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A BENEFIT-FOCUSED ANALYSIS OF CONSTITUTIONAL HEALTH RIGHTS

Dissertation submitted by

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I declare that this dissertation is my own, unaided work. I further declare that this dissertation has never before been submitted for any degree or examination in any university.

Marius Pieterse

1 December 2005

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ABSTRACT:

Socio-economic rights have the potential to contribute to the achievement of social justice through insisting on the satisfaction of vital material needs. However, their effectiveness in this regard is compromised when they are incapable of tangibly contributing to the satisfaction of the needs that they represent. By including justiciable socio-economic rights in the text of the 1996 South African Constitution, its drafters indicated that South Africans are entitled to demand effective relief that amounts to adequate reparation for the harm suffered through the non-satisfaction of their vital material needs. The legitimacy of the constitutional order partially depends on the ability of socio-economic rights to live up to this promise. This dissertation examines the extent of this promise and the extent to which it is currently being fulfilled, in relation to a discrete set of rights - those that operate together to achieve the highest attainable standard of physical and mental health. I argue that successful reliance on health-related rights in litigation must, in appropriate circumstances, produce tangible benefits for individual rights-bearers. I explore the extent to which constitutional health rights may realistically be expected to render tangible benefits, examine the degree to which this potential of health rights is realised through current judicial approaches to their vindication and suggest manners in which such approaches may be modified and/or supplemented in order for tangible benefits to result more readily from successful vindication of health rights. In doing this, I attempt to show that a benefit-orientated approach to the interpretation and enforcement of health rights is not only required, but also facilitated by the Bill of Rights in the 1996 Constitution. Moreover, the Bill of Rights enables South African courts to interpret and enforce health rights in accordance with their benefit-rendering potential, without overextending judicial capabilities or transgressing the institutional boundaries of the judicial function. Courts are accordingly implored to acknowledge and affirm the justiciable nature of health-related rights and to adopt interpretative, evaluative and remedial practices that enable their tangible vindication in appropriate circumstances.

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CHAPTER 1
INTRODUCTION

1.1 THE SIGNIFICANCE OF AWARDING RIGHTS-STATUS TO SOCIO-ECONOMIC CLAIMS

(a) Rights talk, needs talk and the challenge for socio-economic rights

The claim that human rights have the potential to alleviate socio-economic hardship, and hence to bring about meaningful social change, has historically been received with a measure of skepticism. This is not only because liberal rights have often been utilised to thwart state efforts at social redistribution[1] but also because of the tendencies of rights discourse towards abstraction and proceduralisation, which often have the effect of removing the focus of rights-based litigation from the concrete experiences of material deprivation at its centre.[2] For these reasons, among others, scholars affiliated to the Critical Legal Studies movement in the mid 1980s suggested that focusing on needs rather than rights would better serve the quest for social justice and would be

[1]On the use of liberal rights to frustrate social reform efforts, see Andre Du Toit 'Understanding rights discourses and ideological conflicