's ambitions, wherever you are, and with whomever you are. You must, in particular, treat people how you would like to be treated. In the case of the pandemic, as mentioned above, the intention is to exclude foreign nationals from life-saving healthcare services (the vaccine), which is intuitively wrong since this is not how we would like others to treat us. The exclusion of persons, based on furthering national interests (which can be assumed in the case of vaccine roll-out), from vital public healthcare interventions is a public health threat, especially in a pandemic. Whether motivated by national interest, carelessness or malice, decisions like this result in the loss of lives and fail to honour persons.

The third formulation states the idea of a "systematic union of various rational beings under common laws," sometimes known as a *Kingdom of Ends*. It is strongly related to the idea that every rational will must view itself as establishing laws that bind all rational wills (Johnson and Cureton, 2022). Therefore, *we must* act in line with the maxims of a person providing universal laws for the kingdom of ends that may be. It integrates the other two in that it (i) mandates that we follow the rules set forth by an ideal moral law, (ii) that this law establishes universal laws that bind all rational wills, among them our own, and (iii) that these laws are of "a merely possible kingdom"—each of whose members enjoys the status of the legislator of universal laws equally—and are therefore to be regarded as an end in themselves at all times. This formulation is based on the intuitive notion that our primary moral duty is to only act in accordance with values that could be accepted by a community of completely rational beings, each of whom would have an equal say in enacting these values for their community (Johnson and Cureton, 2022).

Furthermore, Kantians believe that people must never be seen merely as a means to an end but rather as ends in themselves (Tsotsi, 2009). Rachels and Rachels (2010:130) wrote that "treating people *as an end* means treating them well on the most superficial level. We must promote their welfare, respect their rights, avoid harming them and generally endeavour, so far as we can, to further the ends of others" (Rachels and Rachels, 2010). Foreign nationals mostly come to SA in search of a better standard of living as economic migrants. They contribute to the economy in many significant ways, such as paying taxes (for example, VAT and PAYE), working low-skill jobs, and many other contributions that will be discussed later on (StatsSA, 2011). However, when they require some healthcare services, they are met with mistreatment and discrimination (Daily Maverick (Spotlight), 2021).

According to Kantian ethics, this stigma and discrimination shown towards foreign nationals at public healthcare facilities, including acts such as the demand for legal documents, affordability misclassifications, conditional access to healthcare, refusal of treatment, and, in some cases discrimination and verbal abuse by healthcare workers, is morally wrong (White and Rispel, 2021). It undermines their personhood and violates their rights to healthcare. Kantian ethics also do not support any form of harm, ill-treatment or suffering towards a person (Rachels and Rachels, 2010).

Again, Kant claims how you treat a person should reflect and respect their inherent moral being or status. They are to be treated as persons in their own right. In other words, he prescribes that no one be used as a means to an end, just as a resource, but rather to respect their human rights and the choices they make as autonomous beings (Hodson, 1983). So, excluding foreign nationals from the provision of healthcare is disrespectful to individuals who have a moral status by virtue of rationality. In Kantian ethics, all people have rights that should be upheld by virtue of their rationality. Depriving one of the basic human rights to healthcare would be a violation of their rights, their personhood and dignity, which is, therefore, unacceptable under Kantian ethics. This Kantian deontological approach bases all its arguments on morality on respecting people. As people, we are born with fundamental human rights, including the right to human dignity and respect (Hodson, 1983).

Respect for persons and human rights speaks to equality and fraternity. Suppose we all choose to be part of a community that upholds Kantian morality. In that case, we ought to

accept and respect the rights of others and their personhood. In this regard, we cannot take a distant approach and turn a blind eye to the struggles of inequality in our communities. We have to accept that we have an obligation to support and implement the established policies and legislature that state that foreign nationals have a right to access state-funded services from healthcare facilities to enhance their personhood. This will be a way to treat humanity, either in one way or another, as an end and never merely as a means.

One of Kantian theory's most vital points is the duty to treat everyone equally. For example, it would not be considered a moral act for someone to grant oneself exceptional rights. This could include that discriminating against others is not treating people as equals. Additionally, one has a fundamental duty to respect another person's choice and human rights. Furthermore, Kantian ethics does not support any harm or pain towards another *person*. To this end, discrimination of other persons at public healthcare facilities and maltreatment of persons by healthcare workers is unacceptable from the Kantian perspective.

2.5 Principlism and Who Ought to receive *What* Healthcare?

In the previous section, I argued using Kantian ethics that the State has an ethical obligation to provide state-funded healthcare to foreign nationals as it respects individuals who have rights by virtue of their personhood. Excluding foreign nationals from such provisions violates these rights (specifically the healthcare right).

Biomedical ethicists in our modern times often use a principle-rooted point of view when questions that pertain to healthcare confront them. In this section, I will discuss how Principlism yields the same conclusion. It claims that moral problems can be best approached by applying basic principles (Beauchamp and Childress, 2008). Essentially, Principlism draws from many moral theories, including Deontology and Utilitarianism, as all four principles find some relation to these moral theories.

To interpret what the morally right or wrong act is in a particular situation or case, you need to apply principles, considering both the rules and consequences of that action. Beauchamp and Childress (2008) – hereafter: B&C – describe Principlism as a framework that may address ethical challenges (Beauchamp and Childress, 2008). B&C lists four basic principles: respect for autonomy, beneficence, non-maleficence, and justice. Under Principlism, excluding foreign nationals from state-funded healthcare would be morally wrong and unjust. To thoroughly defend my stance, I refer primarily to beneficence, non-maleficence, and justice principles.

Beneficence And Non-Maleficence

Beneficence is an ethical principle that prescribes the positive duty to act in ways that promote the welfare of others, do good for others and act in their best interests (Beauchamp and Childress, 2008). It is a positive duty to do good for others. Non-maleficence, on the other hand, is defined as refraining from harming others. It prescribes a negative duty to refrain from harming others through acts of commission or omission (Beauchamp and Childress, 2008). Acts that prevent and eliminate harm are perceived as *good acts* taken for the benefit of others and are often categorised with other acts that bring about positive outcomes as examples of beneficence (Anthony, 2009).

The utilitarian principle of utility influences Beauchamp and Childress's thinking about beneficence. Utilitarianism prescribes that the utility of an act ought to be weighed against the act's capacity to maximize/optimize happiness. (Rachels and Rachels, 2010). As seen in the case of the vaccine roll-out, where foreign nationals are excluded from life-saving healthcare interventions, the overall utility is decreased and there is no beneficence to those who are disadvantaged. Therefore, this approach is morally wrong.

Suppose the principle of non-maleficence is the omission of wrongdoing/causing harm. In that case, this deliberate act of exclusion of foreign nationals from the vaccine roll-out, which is essentially exclusion from a life-saving health intervention, is a failure to act for the good of others. An exclusionary principle based on nationality is harmful. It intends to inflict harm whether it manifests in real-time or not. This means that under the principle of non-

maleficence, especially in this case, excluding foreign nationals from state-funded healthcare is morally wrong.

I specifically focused on the principles of beneficence and non-maleficence because these principles exhibit the moral notions shared that are dominant in African culture (Behrens, 2013). However, respect for autonomy is based on respecting another person's right to self-determination/choice (Beauchamp and Childress, 2008). It is also based on respecting others and the idea that people should make independent decisions. This does not necessarily support communality and all that is required from us and in us when we live in communities as seen in the African communitarian ethic of *Ubuntu* (Metz, 2021). Against this background, beneficence and non-maleficence are more relevant for interrogating my primary research question. Nonetheless, notice that respect for autonomy is not necessarily doomed because of the way it is conceptualized by B & C. The more African principled term *respect for persons* proposed by Kevin Behrens (2013:2) in his paper, *Towards an African Bioethics*, can be one-way revising respect for autonomy to align with African values (Behrens, 2013).

Justice

Justice is the fourth principle in Principlism, and it has a derivative referred to as distributive justice. In various contexts, different people have varied ideas of what justice is. Under this principle, excluding foreign nationals from providing state-funded healthcare is unjust based on the principle of justice that prescribes that we ought to act fairly and treat people justly. John Rawls' opinion of justice is relevant here. Rawls contends that how we can understand justice is connected to the way we reason as people. He wrote:

> We do not look at the social order from our situation but take up a point of view that everyone can adopt on an equal footing. In this sense we look at society and our place in it objectively: we share a common standpoint along with others and do not make our judgements from a personal slant. (Rawls, 1971; Rawls, 1993)

This relates to how we treat others and our duty to ensure fairness. Therefore, justice is described as the fair, proper and equitable manner in which people are treated concerning what is owed or due to them (Rawls, 1971). Rawls suggested that distributive justice principles are normative principles that advise scarce resource rationing (Rawls, 1971). The principle of justice makes various ways of materializing fairness possible. Some support *Strict Egalitarianism*, and some are inclined towards the *Difference Principle*, while others support the *Resource-Based principles* (Rawls, 1971; Dworkin, 1981).

Strict or Radical Egalitarianism is commonly used to ration scarce resources in healthcare. It is the idea that everyone should have the same level of service and supplies (Rawls, 1971). This principle is justified by the concept of the same respect for everyone and that the most formidable way to give respect to everyone is by providing quality and access to basic goods and services (Nielsen, 1979). Rawls proposed that every person had an equal claim to basic rights and liberties (Rawls, 1971). For the right to health to be seen as a moral right, it is best supported by the equal provision of access and opportunity (Shelton, 1978). Justice, henceforth, requires that individuals have access to the essential minimum of health. Access to the essential minimum of health refers to the lowest standard of healthcare that the State ought to provide, and individuals ought to receive at least this. The State is responsible for

ensuring this for all those in the country. Therefore, excluding foreign nationals from state-funded healthcare would mean the State still needs to honour its duty.

The 2007-2008 National Public Service Access Survey carried out on 3,000 foreign nationals organised by the Migrant Rights Monitoring Project (under the ACMS at Wits University) in cities such as Johannesburg, Pretoria, Cape Town, Durban, and Pretoria Port Elizabeth, around 30% of those who took part in the survey had had some challenges when they needed to access some healthcare services at public healthcare facilities (Vearey, 2011). This survey contributes to research that was done in earlier years by the 2003 National Refugee Baseline Survey, wherein around 17 % of refugees and African asylum seekers who sought access to emergency healthcare services did not receive any assistance, and of which 45% of these cases specified that the administrative staff at the State healthcare facilities were the ones denying them access to healthcare services.

The survey results also depicted that around 26% of refugees and asylum seekers were denied admittance to healthcare assistance as they couldn't afford the treatments and 14 % indicated that the public healthcare facility refused their legal documents (Belvedere, Pigou and Handmaker, 2008). As a result, the refugees and asylum seekers had to pay for services from their own pockets or would ask for assistance from their friends and family (Belvedere, Pigou and Handmaker, 2008). Although sample size limitations might have affected these studies (therefore, the results might not represent the current situation), they do signal non-implementation of the law.

A critic may point out here that nationalism is of paramount importance in respect of patriotism- governments should first and foremost prioritise their own and then consider foreign nationals. Firstly, that is a flawed concept as governments are yet to consistently prioritise the livelihoods of their citizens in the current capitalist state. This is seen in the low living standards of citizens caused by corruption, poor service delivery and the high inequality rates amongst the rich and the poor, particularly in SA. Furthermore, the legislature of the country in itself recognises foreign nationals as persons who are to benefit equally in public healthcare services and does not exclude them.

Secondly, states cannot prioritise the well-being of South African citizens more than that of foreign nationals, as they are required by the utilitarian principle to be equally concerned for the well-being of all those in the country. Kantian deontology emphasises equal respect for persons' rights and treating persons as ends. Hence, if the State were to prioritise its own over foreign nationals, that would mean that it disregards and disrespects the rights of foreign nationals and their dignity. It would be treating them as a means to an end, as they would not be seen as deserving of rights based on the categorical imperative to honour the humanity in oneself or of another. Similarly, *Ubuntu* prescribes that we act in ways that bring about harmony by advancing the good of others and showcasing humanity to them. We do what we would like to be done for and to us, therefore promoting nationalism when it comes to access to healthcare and resources would be an act that does not keep harmony in our communities and would be morally wrong as it would promote a spirit of othering and not solidarity or communion.

2.6 Considering State-funded Healthcare Access from Public Health Ethics Perspective

In the previous sections, I argued using the bioethical principles of beneficence, non-maleficence, and justice to support the claim that the State has an ethical obligation to provide state-funded healthcare to foreign nationals. Public health ethics are also relevant in this regard, even though they speak from a population-based perspective rather than an individualistic one.

Public health ethics is a field of applied ethics still in its infancy. It aims to outline the moral implications of various circumstances to improve the health and healthcare access of the country's population (Marckmann *et al.*, 2015). Public health ethics include the use of frameworks to justify the public value of (possible) practices (Kass, 2001). The field of public health ethics has advanced significantly since the early 2000s when the most well-defined perspective on the subject first emerged (Kass, 2004). Public health ethics serve public health. This differs from medical practice since its goal is to address issues concerning the population's health vis-à-vis the prevention of diseases, health promotion and protection. In contrast, the medical practice mostly aims to promote and treat the individual's health (Kass, 2004). We saw how important it is to have public health frameworks in place during the pandemic as they have assisted in promoting and protecting population health worldwide.

Public health ethics prescribes notions like utilitarianism, beneficence, and the African communitarian ethics of *Ubuntu* in that they are centred on doing what is best for the population. Public health requires a focus beyond how one individual is affected and

recognises how people from various social corners may be jointly impacted by certain acts threatening equality to healthcare access and other services.

Of fundamental importance in public health ethics is the issue of othering. *The othering* of foreign nationals has affected our communities as the greater good and progression of social goods such as healthcare access have been compromised. An example of *othering* is the exclusion of foreign nationals from the South African vaccine roll-out, as mentioned before. Vaccine hoarding or nationalism has led to the biggest threats to public health the country and the world has ever faced in recent years as it allowed the spread of the COVID-19 virus (over the last year), resulting in the deaths of many people around the country. Furthermore, at an enlarged scale, the hoarding of vaccines by the northern-rich countries left continents such as Africa and South America struggling to contain the infection rate and death rate caused by COVID-19 during the pandemic. This has held back the world from acquiring herd immunity at an efficient rate, lengthened the duration of the pandemic and further impoverished many countries. The point of the preceding, similar to my point under Utilitarianism, is that exclusionary principles are not in the best interests of public health.

2.7 Conclusion

I have defended the claim that the State has an ethical obligation to provide foreign nationals with state-funded healthcare by applying various moral theories, respectively. The application of various moral theories to various unfair realities that foreign nationals had faced when accessing public healthcare facilities prescribed the acts as morally wrong. Thus, the

argument that the State has a morally recognised obligation to do what is fair and proper in providing state-funded healthcare for all holds.

Although access to healthcare for all is a public health priority and the backbone of existence, we must also realise that the point to which healthcare for all can be provided is limited as it relies on the availability of resources and other circumstantial factors to the South African context. In the next chapter, I will justify the position that providing state-funded healthcare to foreigners is also a legal duty. Under the Constitution, I acknowledge Section 27(2), which says that the State ought to take reasonable measures towards the progressive realisation of the right and Section 36, which speaks on the limitation of rights based on State resources. Section 36 (1) (a–e) of the Bill of Rights of the Constitution of the Republic of SA is particularly relevant to my analysis. I also demonstrate that the NHA and international law support that excluding foreign nationals from state-funded healthcare would be unconstitutional and unlawful.

CHAPTER 3: ACCESS TO HEALTHCARE AND EXISTING LEGISLATION

3.1 Introduction

In the previous chapter, I argued that the State has an ethical obligation to provide state-funded healthcare to foreign nationals despite the South African public healthcare crisis. I drew on several examples including those from the COVID-19 pandemic, this was for several reasons. Notably, the South African public health crisis raises key questions regarding scarce resources. The pandemic is a quintessential instance of resources scarcity.

Against this background, I synthesised the theory of utilitarianism to support the provision of state-funded healthcare to foreign nationals as this would increase utility for everyone; the adaptation of the African Communitarian ethic of *Ubuntu* prescribes that it would be a violation of the African principles, mentioned previously, to exclude foreign nationals from state-funded healthcare; under the consideration of Kantian ethics, I synthesised that it equally mandates that the provision of state-funded healthcare is the right thing to do and the exclusion of foreign nationals would be disrespectful as it is an infringement of their basic human healthcare right. Similarly, I demonstrated that the principles of beneficence, non-maleficence and justice imply that excluding foreign nationals from the provision of state-funded healthcare would be morally wrong and unjust. Lastly, from the public health ethics perspective, providing state-funded healthcare to foreign nationals would be in the best interest of public health.

The reader will be correct to observe that the previous chapter only explores the morality of excluding foreigners from various ethical perspectives. This chapter explores this question from a legal standpoint. Specifically, the chapter explores whether it is lawful to exclude

foreign nationals from state-funded healthcare in SA, despite the public healthcare crisis. I argue that excluding foreign nationals from the provision of state-funded healthcare would be unlawful by drawing on the legal provisions. Due to the current political and economic climate, questions will arise regarding whether foreign nationals should be provided or entitled to this right. I will explain this using the current law on the right to health and the judiciary's interpretations in cases they have deliberated on in Courts.

It is worth emphasizing here that all socio-economic rights, including the right to access healthcare, are stipulated in the Constitution. The rights provided in the Constitution are afforded to everyone on South African land, without considering their nationality or citizenship. All are entitled to such rights as long as they are in South Africa. Furthermore, as I have hinted in the Introduction, this right also extends to those who cannot afford healthcare, implying that state-funded healthcare would also be available. The Constitution, in Section 7 (1), states that:

> This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom. (The Constitution of the Republic of South Africa, 1996)

In addition, the mentioned socio-economic rights, including healthcare rights, are further upheld, and protected within the Constitution. The State is obliged to safeguard, uphold and fulfil the rights captured in the Bill of Rights in the South African Constitution as per Section 7 (2) of the Constitution (The Constitution of the Republic of South Africa, 1996).

Further, the Preamble of the Constitution functions as an encouraging reminder of what South Africans are to believe, and it read as follows:

We, the people of South Africa,

Recognise the injustices of our past.

Honour those who suffered for justice and freedom in our land.

Respect those who have worked to build and develop our country; and

Believe that South Africa belongs to all who live in it, united in our diversity. (The Constitution of the Republic of South Africa, 1996)

The significance of the inclusion of the last line should not be understated as it is inclusive of one of the values the nation is known to uphold globally, namely *Ubuntu*. It calls on *all* who live on the land to unite. The acts of discrimination and exclusion do not exhibit unity and societal harmony.

In considering the legal framework, I rely on Section 27 of the South African Constitution (found in Chapter 2, known as the Bill of Rights (BOR)) that prescribes healthcare right for all, including those who *are unable to support themselves and their dependents.* I will also draw on Section 4(3) of the National Health Act (NHA), which stipulates the entitlement to free primary healthcare services for all at public healthcare facilities, and on Section 27 (g) of the Refugees Act that stipulates foreign nationals' right *to have access to equal* basic services in healthcare as South African citizens. In addition, I will also draw on the Immigration Act of 2002.

Furthermore, I consider the following cases: Khosa v Minister of Social Development (2004) (regarding equality and non-discrimination); Soobramoney v Minister of Health (2002) and Minister of Health v. Treatment Action Campaign (2002) (both, regarding the progressive realisation to the right to healthcare). Mainly, I appeal to these cases to highlight historical accounts of judicial deliberations that could support access to state-funded healthcare in the

face of scarce resources. I will justify how these deliberations equally apply to foreigners. I also look at Larbi-Odam and Others v Member of the Executive Council for Education (North-West Province) and Another (1997) (case about discrimination under the equality clause in the Constitution).

One critical differentiation – essential for following the discussion in this chapter – is the distinction between civil and human rights. This is important because the healthcare right is a both recognised as a human and a civil right as it is set out in international laws and the Constitution under the BOR. A human right is distinct from a civil right since a human right arises simply by being a human being (Law Library Howard University School of Law, 2018). These are rights that one has as a recognition of their personhood, regardless of geographic location. In contrast, citizenship is the only way one is entitled to civil rights (Law Library Howard University School of Law, 2018).

Human rights tend to be universal and recognised internationally. In contrast, civil rights are specific to a country and tend to be recognised locally and nationally (Law Library Howard University School of Law, 2018). Additionally, human rights are regarded as among the most essential rights. Some of these are the right to freedom of expression, life, safety from torture, fair trial, and education. The Bill of Rights (BOR) is introduced in Chapter 2 of the 1996 Constitution of the Republic of South Africa (hereafter: the Constitution), from Sections 7 to 39 (The Constitution of the Republic of South Africa, 1996). The BOR outlines all South African citizens' civil rights, which operate as a co ntract between the government and its people.

Following World War II, human rights were taken more seriously, especially in light of the Nazis' horrors against Jews and other vulnerable populations. These events significantly contributed to the WHO's 1946 Constitution, wherein the healthcare right was ratified. 1948 saw the UN General Assembly adopt the UDHR, which strengthened the organization's foundation in international law and policy (The United Nations General Assembly, 1948). The general UN assembly enacted the International Covenant on Civil and Political Rights (ICCPR) on the 16th of December in 1966 and set out its implementation in 1976 a fter gaining a significant number of treaty member nations (International Covenant on Civil and Political Rights', 1966). According to these international agreements and declarations, human rights are defended as universal, whereas civil rights are particular to a country and are stated in that country's constitution. The goal was to solidify further the political and civil rights mentioned under the UNDHR (that has been previously discussed).

Nonetheless, civil rights intersect with human rights. An example is where the BOR mentions the right to freedom of speech and life, both defined as essential human rights but equally recognized by different States as civil rights. Theoretically, regardless of citizenship or immigration status, everyone living within a country's borders is entitled to some human rights. However, *progressive realization* addresses the real-world limitation that countries experience which hinders them from providing everyone with their due. This is especially true for third-world countries as they experience limitations such as scarcity of resources, lack of political stability, corruption, and so on. In this regard, I acknowledge that my argument would imply that governments have at least a prima facie duty and not necessarily an absolute duty to provide state-funded healthcare.

As mentioned before, the healthcare right is a right that is both recognised as a human right and a civil right as it is enlisted in international laws and the Constitution under the BOR. Even though the State recognises the healthcare right as a fundamental human right, the Human Rights Commission once noted that there is no clear definition of what that implies and that actual assessment of the fulfilment of the right may not be achievable (Gruskin and Daniels, 2008). This is one drawback of a concept entirely reliant on human rights (Gruskin and Daniels, 2008).

According to Gruskin and Daniels (2008), a strategy reliant on human rights is particularly efficient at identifying any political, social, or other issues that governments need to solve and at emphasizing states' duties to do so (Gruskin and Daniels, 2008). However, because human rights prescriptions cannot identify which group should be given priority, human rights often offer insufficient guidance in the decision-making process to implement a right. Instead, they imply that individuals seeking healthcare, especially in state-funded facilities, ought not to be denied unless the care they seek or require is not available. Notice that this does not imply that individuals no longer have that right but that there is nothing to give. And a government's failure may be responsible for this. Despite having deep ethical roots, human rights fail to offer guidance on prioritising the realisation of various rights for anyone (Gruskin and Daniels, 2008). Gruskin and Daniels (2008) contend that the advantages of human rights and moral precepts like distributive justice (and others mentioned in the preceding chapters) can be used together to address allocation issues to fulfil individual rights.

This is another issue with the South African legislature that makes it challenging to address the decision-making process when providing state-funded healthcare to foreign nationals by the state. Differences in the text, understanding, and application of laws and policies at the provincial stage increase this legislative gap (White and Rispel, 2021). Resource shortages in the state-funded health sector worsen the perception of the healthcare system's dysfunction, which impacts the economic status, level of healthcare, and accessibility of all those dependent on the public sector (which further limits foreign nationals' access to state-funded healthcare). However, besides the documented dysfunctionality of legislature, foreign nationals experience, in addition, instances of medical xenophobia in the face of healthcare access. The only way South Africa can achieve its goal of universal healthcare (UHC), as articulated through the NHI system, is through the continuous rectification of such issues (White and Rispel, 2021).

These disjuncture's in the legislature do not justify the infringement of the healthcare right that occurs in the instance of exclusion of foreign nationals from state-funded healthcare. In the argument that excluding foreign nationals from state-funded healthcare is unlawful, unlawful is defined as implying unconstitutional or not permitted by l aw or illegal. This means, considering the interpretation of the South African legislation in this chapter, excluding foreign nationals from state-funded healthcare, would be unconstitutional and unlawful. I explore this meaning in my subsequent subchapters.

3.2 The Constitution and Unconstitutionally Excluding Foreigners

The Constitution is a set of foundational values and principles a country uses to run its affairs (The Constitutional Court of South Africa, 2021). It can be viewed as an agreement between the country, the State, and its people. It outlines citizens' obligations and rights and safeguards against the abuse of authority. The Constitution of the Republic of South Africa is the nation's utmost superior legal document (The Constitutional Court of South Africa, 2021). In the country, it is seen as the highest law, also known as the *lex fundamentalis*.

It is also known as the 'birth certificate' of the democratic and free SA we know today (The Constitutional Court of South Africa, 2021). Parliament passed the Constitution in 1996, outlining the rights and obligations of its citizens, enacting the Republic's legal foundation, and outlining the nature of the government (The Constitution of the Republic of South Africa, 1996). Parliament may serve as the supreme legislative body in the context of the Constitution and governmental system. However, any unconstitutional Act, Law, or Governmental Body, including Parliament, is invalid (The Constitutional Court of South Africa, 2021).

Human dignity, gender and race equality are just a few of the values upheld by the Constitution. These principles uphold democracy and are shared by many other democracies globally (The Constitutional Court of South Africa, 2021). Healthcare providers at public healthcare facilities and civil society groups (CSOs), such as non-governmental organisations (NGOs), base their operational policies and decisions about foreign nationals' ability to access state-funded healthcare services on the prescriptions of the Constitution and any other policies rendered out by the National Department of Health (NDOH). However, some

policies and acts in SA deviate from the Constitution and complicate healthcare decision-making regarding the right to healthcare for foreign nationals in public healthcare.

Our Constitution is integral to developing and implementing health laws and policies. The BOR primarily determines all legislature and related policies and is directly implemented by our judiciary (Hassim, Heywood and Berger, 2007). Section 7(2) of our Constitution lists pertinent obligations of the country. According to Section 7(2), the State needs to uphold, respect, and advance the BOR's principles (The Constitution of the Republic of South Africa, 1996). Therefore, the State is required to:

- Uphold everyone's right to obtain healthcare services in a way that does not interfere unduly or unreasonably with their ability to do so, whether such is acquired from private or State facilities.
- Defend the healthcare right through creating and enforcing an inclusive legal system to deter obstruction of others' access.
- Set out a legal framework that would aid people to easily benefit from their rights.
- Uphold the healthcare right through establishing favourable circumstances for people to receive healthcare, either by improving healthcare systems, training healthcare professionals, providing incentives to healthcare workers, and providing emergency transportation and efficient services relating to healthcare. (The Constitution of the Republic of South Africa, 1996)

I will refer to some rights under the BOR as socio-economic rights. Socio-economic rights are human rights that afford us access to basic standards of living, live a dignified life, and

perform our everyday duties within our societies (Brand and Heyns, 2005). These include the right to housing, education, health, employment, etc. The Universal Declaration of Human Rights and many other related treaties for human rights recognised globally, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), uphold these rights.

Socio-economic rights, like the right to healthcare, are incredibly vital for minorities such as foreign nationals who might be vulnerable in their communities since these facilitate their successful integration into these communities and societies as they gain access to resources and opportunities to basic needs for living. The State, together with all stakeholders, such as healthcare providers, have an integral role in the advancement of socio-economic development strategies in order for them to include health services as it is one of the most crucial socio-economic rights for an individual and societal good standard of living (Brand and Heyns, 2005).

The reader will note that the Constitution's BOR does have rights that do not apply to foreign nationals. These rights are reserved for the enjoyment of citizens only. They are as follows: political rights as understated in Section 19 (such as voting), Citizenship as understated in Section 20, applications for specific residencies and passports in terms of Section 21(3) and (4) and freedom of employment and trade and commerce as stated in Section 22. In this research study, I outline a few sections enshrined in the BOR in order of their relevance to argue that the exclusion of foreign nationals from state-funded healthcare is unlawful. These sections include Sections 9, 10, 11, and 27.

Section 27: Right to access to healthcare.

I will start with Section 27 of the Constitution as it is the main section where I draw my argument, and the subsequent sections support it.

Section 27 of the Constitution asserts the right for all to:

> (1a) access to healthcare services, including reproductive healthcare, 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 Constitution of the Republic of South Africa, 1996)

From the above, the reader will note that there is no discrimination according to nationality or legal status as per use of *all*. Most importantly, subsection (2) highlight the progressive realisation of this right which is a crucial element in the access to healthcare for all. It solidifies the obligation of the State to the deliverance of healthcare for all. The *progressive realisation* can be defined as the obligation the State has to improve and fulfil the realisation of rights classified as socio-economical for everyone, though subject to available resources (Hassim, Heywood and Berger, 2007).

Section 27's goal is to assure substantive and formal equality for all those in SA when utilizing healthcare services. SA is known for its high inequality; therefore, it is crucial that the State recognises these shortfalls in the advancement of access to healthcare for all. Formal equality is the idea that all people must receive equal treatment, while substantive equality seeks to remove or exchange the *social standards* that impede equality (Hassim, Heywood and Berger, 2007). Race, sex, gender, and HIV status are examples of formal conditions which ought not to hamper access to healthcare services in the country (Hassim, Heywood and Berger, 2007). Section 27 aims to promote level opportunity concerning access to

healthcare services regarding substantive equality, such as level to one's earnings or where one resides. The state's positive duty is not only to refrain from interfering with others' healthcare access, but it must also provide that service to everyone residing in SA (Hassim, Heywood and Berger, 2007).

Moreover, it can be deduced that Section 27 mandates States to make healthcare available to those who cannot afford the same to ensure substantive equality as the right to access healthcare applies to *all*. The State should make means to protect the right to healthcare at public healthcare facilities by making sure that healthcare professionals respect this right. The State is responsible for guaranteeing that the already available healthcare services are accessible to those in need. To ensure this, it should implement codes of conduct that inhibit healthcare professionals from using their discretion when providing and accessing state-funded healthcare for foreign nationals.

Unfortunately, leaving access to state-funded healthcare at the discretion of healthcare professionals tends to lead to limited or no access to healthcare for foreign nationals as they have spoken out about being met with discrimination and mistreatment (Ncube, 2017). For instance, the cases of the two pregnant women in the previous chapter (*Araya Y* and *Francine Ngalula Kalala*). It is also imperative for healthcare professionals to stand by the commitments they made once they were sworn into the profession, according to the Hippocratic Oath. This Oath is taken as a commitment and as a long-standing binding code of conduct for healthcare professionals that tackles two crucial issues: being of help to the sick and safeguarding patients from harm and injustice on a personal and societal level (Kantaraji and Steensma, 2014).

The healthcare right to seek emergency treatment, as stipulated in Section 27, has long presented difficulties for national, provincial, and municipal healthcare professionals and providers. Foreign nationals frequently attempt to enter the healthcare system. Healthcare professionals constantly struggle with how to treat their patients when dealing with legal issues related to their patients' status (Hassim, Heywood and Berger, 2007). The Constitution's reasonably broad definition of *access to healthcare* may make it open to interpretation, but some cases may be subject to restriction under Section 36 of the Constitution. Surely, in some cases there will need to be a more nuanced approach that relies on more than the consultation of legislation, customary law, common law, and case law to aid in the interpretation of some sections (outlined in Section 39). The State needs to do more in educating those at points of healthcare on the laws and regulations and how these are to be applied in different cases.

To monitor compliance to the prescriptions of the Constitution, investigations into violations of these rights must be conducted via the South African Human Rights Commission (SAHRC). Through the hearings they hold to investigate the implementation of the right to access healthcare, the SAHRC has a constitutional obligation to protect, promote, and realise human rights. The findings of such hearings could provide valuable counsel. They can be a forum for government and other groups to plan and implement strategies to enhance the implementation of the rights recognised by the Constitution, in addition to being used to assess the achievement of those rights (Hassim, Heywood and Berger, 2007).

Section 9: right to equality

To promote human equality, Section 27 of the Constitution supports Section 9, referred to as the *equality clause* (Hassim, Heywood and Berger, 2007).

Section 9 states that:

> (1) Everyone is entitled to equal protection and treatment under the law.
> (2) Full and equal realization of all rights and liberties is a component of equality. Legislative and other actions that protect or advance individuals or groups of individuals negatively impacted by unequal treatment may be conducted to advance the cause of equality.
> (3) The State is not allowed to act unfairly toward anyone based on one or more factors, such as social or ethnic origin, gender, race, sex, marital status, pregnancy, colour, age, sexual orientation, religion, disability, language, belief, conscience, place of birth or culture.
> (4) No one may unfairly discriminate against someone implicitly or explicitly for any reasons in accordance with sub-Section(s) (3). Unfair prejudice must be addressed or outlawed by national legislation.
> (5) Unless it is proven that the discrimination is fair, it is unfair to use one or more of the reasons specified in sub-Section (3). (The Constitution of the Republic of South Africa, 1996)

The implied notion by this Section of the Constitution is that everyone is on an equal footing and is entitled to the same level of protection and legal advantages. Since everyone is equal, bigotry on the basis that one speaks a different language, has a different culture, marital status, age, religion, or any other factor that may be different from you is duly viewed as

always unfair and unjust. Only in very strict and unlikely instances is it justified and demonstrated to be fair. Appropriate national legislation ought to be referred to in order to assess and stop unjust discrimination based on the aforementioned discriminatory grounds (The Constitution of the Republic of South Africa, 1996). This legislature can be the Constitution and the many other Acts passed under South African law.

It is critical to recognise that foreigners are and can be vulnerable and a minority in any country. For instance, in the Larbi-Odam and Others v Member of the Executive Council for Education (North-West Province) and Another (1997)[13] which was a case about discrimination against a foreign national regarding employment eligibility (which is also a socio-economic right just as the right to healthcare as per the Constitution), found that because foreign nationals are minorities in any country they find themselves in and have little to no political standpoint, it was determined that citizenship was an indeterminate basis of discrimination under the interim Constitution's *equality clause* (The Constitution of the Republic of South Africa, 1996). Citizenship is a personal trait that cannot be changed, and occurrences of threats and abuse make foreign nationals even more vulnerable. The Court determined that excluding someone based on citizenship would be discriminatory when applicants for employment include both citizens and foreign nationals (Mavenika, Odeku and Raligilia, 2014).

[13] Larbi-Odam and Others v Member of the Executive Council for Education (North-West Province) and Another (CCT2/97) [1997] ZACC 16; 1997 (12) BCLR 1655; 1998 (1) SA 745 (26 November 1997)

Non-discrimination and equality principles encompassed in all SADC countries' Constitutions, meaning that neighbouring countries such as Zimbabwe also share the same sentiments concerning human rights and understanding these rights. These constitute some of the provisions that establish a constitutional foundation for foreign nationals to affirm their healthcare right to state-funded healthcare. Foreign nationals face immense discrimination and stigma at points of care in South African public healthcare facilities as reported by media outlets through requests for identity documents, financial misrepresentation, limited access to healthcare, treatment refusals, and, in some cases, verbal abuse and prejudice from healthcare professionals (South African History Online, 2015; Daily Maverick (Spotlight), 2021). This has stripped them of their equality and human dignity as some cannot speak against this conduct as they fear deportation, xenophobia and being charged exorbitant medical fees (White and Rispel, 2021).

While I do understand that a country's citizens have the right to healthcare as a civil right, it is imperative that we protect that same right as a human right for foreign nationals. Moreover, this also constitutes what Beauchamp and Childress refer to as *a decent minimum of the good life*. Beauchamp and Childress have studied and written about various conceptualizations of justice, including egalitarian theories of justice, as discussed in the previous chapter. Egalitarian theories particularly stress equitable access to all of the things in life that a rational person appreciates (Beauchamp, 1995; Beauchamp and Childress, 2008). According to Beauchamp and Childress, society ought to establish a legal right to a basic standard of healthcare with resources allocated according to egalitarian and utilitarian principles. " (Beauchamp, 1995; Beauchamp and Childress, 2008). Even though this is an ethical theory, it

is very important in influencing laws and regulations and also guiding the application of these in practice.

Section 10: right to human dignity

Section 10 of the BOR prescribes that:

> Everyone has the intrinsic right to respect and protection of their dignity. (The Constitution of the Republic of South Africa, 1996).

Dignity is regarded as being worthy of respect or honour. This idea is used to emphasize that all people ought to receive respect and care since all people have inherent value that is equivalent to that of others regardless of their age, gender, health, socio-economic condition, race, political beliefs, or faith (ten Have and Gordijn, 2014). This innate quality must always be safeguarded and respected.

Everyone has a right to human dignity, which entitles them to respect for who they are as people. Respecting this right encourages an impartial approach to accessing scarce resources (such as those in healthcare) among people. Former Justice of the Constitutional Court of South Africa, Zakeria Mohammed (Justice Yacoob), argued that undocumented foreign nationals had a right to equality, dignity, and freedom in a case presented for Lawyers for Human Rights and Others v. Minister of Home Affairs and Others (2004)[14] even though the ruling did not make

[14] Lawyers for Human Rights and Others v Minister of Home Affairs and Others (CCT 18/03) [2004] ZACC 12;2004 (4) SA 125 (CC); 2004 (7) BCLR 77 (CC) (9 March 2004). A case presided on by Justice Yacoob.

particular reference to healthcare access as it was referring to point out the inherent dignity that everyone deserves and is entitled to (Alfaro-Velcamp, 2017).

Considering the various scenarios of the exclusion of foreign nationals from the provision of state-funded healthcare described and referenced in this paper, the right to human dignity would not be upheld. The exclusion of foreign nationals would, therefore, be undignified and in contempt of human rights which is unconstitutional and unlawful. It is valid to defend and uphold the rights of those likely to be vulnerable (because they are a minority and lack political might) and underprivileged. Further, it can be deduced from the justice principle discussed in Chapter 2 of this paper, that the right to obtain healthcare is unrelated to financial capacity to pay for it and should not be determined by it (Green, 1976). Healthcare access should be established so that those least fortunate benefit (Green, 1976). As per the goal of Section 27, which is to maintain formal and substantial equality in SA, access to this right by the disadvantaged and vulnerable ought to be the main objective as this ensures well-being/welfare.

Section 11

Section 11 states that:

> Each individual has a right to life. (The Constitution of the Republic of South Africa, 1996)

This right is associated with the healthcare right. Good healthcare is vital for maintaining life. In pursuing a quality life, one should have access to healthcare, including state-funded healthcare, irrespective of status, financial capacity, and nationality.

As the South African Constitutional Court is yet to deal with a case that specifically involves foreign nationals in this regard, case law regarding the restricted access to the right to healthcare that foreign nationals experience is not yet accessible. Therefore, the Court has yet to explicitly deliberate and deliver a verdict over if or how (what circumstances) foreign nationals may exercise their right to access state-funded healthcare facilities and services. Nonetheless, several other cases which are relevant and related in some ways can help us understand healthcare rights more broadly.

For instance, in the Soobramoney v. Minister of Health (1998)[15] case, the Court addressed questions regarding the progressive realization of healthcare. It determined that the state's obligations considering the right to obtain state-funded healthcare access depended on the means available for those objectives. The Constitution's Section 27(1) rights may be restricted because of scarce resources, the Court found. Consequently, distributive justice applies to the right to obtain healthcare services and any other socio-economic right. The Court determined that the State must efficiently distribute its resources to satisfy all fundamental demands brought against it.

A critic will be correct to observe that I mentioned that the current healthcare crisis in SA has the nature of a scarce resource. Hence, a critic might contend that the State is justified in limiting access to health by foreign nationals. This could be the case except that when foreign nationals are denied access to health, it is not merely because the State lacks resources but

[15] Soobramoney v. Minister of Health (Kwazulu-Natal) (CCT32/97) [1997] ZACC 17; 1998 (1) SA765 (CC); 1997 (12) BCLR 1696 (27 November 1997).

because they are foreigners – *Amakwere-kwere*. *Amakwere-kwere* is a derogatory *Nguni* word used to refer to foreign Africans in SA (Collins English Dictionary Complete and Unabridged, 2014). Furthermore, this violates the spirit of Section 27 and a foreign national's equal right to be treated with dignity. Moreover, rationing decisions ought not to discriminate against individuals based on nationality.

In her article from 2017, Dr Theresa Alfaro-Velcamp notes how South Africans' socio-economic rights, particularly access to healthcare, have been decided by the Courts in the post-apartheid era, setting precedents like providing HIV-positive moms and new-borns with complimentary anti-retroviral treatment (ARVs) (Alfaro-Velcamp, 2017) . The South African Constitutional Court denied the *minimum core* duty in a different instance involving exercising socio-economic rights.

Justice Yacoob stated in the Grootboom[16] judgment that findings in a certain case might demonstrate a *minimum core* of certain services that ought to be considered when assessing the appropriateness of measures taken by the government. However, in the Minister of Health and Others vs Treatment Action Campaign and Others (2002)[17] case, commonly referred to as the TAC case, he stated that rights classified as socio-economical ought not to be understood as giving everyone entitlement to the provision of the *minimum core*. I elaborate on the minimum core in the next sections. Additionally, the Constitutional Court determined

[16] Government of the Republic of South Africa and Others v Grootboom and Others (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000).
[17] Minister of Health and Others v Treatment Action Campaign and Others (No2) (CCT 8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002).

that the *minimal core* ought to be viewed as potentially compatible to fairness and rationality under Section 27 (2) rather than as a right bestowed by itself under Section 27 (1). The State must take reasonable action to grant progressive deliverance of rights classified as socio-economical as outlined in Section 27, the Court noted.

The Constitution uses *everyone* in its prescriptions of rights. The use of seemingly *everyone* ambiguous but I contend that it has a positive and inclusive interpretation. This interpretation is seen in the National Health Act language use, as well. The BOR provides:

> Everyone must be entitled to and shall be protected by the enshrined and enforceable provisions of the Constitution's fundamental rights and civil liberties [...]. (The Constitution of the Republic of South Africa, 1996)

Also noteworthy is the Constitution's sparse usage of the word *citizenship*, which is mostly only found in Section 19, which pertains to political rights and Section 20, which speaks on citizenship directly (The Constitution of the Republic of South Africa, 1996). The word *everyone* in context refers to the rights of all those in SA throughout the BOR and the majority of the Constitution (The Constitution of the Republic of South Africa, 1996).

South Africans are guided by three laws and immigration regulations that are important under the Constitution concerning their access to state-funded healthcare and emergency treatment. The South African Constitution's intentions for socio-economic rights, healthcare and emergency healthcare access, are made clear by the National Health Act of 1998.

3.3 The National Health Act and State-funded Healthcare

All rights guaranteed by the Constitution are intertwined, inalienable, and mutually supportive. Alternatively, since all rights are intertwined, it is crucial to realize some rights to enjoy others. The Constitution is expanded by the National Health Act (NHA). The national, provincial, and district healthcare systems are organized per the National Health Act (Act 61 of 2003). It aims to provide guidance in the healthcare services, as well as improve and align healthcare services with the nation's socio-economic strategy for development (National Health Act, No. 61 of 2003). In order to implement everyone's entitlement to healthcare, Parliament established the National Health Act (Act 61 of 2003). Section 27 of the Constitution, which obligates the State to gradually realize the right to receive healthcare services within its resources, guarantees this right.

The NHA supports the argument that the exclusion of foreign nationals from the provision of state-funded healthcare is unlawful as Chapter 1, titled [Objectives] Of Act Section 2(c), prescribes:

> The [Objectives] of this Act are to provide regulation of national health and to provision of uniformity concerning healthcare services nationwide by upholding, safeguarding, fulfilling, and promoting the rights of:
>
> (i) South Africans towards the progressive realisation of the constitutional healthcare right [...]
>
> (iv) vulnerable populations, including children, women, the elderly, and people with disabilities. (National Health Act, No. 61 of 2003)

The objectives mentioned above are related to Section 27 of the Constitution. As mentioned before, *progressive realisation* can be defined as the obligation the State has to improve and

fulfil the realisation of rights classified as socio-economical for everyone, though subject to available resources (Hassim, Heywood and Berger, 2007). The objectives speak of vulnerable persons, and I submit the consideration of foreign nationals in that list. Foreign nationals are, in most cases, a minority in any country. Therefore, one might understand that they are easily prone to ill-treatment and have little to no political standing within that country. Some are undocumented, and their unclear legal standing makes them vulnerable as displaced persons, so their socio-economic rights benefit is just as limited as documentation in SA is very important in accessing any social welfare services (McLaughlin and Alfaro-Velcamp, 2015).

The NHA also imposes obligations on he althcare professionals, with the goal of ensuring healthcare access for all. Considering this, the NHA's *Responsibility for health* Section 3(1) mandates that to the extent possible, given the resources at disposal:

> (a) make an effort to safeguard, advance, preserve, and improve public health
> (b) encourage the Republic's socio-economic development strategy to include health services. (National Health Act, No. 61 of 2003)

To improve the health system in our country, it is essential for us and the State to integrate the NHA's several components in policy development and other regulations. This is because the NHA acknowledges the prior disparities in the health services offered and works to create a united healthcare system. Additionally, the BOR and Section 27 are recognized by the Act.

Most importantly, for the argument that the exclusion of foreign nationals from state-funded healthcare is unlawful, the NHA stipulates who is eligible to receive free healthcare services

in public healthcare facilities in Section 4 (3), titled *Criteria for complementary health services in State health facilities*. It provides that:

Withstanding any changes by the Minister, state-funded clinics and community health centres shall provide the following:

> (b) […] everyone with free primary healthcare service, except for members of medical aid systems, their dependents, and anyone receiving compensation for compensable occupational disorders. (National Health Act, No. 61 of 2003)

The NHA uses language similar to the Constitution's in its inclusivity as it refers to all persons. It does not specify its inclusion or exclusion of foreign nationals. Therefore, in interpreting its stipulations, it includes foreign nationals.

The vast difference in the presence of the healthcare right in theory, as provided by these legislations versus in practice has been an issue for years. There are many inhibitors, mainly coming from the State. The State has regular Amendments of Acts and policies which disrupt and confuse those who are on the ground. Moreover, there is a lack of coordination between state structures which makes the implementation of some regulations inconsistent (Kavuro, 2022). Other inhibitors of the implementation of the rights are healthcare professionals' and State officials attitudes towards foreign nationals as I have mentioned different scenarios of discrimination. Even though Courts have deliberated on similar socio-economic rights, the State has been passive in its enforcement of these rights. It is still common practice.

To attest to the public holding the State accountable, CSOs have submitted their concerns to Parliament about the State's violations of the international refugee protection treaties it is signatory. They submitted examples that demonstrate the political unwillingness to uphold

foreign nationals' rights protection and the politicians having an influence on the protection of some rights being undermined (Kavuro, 2022).

3.4 The Refugees Act, Immigration Act and Healthcare for Foreigners

The Refugees Act 130 of 1998 was established in agreement with the 1951 Convention Relating to Status of Refugees, the 1969 Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa, the 1967 Protocol Relating to the Status of Refugees, various significant agreements furthering human rights. SA agreed to several responsibilities to accept and care for refugees according to the criteria and guidelines created by international instruments of law. According to international law, one of these commitments was to cater to the rights and obligations following the recognition of refugee status. As mentioned before, I take refugees as included under the term foreign nationals. The Refugees Act especially mandates including this group of foreign nationals in state-funded healthcare. Chapter 5, Section 27 (g) provides that:

> Refugees are guaranteed the same primary healthcare and education that the Republic's residents occasionally obtain. (South African Refugees Act 130 of 1998)

Within this statement, the Refugees Act recognises and makes provisions for the right to healthcare for foreign nationals. As I have shown, such healthcare will also include state-funded healthcare. Although the Act grounds the provision of the right to state-funded healthcare on their legal status, it still does not allow for the exclusion of refugees, which are foreign nationals, from the provision of state-funded healthcare.

I acknowledge here that the Refugee Act creates a disjuncture in the legislature. The Constitution and the National Health Act are inconsistent with the Immigration Act of 2002 and the Refugees Act because they do not condition the provision of the right to health (state-funded healthcare) on legal status. The Immigration Act 13 of 2002 was established to regulate the admission and departure of people in and out of the country. Healthcare providers are required by the Immigration Act to verify patients' legal status before providing care. Under the Immigration Act Section 44:

> [...] Any government body must make every effort to determine the status or citizenship of those using its services whenever possible. It must notify the Director-General of illegal foreigners or those whose status or citizenship cannot be determined. However, this requirement must not prevent the provision of services to which illegal foreigners and legal foreigners are entitled under the Constitution or other laws. (Immigration Act 13 of 2002)

This means that the State must make an effort to make sure it has reliable authorities who can ensure the status of foreign nationals in the country. Further, the State must have reliable lines of communication and offices of immigration offices. It is a struggle for foreign nationals to get their permits as it is. For instance, the Refugee Reception offices were closed down 2011 and 2012, and during the 2020 national lockdown there were no offices open for foreign nationals to renew their permits even after an extension was announced by State officials (Kavuro, 2022). These kinds of inconsistencies make it difficult for foreign nationals to gain access to essential services in the public and the private sector.

Additionally, the Immigration Act states in Section 49 (4) that it is an offence and subject to a fine for anybody to knowingly assist an illegal immigrant in receiving State services they are not entitled to. This clause highlights how, in terms of healthcare access, the Constitution and Immigration Act disagree. The implications of this disjuncture are grave for foreign nationals. As mentioned before, the lines of differentiation between the groups of foreign nationals are blurred. Unless one has a valid permit, the default assumption is that they are illegal and economic migrants. This stereotyping is one of the root causes of the mistreatment and discrimination of foreign nationals. Notably, illegal immigrants may refuse to approach a healthcare facility for fear of deportation. This may be harmful to public health, suppose such an illegal immigrant has an infectious disease that is easily transmittable. Although the Immigration Act is a document meant to protect the public interests of the country, we must highlight the consequences of discrepancies within the legislature.

3.5 International Frameworks and State-Funded Healthcare for Foreigners

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I appeal to the international treaties and declarations SA has adopted in this section. Although these declarations do not have any legal force, they do show solidarity with the international struggles of the realisation of human rights and the importance of acting humanely towards vulnerable groups and what this entails. For example, the 1948 United Nations Declaration of Human Rights (UNDHR) serves as the historical institution for the healthcare right under the international system of humanitarian rights (The United Nations General Assembly, 1948). Although the UNDHR has no legal significance as a statement of justice, the fact that it still

aims to achieve a universally accepted standard of welfare makes it significant. Most of its recommendations are regarded by experts in law as a component of international customary law (Leary, 1994). Equality and dignity are outlined in Article 1 of the UNDHR. These ideas serve as the cornerstone of universal human rights (Mann, 1998).

By referring to *dignity*, Article 1 declares that all human beings have an innate sense of dignity, which underlies all rights and the right to health. Therefore, any action that prevents foreign nationals from accessing healthcare services would be morally wrong, as well as a break in the promise to uphold human rights. Additionally, the healthcare right under Article 12 of the 1966 International Convention on Economic, Social, and Cultural Rights (ICESCR), the primary text primarily addressing socio-economic rights, is given a normative effect. This paragraph is considered the most significant global guarantee of the right to healthcare because of its extensive inclusivity of socio-economic rights (Chapman, 2002). Additionally, Dankwa (1998) noted that Article 25(1) is a better form of Article 12, which reads:

> Every person has the right to a standard of living that is sufficient for their health and their family's health, including access to food, adequate housing, clothing, healthcare, and other essential social services. They also have the right to security in case of unemployment, illness, widowhood, disability, old age, or other forms of loss of livelihood due to events beyond their control. International Convention on Economic, Social, and Cultural Rights, 1966 as quoted from Dankwa, Flinterman and Leckie, 1998)

Dankwa (1998) notes this because when states adopted the UNDHR, the Human Rights Commission had already been mandated by the General Assembly to create a treaty on that same issue. As a result, the State parties felt they were not abiding by a document that had legal weight (Dankwa, Flinterman and Leckie, 1998). Other international law instruments that have adopted this right include the Convention on the Elimination of All Forms of Discrimination Against Women (2003) Article 4, the Convention on the Rights of the Child Article 24; and the International Convention on the Elimination of All Forms of Racial Discrimination Article 5(iv) (Dankwa, Flinterman and Leckie, 1998).

Article 12 (2) (c) and (d), which outline the actions that governments ought to make progress to fulfil the implementation of the healthcare right, are also crucial to this research. States must take the necessary actions under these sub-articles to limit, treat, and regulate epidemics, endemic sicknesses, occupational illnesses, and other illnesses (Leary, 1994). They must, among other things, establish conditions to ensure everyone can access healthcare. Understanding this Article requires assuming that the states would provide their citizens with access to healthcare services. In this regard, the State must set up emergency healthcare systems and make appropriate technologies available, implement and improve immunization programs, ensure all healthcare services are provided and provide healthcare in the event of illness. This clause is consistent with Section 27(3) of the Constitution, which ensures everyone the right to emergency healthcare.

Three responsibilities are placed on State parties by Article 12. These requirements have served as interpretation aids and have effectively generated accountability (Dankwa, Flinterman and Leckie, 1998). The duties include respecting, defending, and advancing the

healthcare right. The State ought to respect the healthcare right by not refusing or restricting access to equal healthcare for all. This is a negative duty. In the circumstance of foreign nationals, the obligation entails not refusing access to palliative, preventative and curative healthcare treatments and restricting or purposefully providing misleading healthcare information.

In order to prevent third parties from violating this right, states must exercise their duty to protect it (Dankwa, Flinterman and Leckie, 1998). Therefore, it is understood that those who violate the right to health encompass all those with the potential to interfere with fulfilling this right. Accordingly, State parties to ICESCR need to reform their citizens' attitudes and behaviours that may harm foreign nationals' realisation of their right to healthcare access (Dankwa, Flinterman and Leckie, 1998).

Therefore, from the wording of the preamble of the 1951 Convention, the mission and objective of the global community can be inferred (Hathaway, 2005). The objectives of the preambles are to extend foreign nationals' protection in the global community and to ensure that they can utilize their rights as per primary international human rights instruments. Given that the ICESCR guarantees the healthcare right and that the ability to benefit from healthcare services is considered to be one of the minimal primary responsibilities imposed on governments, one may say that this right to healthcare is one of the broadened rights that is in line with the international community (Leary, 1994).

Hathaway (2005) further contends that while Article 2 of the 1951 Convention imposes a parallel duty on foreign nationals to adhere to the laws of the country that they live in, it may

not establish a mutual obligation in the country that they live in to recognize their rights once they fulfil their end of the bargain (Hathaway, 2005). However, this ought not to be, Hathaway argues. Foreign nationals ought to be free to receive healthcare services whether or not they contravene the law because of the possibility that countries might not keep their end of the deal (Hathaway, 2005).

Additionally, the healthcare right, similar to other socio-economic rights, is intended to ensure that those rights are fully realized rather than mandating that states provide all kinds of services (these could range from basic healthcare services to tertiary healthcare services) at strictly no cost. This may entail ensuring that all infrastructure is provided to facilitate the actual provision of this right and that qualified healthcare professionals are available to serve the right to the people.

Access to healthcare is taken as a humanitarian right gradually coming into being from the international conventions (Dankwa, Flinterman and Leckie, 1998). Article 2(1) of the ICESCR encourages governments to exercise their rights to the fullest extent possible while using their financial and technical resources, external support, and collaboration. Article 2(1) is crucial for understanding the depth of a country's commitments (Dankwa, Flinterman and Leckie, 1998). The Article places states under obligations for action and output. While the latter calls on States to meet a predetermined goal as an indicator of the standard of the realization of the healthcare right, the former urges countries to take fairly measurable actions to realize the benefit of the healthcare right.

Article 2(1) also acknowledges the resource shortage that developing countries face by requiring health rights to be gradually realised and supported by resources. However, even though the text establishes the idea of progressive realisation of socio-economical rights, it may not suggest that these rights may be perpetually delayed (indefinitely). The states are expected to take decisive, transparent action that is focused and concrete. The comprehensive fulfilment of these rights is something that states are supposed to work toward with efficiency and effectiveness. The guarantee of exercising one's healthcare right must also accord with the standards of acceptability, availability, and quality.

3.6 The Minimum Core Obligation Towards Foreign Nationals

The phrase progressive realization of the healthcare right by the State has been used multiple times in preceding sections and chapters. The State has to make appropriate laws and other means, to attain this *progressive realization* of rights, according to Section 27 (2) of the BOR (The Constitution of the Republic of South Africa, 1996). It is vital to recognize that States (mainly developing States) cannot always guarantee the realization of some of the rights prescribed in the legislation. However, States must implement the most fundamental minimum standards for healthcare regardless of economic status (Bilchitz, 2003). This is their core minimum obligation. The *minimum core obligation* ensures that socio-economic rights will no longer be seen as aspirational goals. This prioritizes the satisfaction of people's basic needs.

Amid these reservations, quality healthcare must still be delivered to people. What would this quality healthcare encompass? This includes the clinical competence of the healthcare

providers, the ambience and environment of the hospital, and the in-patient experience influenced by the available resources, such as the quality and affordability of medical treatments and equipment and by the behaviour of the clinical staff (Mosadeghrad, 2014). For this reason, Forman and colleagues (2013) reckon that the minimum core obligation in healthcare services primarily includes essential primary healthcare (Forman *et al.*, 2013). This essential primary healthcare includes access to healthcare facilities, treatments, and services without any discriminatory behaviour towards anyone, especially vulnerable or marginalised groups, assurance of sustenance, sanitation and shelter, availability of essential medicines as outlined by WHO, compliance with the national public healthcare strategy, and ethical rationing of resources such as medical treatments, services, and equipment and prioritisation of reproductive, maternal and child healthcare (Forman *et al.*, 2013).

The Declaration Alma-Alta, approved by WHO and UNICEF in 1978, lays forth, among other things, the minimal requirements the State must meet to guarantee the healthcare right (WHO, 1978). These fundamental obligations, at a minimum, include: delivering necessary medications as periodically specified by the WHO Action Programme of Essential Drugs; ensuring non-discrimination concerning all benefiting from health facilities, services and goods; guaranteeing the equitable distribution of all medical resources and supplies; adopting and putting into practice a healthcare strategy and action plan for the whole country; and addressing the general public's health concerns based on epidemiological evidence (WHO, 1978).

According to Ngwena and Cook (2005), this strict interpretation of the minimum core obligation stems from a strong egalitarian worldview that emphasizes *substantive*

equality and calls for the government to make provisions for a baseline of healthcare access (Ngwena and Cook, 2005). SA undersigns the Covenant on Economic, Social, and Cultural Rights (CESCR), which obliges the State to guarantee at least the fundamental forms of the enumerated rights (Leary, 1994). The laws mentioned above, along with others like 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, expressly defend the rights of vulnerable groups by enforcing specified healthcare access rights (i.e., refugees, children, and women).

The preceding argument has implications for the type of healthcare that should ordinarily be available freely. This will include those already included in the most legislature and memorandums, like primary and emergency healthcare provisions. In extenuating circumstances and subject to available resources, the State may also make expensive available treatments such as dialysis and cancer drugs to poor patients.

3.7 South African Policies and the Qualified Right to State-Funded Healthcare

The execution of national policy is a pivotal point. The legislative framework, which includes the Constitution, laws, and case law, gives South Africans a chance to experience health as the World Health Organization defines it: a condition of total well-being rather than just the absence of disease (WHO, 1978). In most situations, this country also acts as a reminder that legal provisions alone do not guarantee South Africans' rights. The ability of the State to carry out the provisions of the Constitution depends on its resources, personnel, and other political and economic variables.

SA has many policies about access to healthcare (state-funded healthcare). I looked at two used nationwide and provided some relevance to this paper. One specifies the principles that healthcare professionals and the healthcare system must uphold in providing the nation with healthcare and is referred to as *Batho Pele*, which means *People First*. The second is an example of a strategic plan implemented to tackle one of SA's biggest epidemics, HIV—the HIV & AIDS Strategic Plan for South Africa (2007). I then consider the NHI and its effect as an enacted bill and a policy on the right to health for foreign nationals.

A relevant document regarding foreigners' access to healthcare is the Batho Pele Policy Document. Eight national service delivery values are outlined in the policy, and methods are provided to change how public services are provided to foreign nationals in light of these values. These values include:

- consulting with users regularly.
- establishing service ideals.
- expanding attainability and availability of services.
- assuring improved standards of cordiality.
- communicating regularly and improving messaging on services.
- promoting greater transparency.
- addressing errors and inefficiencies; and

- obtaining the highest worth for the public funds that are spent. (Department of Health, 2021)

Public healthcare professionals are required to carry themselves professionally when caring for foreign nationals in accordance with these principles.. This is reinforced by the underlying mission declaration of the *Batho Pele* State healthcare policy, which declares unequivocally that access to State services as a right in a democratic and civilized society is a valid entitlement [for all] (Department of Health, 2021).

Foreign nationals are expressly included in the South African HIV & AIDS Strategic Plan (2017-2022), an intersectoral approach to the widespread disease of AIDS that seeks to provide treatment, support, and care for about 80 percent of the HIV-positive population by 2011 (South African National AIDS Council, 2017). In a February 2007 memorandum sent to Provincial Managers and CCMT Project Managers, the NDOH Project Manager: Comprehensive HIV /AIDS Care, Management and Treatment (CCMT) stressed that no one is to be refused antiretroviral therapy (ART) based on their legal status or possession of identity documents (SANAC, 2017). As a result, a directive from the NDOH reinstating Section 27(g) of the Refugee Act was issued in September of the same year. It reinforced that regardless of permits, foreign nationals ought to benefit from State healthcare services by using the NDOH citizen's means test. The Gauteng DOH declared in a memorandum in 2008 that denial of access to healthcare services, such as ART, should not happen to patients, regardless of their possession of valid identification papers.

Furthermore, the State is looking to implement the National Health Insurance (NHI) as part of the National Development Program 2030 (also known as the NDP 2030) (National Health

Insurance Bill, 2019). The NHI is a system set to finance the country's national healthcare. It is curated to gather funds from taxes and other financial sources to provide universal access to efficient, reasonably priced health services in accordance with their health requirements, without strict consideration of their socio-economic position (National Health Insurance Bill, 2019). NHI aims to prevent people and their dependents from experiencing financial burdens due to requiring healthcare. NHI's mandate is derived from Section 27 of the BOR. This obligates the State to implement just laws and other measures to advance the progressive fulfilment of the right to healthcare (National Health Insurance Bill, 2019).

The NHI has already been introduced throughout the 14-year term that started in 2012 (National Health Insurance Bill, 2019). The target date for comprehensive implementation is 2026. Different mandatory pre-payment resources, primarily based on general taxes, will be used to support the NHI. Medical Schemes will still offer services/products, but those services/products will be limited (National Health Insurance Bill, 2019). A recent version of the Bill (2019 version) was presented to Parliament, including foreigners. Previous versions were not explicit about the inclusion of foreign nationals. The Bill separated foreign nationals according to their legal status. Per the Refugees Act and international agreements SA has signed, the fund would offer refugees and permanent residents similar benefits to healthcare as citizens.

However, only emergency medical services, services for disorders that warrant reporting to the public health authorities (like HIV and TB), and paediatric and maternity care would be available to asylum seekers or illegal/undocumented foreigners. This limitation may have far-

reaching consequences on the right of every individual, regardless of their residency status, to healthcare that enables dignity as listed in Section 10 in the Constitution and to the healthcare rights of Section 27. This does not fulfil the obligations under Section 27 to achieve progress/ reasonable healthcare. Instead, it is retrogressive. Asylum seekers and undocumented foreigners will not even get access to essential public healthcare services. This is inconsistent with policy and legislature (Batho Pele, Section 27 of the Constitution and the NHA, etc.).

3.8 Limitation Clause and Foreign Nationals in South Africa

It is apparent from some of the South African Court's outcomes on the minimum core obligation that rights are susceptible to limitations and may be so in the future. Article 4 of the ICESCR prescribes that insofar as such constraints align with the essence of socio-economic rights and only aim to improve the interest of society in its entirety in a democratic society, a State may restrict a right only as *determined by law* (Leary, 1994).

According to Article 4, the term *determined by law* suggests that any restrictions stated in South African legislation may apply to foreign nationals' accessibility to healthcare services. However, it may not be so, as such restrictions must be set by the *national law of general applicability* and only if it complies with the ICESCR and is enforceable during the restriction period. It must not be *arbitrary, unreasonable, or discriminatory.* It must be clear and accessible to all and accompanied by proper oversight and solutions if such limitations are imposed improperly or abusively (Leary, 1994).

Additionally, such restrictions must be made to protect everyone's health and not jeopardize the fundamental core of the healthcare right or the democratic functioning of society. This is consistent with how this section is interpreted within the Limburg Principles, which indicate that the Article's intention would not have been to impose restrictions on rights that would jeopardize an individual's ability to live, survive, or maintain his integrity (The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, 1987). This means the Article's introduction is not meant to cause harm or leave individuals worse off.

In SA, we see the limitation to rights in Section 36 of the Constitution, also known as the clause of limitation (Iles, 2007). It stipulates the periods in which these limitations are to be implemented. Section 36 (1) (a–e) stipulates that:

> In an open and democratic society founded on human dignity, equality, and freedom, the rights in the BOR may only be limited in terms of law of general application to the degree that the limitation is fair and reasonable in that society, considering all relevant factors, including:
>
> (a) The nature of the right.
>
> (b) The importance of the purpose of the limitation.
>
> (c) The nature and degree of the limitation.
>
> (d) The relationship between the limitation and its purpose.
>
> (e) Less restrictive means to achieve the purpose. (The Constitution of the Republic of South Africa, 1996)

The rights prescribed as per Section 36 (1) (a–e) can be restricted solely in *the conditions of the law of general application*. The law mentioned above of universal applicability does not

currently have a description (Iles, 2007). The implications of the lack of description do not necessarily have a bearing on this paper as Section 36 is superficially discussed as an emphasis on the State's ability to limit rights and what that means.

Moreover, the Constitution does not consider the restriction of a constitutionally protected right acceptable except if it is of compelling governmental interest. This indicates that there must be a compelling justification for restricting a right. The State must consider the restriction to be significant in some way (Iles, 2007). The importance of the advancement of the public interest must be determined by the Courts through a comprehensive examination of the public interest served.

In general terms, how do the Courts go about limiting a right? They must consider the connection between the limitation's objective and the limitation itself. The least restrictive approach must have been explored to get the desired result within the restrictions (Rautenbach, 2014). This is so that any harm caused by limiting these rights would be kept to a minimum. To implement these least restrictive measures, it is crucial to have comprehensive knowledge of the right's nature, scope, and purpose. Evidence of such knowledge must exist, and the Courts may require it to be presented (Rautenbach, 2014).

In terms of Section 36 (1) (a–e) of the BOR, the benefits should outweigh the harm. The Constitution also allows an opportunity to challenge limitations to rights. This is stated in Section 38 of the BOR:

Anyone named in this segment has the legal right to go before a Court of law and claim that one of the rights in the BOR has been violated or is in jeopardy of being violated. The Court

may then give appropriate redress, including a declaration of rights. People who can approach it include:

- Anyone acting in their interest.
- Anyone acting on behalf of another person who is incapable of representing themselves.
- Anyone acting as a member of, or in the interest of, a group of persons.
- Anyone acting in the public interest; and
- An association acting in the interest of its members. (The Constitution of the Republic of South Africa, 1996)

The Constitution and the NHA and international law supported that it would be unconstitutional and unlawful to exclude foreign nationals from state-funded healthcare. Under The Constitution, I acknowledge Section 27 (2), which says that the State must take fair actions toward achieving the progressive realisation of the right and Section 36, which speaks on the limitation of rights based on State resources. There has been no adjudication on limiting the right to healthcare for foreign nationals, explicitly, as yet. Therefore, suppose there would be a case that the right to state-funded healthcare to foreign nationals is said to be limited under Section 36, according to the provided guideline there would need to be an opposing argument that depicts the purpose of limiting access to state-funded healthcare to foreign nationals, how it would be serve the State in its purpose, and how that would affect the country's position in the international recognition of socio-economic rights.

3.9 Foreign Nationals and Their Economic Contributions

Those who have contributed to our development ought to be respected in one way or another, including ensuring their healthcare. Suppose foreigners have made a notable contribution to the country's economic growth. In that case, one ethical way of relating with them from the *Ubuntu* perspective is not to make policies that discriminate against them. This would include not excluding them from state-funded healthcare. An emphasis on integrating foreign nationals in communities and fighting against their discrimination in policy would further incentivize them to contribute more to the country's economy.

As mentioned before, South Africa is a receiver of migrants from Africa. Most migrants come from the Southern African Development Community (SADC) region (StatsSA, 2011). This has been the case after apartheid as migration increased after 1994. During apartheid, migrants came as workers in mines and agriculture (mainly from the SADC region). Now, migrants are a mixture of qualified and unskilled workers, asylum seekers, and documented and undocumented immigrants (StatsSA, 2011). Apart from the asylum seekers and refugees from neighbouring African countries who tend to seek refuge in the South African borders, many come to South Africa as undocumented migrants who seek opportunities for a better standard of living.

Reasons for migration typically range from ones that are economically, socially, and politically inclined. We see this more vividly in the increase of international migration to SA after Apartheid as it became signatory to the Organisation of African Unity Conventions on Refugees and the United Nations (UN) in 1994 (Convention relating to the Status of Refugees, 1951). Before that period, any category of foreign nationals was not recognised in SA. There is also an increase in migration into the country because of the better educational and career opportunities; the social infrastructure; and the medical infrastructure versus the

poor political structures and uneasiness in other neighbouring African countries (StatsSA, 2011; South African History Online, 2015). Besides the access to improved infrastructure in SA versus in the neighbouring SADC countries, SA is a chosen destination primarily because people seek access to essential services such as healthcare facilities, schools, good roads, water (portable) and electricity (StatsSA, 2011).

Most foreign nationals that tend to migrate to SA are within the employable age, with 34% being between the ages of 25-34; 18.4% being between the ages of 15-24; and 17.5% being between the ages 35-44 (StatsSA, 2011). As a result, when foreign nationals averaged the age profile in SA, it was found that 85,3% are economically active. This indicates that foreign nationals make significant contributions to SA's labour supply. Gauteng being central to our growing economy, is the most preferred destination. A few reasons for this are because of language (mostly English is widely spoken in Johannesburg, the central city), it is the economic hub (which tends to be preferred by economic migrants) (StatsSA, 2011).

When the Age Dependency Ratio (ADR) was assessed in the 2011 Census, foreign nationals' ADR was 14.7, and the SA population's ADR was 53,01 (StatsSA, 2011). Here, the ADR was used as an indicator to provide an understanding of the number of people who were not working age compared to those of working age (StatsSA, 2011). It is the number of people who are dependents and younger than 15 or older than 64 compared to those who are of an employable age of 15-64.

Therefore, 14.7 of foreign nationals indicate that only a few are dependents of their given population in the country. This ADR shows the high contribution that foreign nationals make to economic productivity and socio-economic development in SA. In comparison, the high

53,01 amongst SA's population shows that working-age people face a considerable burden of supporting those categorised as dependents. Although it does not factor in some scenarios that can affect its estimation, for instance, some people not retiring after age 64, it can be adjusted to factor in a realistic dependency of the country's population. It is a good measure for economic analysts to estimate the economic burdens on the working class and the tax ramifications that may result.

Furthermore, 1/6 foreign nationals in SA have attained higher education (educated and skilled personnel). Previously, it was found that high-level skilled foreign employees had relocated from Northern African countries such as Nigeria, Ghana and other countries to find employment opportunities in various South African trade and employment sectors (StatsSA, 2011). The 2011 Census also estimates that 3/5 foreign nationals (63,1%) were employed in the country. Of that percentage: 60% worked in the formal sector, 17% in private households and 17,2% in the informal sector (StatsSA, 2011).

This shows that the view held by some South Africans that foreign nationals benefit or depend on the State social grant system is untrue. Contrarily, migration can make (and has made) a considerable contribution to SA. It is, therefore, imperative to integrate it into our labour, socio-economic, and pro-poor South African policies, as skilled foreign nationals are very resourceful in SA. It is also imperative for political parties in South Africa to prioritise migration in their political agendas and structure how and where migration can be advantageous to migrants, including the countries they originate from and their chosen countries of destination within the continent.

Despite the grave misconception of foreign nationals being burdensome to the countries they reside in; foreign nationals have made valuable contributions to the economy of this country. Statistics have disputed the misconception that foreign nationals reduce employment rates of natives in host countries. Rather, it has been shown that some groups of foreign nationals are most likely to increase it (Sparreboom *et al.*, 2018). Firstly, as entrepreneurs or investors, foreign nationals stimulate job creation and steer innovative ideas. For example, most township and urban communities have seen a surge in small spaza shops or grocery stores selling basic household essentials. This stimulation in the general economy occurs through impact on levels of productivity and the growth rate of the host country. This has considerably contributed to boosting what is sometimes coined as the *township economy* in many of our communities. Henceforth affecting labour demand, employment opportunities and compensation.

Secondly, foreign nationals can make considerate input to the Gross Domestic Product (GDP) as employees (Sparreboom *et al.*, 2018). Their presence in the host country may also affect the compensation packages and the available employment opportunities of local South African employees, change the income distribution in the host country and alter investment incentives in the business and education sectors. Because of the high employability of foreign nationals in host countries, they also increase the income per capita in that host country, which would be SA. Moreover, foreign nationals may be taxed more which is beneficial to the fiscal balance of the government (Sparreboom *et al.*, 2018). Overall, they encourage the local economy's growth and supply chains (Sparreboom *et al.*, 2018).

Foreign nationals have an integral role in the societal makeup, despite the hostile conditions and threats to their stay in those communities. This has been evident in the many xenophobic

attacks that have occurred in our communities over the years (South African History Online, 2015). If we look at the intuitive contributions, they make in the communities they live in, those who own businesses may make helpful contributions to community goals and other moral acts in their communities (Sparreboom *et al.*, 2018). Moreover, the contributions made through infrastructural investments and rent, foreign national business owners (from local spaza shops to big urban shops and franchises in cities, but I will especially include those who operate in rural and semi-urban communities in the country) have made substantive contributions to the social well-being of the communities they reside in through different ways, such as attending funeral gatherings (where they also may make cash donations), donations to schools, charities and stokvels, which are different forms of circulating credit union (Sparreboom *et al.*, 2018). They also attend community meetings as a social contribution to support community initiatives and comply with that community's policy regulations.

This is important since access to healthcare results in healthy persons who can make even more substantial contributions to the economic development of any nation. Further, from a Kantian perspective excluding foreign nationals from accessing State services such as healthcare when they are making valuable contributions towards the same economy that funds that service would be treating them as a means to an end, and Kantian theory of deontology prescribes us to never use someone as a tool to achieve an objective (Hodson, 1983). People are always to be seen as ends in themselves. Never should we abuse or take advantage of any one (McNaughton and Rawling, 1998).

It is important to admit that although migration can be beneficial to a host country such as SA, there can be disadvantages to it as well. It can be good and bad for the host country and

the foreign nationals' country of origin. It is disadvantageous for the country of origin because there is a 'brain drain' (labour skills) and a decrease in the workforce or labour force (which might lead to an older working group and impact the country's efficiency and productivity (StatsSA, 2011)).

It can also be disadvantageous for the host country primarily because of the perceived threat within the community foreign nationals move in. They increase the employment competition as some provide cheap labour. This has caused most of the tension in SA between foreign nationals and the communities they move in, for instance, as foreign nationals are assumed to be economic migrants who are in the country to steal our jobs (South African History Online, 2015) . This is also especially threatening in SA as an increased unemployment rate (especially youth unemployment) could threaten labour rights and working conditions. Employers might disregard labour laws and start exploiting and lowering employee benefits or compensation because of cheap labour or the high labour turnover, making the working conditions harsh for both foreign national and South African employees.

Migration can be an instrument of development, i.e., facilitating socio-economic and political freedom, but it can also decrease economic growth and inspire social chaos and instability (Sparreboom et al., 2018). Even as it may be, the host country and the country of origin can benefit simultaneously from migration. The host country benefits from gaining skills they might not have from the new labour force—the country-of-origin benefits from remittance, sometimes the reduced burden on providing employment opportunities and social security grants. Evident in the country's periodic occurrences of xenophobic attacks (South African History Online, 2015). Since 1994, after the inaction of a democratic government in SA, xenophobic attacks in the country have been on s gradual rise.

The most recent and significant occurrence was in 2015 when we saw numerous outbreaks around the country from Gauteng, Limpopo, Kwa-Zulu Natal and in the Eastern Cape, where numerous spaza shop owners who were foreign nationals were either attacked, injured, or killed. Their shops were looted (South African History Online, 2015). The resentment comes from the common belief that these foreign nationals are in the country to steal jobs, get government social benefits and engage in crime.

There is always an advantageous element to having foreign nationals in host countries, especially when it comes to state-building as tax revenue contributors (Jacobsen, 2001). As previously stated, unhealthy and ill foreign nationals may be incapable of fully contributing to the country's workforce and unable to perform at their best abilities. It is, therefore, in the state's best interest to include foreign nationals in their plans for healthcare services distribution, considering that health is a predominant determent and indicator of economic growth and poverty.

Suppose foreign nationals are left untreated or have limited access to crucial healthcare interventions. In that case, their health may deteriorate to a point where it will require more expensive healthcare resources than would have been the case if primary healthcare had been availed to treat the illness in its initial stages (Jacobsen, 2001). Further, this may be burdensome on those same scarce State resources. Equally, suppose foreigners are left out of state-funded healthcare services. In that case, they might feel discriminated against and, thus, become disincentivized to contribute their best to the development and economy of the country.

Furthermore, the State is obligated to ensure that this prescribed right is realised within State means and within a reasonable timeframe. The responsibility is bestowed upon the State as the custodian of the land, and it is held accountable for realising this right by our judicial system. The responsibility of providing state-funded healthcare is not solely geared towards providing it for foreign nationals, and there would be no ground-breaking shift in the legislature because, as it stands, the positive interpretation of the language includes them.

Further, other implications exist for excluding foreign nationals from state-funded healthcare. I list some of them below:

- Due to the challenges and threats that foreign nationals encounter when they attempt to access state-funded healthcare services, they tend to the non-governmental organisation (NGO) sector to get healthcare assistance (Vearey, Nunez and Palmary, 2008). This then results in a dual health system, meaning that two sectors are running in parallel, offering the same healthcare services. This inadvertently strains the healthcare resources in the NGO sector as most NGOs depend on donor funds (Vearey, Nunez and Palmary, 2008). The antagonism they encounter from public healthcare institutions may also cause foreign nationals to refrain from using healthcare services. The burden of disease, morbidity, and death could all rise.

- Foreign nationals may lose trust in health professionals meant to provide them with care. This, consequently, means that they may have trouble disclosing important healthcare information that is necessary for treating or diagnosing them and aiding the healthcare data shared with the DOH so that they can monitor, prevent, and control diseases (Vearey, Nunez and Palmary, 2008). Further, the hostility and challenges

foreign nationals experience may impact how healthcare professionals interact with foreign nationals, affecting their doctor-patient relationship.

When a foreign national requires healthcare services for an infectious disease, this could lead to the condition's transmission to others resulting in an outbreak. Therefore, in such cases, controlling the outbreak can incur more expensive costs than if it had been treated from the onset.

- This health threat costs the government even more. For instance, the COVID-19 pandemic and the confusing information about vaccine access for foreign nationals (Vearey et al., 2021) might prolong the pandemic. Another illustration would be if a foreign national had tuberculosis (TB), which is airborne and dangerous if left untreated. This is due to the significant pressures needed to contain TB levels on monitoring systems. This would likewise thwart the public health system's attempts to limit the sickness.

  Also widely known is the fatal combination of tuberculosis (TB) and HIV. The highest co-infection among HIV-positive people in SA is still tuberculosis (TB). As a result, such an outbreak would be concerning in a nation with an alarming HIV/AIDS occurrence, as we do, because it indicates a high risk of contracting tuberculosis (TB). The disease progression of HIV/AIDS is to weaken the immune system, which increases a person's susceptibility to TB. Since illnesses are international in their reach, any public health effort to contain and stop an outbreak would be rendered fruitless. The fact that South African immigration and refugee laws do not promote integration might make the situation worse.

> Furthermore, such measures can have disastrous results when diseases go untreated (for instance, when refugee patients are refused access to healthcare or avoid it). For instance, in the case of HIV, non-adherence may quickly result in a rise in viral load and a decrease in CD4 count (immune system cells).

In other cases, the sickness may become drug-resistant, and the bacteria may evolve into poisonous or virulent forms. Take tuberculosis as an example. If a foreign national patient does not follow their treatment plan, they may get multidrug-resistant tuberculosis (MDR-TB) (London, 2008). MDR-TB, if left untreated, may develop into extensively drug-resistant TB (XDR-TB), which is a sign that a program failed to identify, prevent, or treat MDR-TB correctly.

A scenario like this would have the following effects: First, the patient could become more expensive to treat because MDR-TB and XDR-TB require expensive drugs and prolonged chemotherapy lasting up to two years.

Second, patients may be forced to spend more time in clinics since they require close supervision to guarantee adherence (London, 2008). About two years must be spent in the hospital because of this. Due to the hazardous side effects of the medications used in treatment, second-line medications perform less well than those used to treat TB in the first instance.

One strategy to improve foundational TB programs and transmission prevention measures is to ensure foreign national patients can exercise their right to healthcare services and access medical treatments. This would be essential for stopping the proliferation of conditions where

strains that are resistant to medical treatment are transmitted from one person to the next, putting much strain on the healthcare system (London, 2008).

3.10 Conclusion

This chapter gave an account of the national and international legislature as supporting factors in the argument that excluding foreign nationals from state-funded healthcare would be unlawful. I also fully outlined the obligation at its minimum core and the limitation of the healthcare right in conjunction with the provision of state-funded healthcare to foreign nationals. Per Article 2 (1) of the ICESCR and the South African Constitution, it is appropriate to acknowledge the legislative measures taken by South Africa to safeguard and advance the right of the foreign national to obtain healthcare services. Although Section 27 (2) of the Constitution requires the government to adopt fair actions to realize the right to state-funded healthcare for foreign nationals gradually, legislative measures are only one of the actions that states are required to perform under the ICESCR and the Constitution. The following chapter explores the State's efforts in providing and implementing healthcare for all in SA.

Migration is a social phenomenon and an essential part of our globalised world. This chapter aimed to show how foreigners can be of value to a host country and categorise their contributions. The primary economic output of the influx of foreign nationals in the country is that it drives up demand leading to higher levels of output in the long term (economic

growth). Simply put, firms increase their supply by needing more labour, decreasing unemployment. Another competing factor is that capitalist firms use foreign nationals as cheap labour and pay low wages to increase profits.

As shown in the statistics presented, foreign nationals are mostly economic migrants rather than those who seek to benefit from public services such as healthcare hence disproving the false claims about foreigners made by xeno-proponents. This is further proven by one of the most chosen destinations by foreign nations, Gauteng, because of its economic viability. Gauteng is a province that is built on migrant labour from SA and otherwise. The irony of these xenophobic opinions is that if one investigated their individual history, it would show migrancy. People do not typically migrate for the social oppression of others but to better their own standard of living. The escalating 'othering' of foreign nationals as people who represent risk rather than an opportunity, people to be feared rather than welcomed, may prove to be harmful in the long run, for instance, in cases of infectious disease epidemics.

Although there is a recognizable contribution by foreign nationals to the socio-economy, the media and political leaders portray foreign nationals as threats and invaders, which perpetuates misinformation and mal-information. We see this in the political commentary made by State officials such as the former Minister of health, Aaron Motsoaledi and the MEC of Health in Limpopo, Dr Phophi Ramathuba. As a result, the biggest threat to public sovereignty is the government's inefficiency fuelled by its rampant corruption, which is proof of its failure to defend the Constitution and protect South African citizens.

CHAPTER 4: RECOMMENDATIONS AND CONCLUSION

4.1 Introduction

The previous chapters have aimed to articulate and defend the thesis that the State has an ethical obligation to provide state-funded healthcare to foreign nationals despite the South African public healthcare crisis. They explained how the exclusion of foreign nationals would violate critical ethical theories or legal SA provisions. I also supported foreign national's entitlement to the right to access healthcare, on the basis that foreign nationals make valuable socio-economic contributions to the country, therefore, should not be excluded from state-funded healthcare services.

In this concluding chapter, I suggest some recommendations that could assist in handling this challenge by improving specific policies and practices within the SA healthcare system.

4.2 Recommendations

From a bioethical point of view, there is a limited scope of recommendations that one can provide that are specific to the moral dilemma or the ethical question that this study considers. Therefore, my recommendations will be generalised and attempt to advise or guide improving access to state-funded healthcare. Notably, I encourage a systemic change within government departments such as the Department of Health and any other affiliated departments for all to enjoy access to healthcare as stipulated in The Constitution of the country.

First, I recommend that government needs to focus on improving the following:

- The reformation of the system. Suppose we are to judge the sustainability of the public healthcare system on the function of tertiary healthcare facilities, especially in rural-urban areas versus metropolitan cities. In that case, we will observe a considerable gap in the resources at the facilities and skills of healthcare officials between the two areas. Although there is a general understanding of how that has come about via the effects of Apartheid, there needs to be more catering to areas where most people can access state-funded healthcare. This recommendation would cater to the utilitarian view that the outcomes of an act must provide the highest level of benefit for the most amount of people and I think including rural areas in the development of health services is an act of utility.

  Furthermore, there needs to be more access to comprehensive healthcare at primary levels (such as at clinics), especially in rural areas. This undermines the capacity to diagnose disease to prevent further spread quickly. It equally undermines early treatment of diseases, which causes a m ore significant load for tertiary healthcare facilities in the long run. This implies that the government ought to allocate resources to strengthen primary public healthcare and train community health workers, especially in rural areas.

  Everyone has a right to healthcare, although there has yet to be equal enjoyment of that right in SA. One corrective measure for this is to prevent the mismanagement of funds, insisting on public accountability and prioritising the establishment of proper comprehensive primary healthcare for all to benefit. Improved healthcare at primary healthcare levels would also have improved outcomes for foreign nationals who would like to use the service.

- Second, I recommend the introduction of an adequately facilitated National Health Insurance 2019 (NHI) scheme through the prioritization of universal pricing and requirements for admission. The NHI remains highly criticized as there are a few gaps in how it will work. Moreover, it has exclusionary principles towards foreign nationals and therefore is not a suitable candidate for a comprehensive solution to SA's healthcare crisis, at least in its current form. Further, it strays from the African Communitarian theory of *Ubuntu* that provides that actions that alienate individuals are immoral as they do not contribute to building communal relationships (that are centred at harmonious living with another) which is the broad core thinking in African morality. More particularly, in Ubuntu philosophy. Here, an act is justified only if it honors communal relationships.

  One urgency for implementing the NHI, though, is that the two healthcare sectors in South Africa, the public and the private sector, have ripple effects on each other regarding their markets. For instance, the markets of the two health sectors affect each other in instances where the more exorbitant the private sector fees are, the more expensive it can be to provide healthcare in the public sector, which results in the public sector suffering in the long run.

  The high cost of healthcare can discourage governments from fulfilling their responsibility towards the residents. Furthermore, other effects are when doctors leave the public sector to work in the private sector, which can cripple the overall public healthcare system. One way to address this problem is to standardize healthcare in ways that reduce costs and do not allow for the significant disparity in healthcare expenses

between the private and public sectors. The private sector's pricing must be regulated. This model would ensure everyone can access the care they need, and governments can fund the care of those who cannot afford it in SA.

- Third, the government should invest in establishing ethical frameworks in different State portfolios and departments that will unify all stakeholders. The establishment of ethical frameworks is an important consideration of public health ethics. Public health ethics aim to outline the moral implications of various circumstances to improve the health and healthcare access of the country's population (Marckmann *et al.*, 2015). This includes the use of frameworks to justify the public value of (possible) practices. Such ethical frameworks will come in handy when considering the ethical aspects of access to public healthcare facilities and the rights involved of foreign nationals and weighing the benefits/risks of each scenario or law. Public health requires a focus beyond how one individual is affected and recognises how people from various social corners may be jointly impacted by certain acts threatening equality to healthcare access and other services. This is necessary to improve the rate of the development and implementation of healthcare regulations that can improve the lives of those who depend on the public healthcare system and establish policies and any strategies related to this improvement.

- Fourth, enforcing the right to access state-funded healthcare will equally require establishing a staggered reporting line to monitor the implementation of policy and legislature and strengthen communication across all government departments. Regarding the migration policy development and implementation concerning foreign

nationals and their socio-economic rights, the reporting line would span departments such as the Department of Health, Home Affairs, and Social Development.

- Fifth, education is equally imperative. There needs to be an improvement of information circulation about healthcare rights for foreign nationals as part of healthcare education strategies across the country so that health professionals and citizens are adequately informed and foreign nationals are made aware of their rights and how to access public services that they are provided in the country according to the Constitution.

- Sixth, the sustainability of policies is critical for ensuring implementation and future access to healthcare. According to the Hastings Centre, healthcare can be sustainable if the following is applied (These recommendations staged in the United States of America healthcare system, but I have adapted it to the South African context):
    - Promotion of preventative-focused healthcare in public healthcare facilities as a means of healthcare promotion and sustainability of resources. Public healthcare facilities could focus their efforts on promoting essential primary healthcare provision, which includes but is not limited to ensuring that there is the encouragement of periodic check-ups among patients in communities by using community health workers to enforce this practice. For instance, in the case of the epidemics that SA faces, such as HIV and TB, there needs to be a patient enrolment strategy that focuses on targeting all those who meet the criteria to start medication immediately or comply with health measures.

      The healthcare system needs to be able to accommodate everyone in SA without the pressure of hoarding healthcare services to protect national

interests, as that never helps in pandemics where the importance is on everyone having readily available access to healthcare in order to save lives. Healthcare should be geared towards being preventative rather than treatment centred. That entails involving all members of communities without discrimination based on nationality in adopting preventative healthcare practices. This will reduce pressure on the healthcare system by reducing in-patient visits.

- Lastly, I recommend that the government manage inequalities in providing state-funded healthcare as a means of corrective measures to the current healthcare crisis. Based on the Kantian theory of deontology, it is the right thing to do for the State to provide state-funded healthcare to foreign nationals. Kant prescribes that persons ought to be treated in ways that show respect of their rights and not be treated as means to an end but as an end in itself. This means not reducing foreign nationals to their contributions but recognising their rights as persons, hence working towards eliminating socio-economic inequalities such as poor access to healthcare facilities is vital. This also aligns with providing universal healthcare in the country for all, the rights in the Constitution and the State's obligation to include foreign nationals in state-funded healthcare.

Two rebuttal thoughts about this could be that financing the healthcare of foreign nationals would be an exorbitant expenditure upon the State amidst its debt crisis and that we might see a massive inflow of migrants flooding to SA for state-funded healthcare. To these, I respond that available data does not support the concern around migrant influx especially with regard to healthcare access. There has been more statistical data to show foreign nationals migrating

to SA for economic migration reasons rather than healthcare related migration (StatsSA, 2011).

The fear around the States's increased expenditure on healthcare and decrease in quality of healthcare services provided to citizens is one of the factors that are inhibiting foreign nationals from receiving (full) access to healthcare services (and actualising their right to health). This is driven by self-interests. I argue that the adequate increase of healthcare services would instead be achieved if citizens were to stand in solidarity with foreign nationals. Solidarity entails committing to standing with others who have the same interests as you. An ethicist attempted to depict this in a paper titled " how to derive solidarity with refugees from self-interest" (Kingler, 2018). Herein, he contends that people who opposed solidarity with foreign nationals often had the same fear i.e., the fear of healthcare-related vulnerabilities and therefore shared the same similarities as foreign nationals.

Using scenarios that cater to these self-interests could potentially expand healthcare services for all. For example, epidemiologically if foreign nationals are excluded from treatments of infectious diseases, then it puts everyone at risk. Even though this might be limited to just infectious diseases, it is one method that health policymakers can use as leverage to drive for solidarity by recognizing and highlighting these similarities in public policies and discourse. Furthermore, on the anticipated increase in State expenditure, the State would not be explicitly spending more on state-funded healthcare if they were proactive rather than reactive to health emergencies. The former implies that if the State emphasized public health surveillance, disease prevention and control, the burden – including the cost of care – on the overall healthcare system would reduce.

Another critic could contend that I have not explained what is meant by socio-economic rights, specifically the 'right to health', having no borders and what this 'borderlessness' implies for the duty to provide healthcare to foreign nationals far away, rather than those presenting at a clinic or hospital. To this I would reply that socio-economic rights being borderless means that people from all over the world have the right to healthcare as an international human right as it is also declared and recognised in many statutes and charters globally.

Furthermore, in the South African context, it is encompassed in our Constitution and other mentioned legislature. The right to healthcare can be accessed beyond immigration borders. Furthermore, the duty to provide care to foreign nationals that are unable to present in clinics and hospitals is the same as that to provide care to citizens in rural areas, for instance, and have limited access to clinics and hospitals. Healthcare professionals still do outreach programs where they do home-visits so that duty would still remain.

Another critic could also contend that by saying that "where resources are so scarce that only X or Y (of X and Y) can receive adequate care, that using nationality to determine who should receive this care is always wrong" is not robust enough. Basically, by just saying that it is always wrong to use one's nationality as way to prefer one person over the other or saying that it is always wrong to use special relationships is not engaging.

To this I would reply that all of the moral theories used in this paper yield the same conclusion that it is immoral to subscribe to nationalism especially when it comes to causing less harm and offering aid. In this paper I used the theory of utilitarianism that prescribes that

an action is morally right only if it results in the most good for the most amount of people. The outcomes of an act must produce the highest level of benefit for the most amount of people. Nationalism is strongly based on self-interest and so it does not consider benefiting the most amount of people therefore it is morally wrong. We ought to consider the interests of all.

Under the Kantian theory of deontology, the right thing for the State to do would be to provide healthcare for all based on its duty. Kantian deontology prescribes that human beings ought to be treated in a way that shows respect so that means not merely using them as means to an end but as an end in itself. For example, not reducing foreign nationals to their contributions but recognising their rights as persons, hence working towards eliminating socio-economic inequalities such as poor access to healthcare facilities is important.

In the African Communitarian theory of *Ubuntu*, special relationships are prioritised as Ubuntu is seen as a partialist theory thus seemingly agreeing with the adopting the nationalist agenda. I contend that Ubuntu also suggests that all human beings are potential members of a family or community and, in principle, foreign nationals can be seen as human beings we can still have communal relationships with which is also important. The appeal to being in community with a person does not require one to have full blown relationships in order to have a duty to assist.

Lastly, nationalism in the case of scarce resources would not conform with spirit of the legislature such as the Constitution, as extensively explained in this paper.

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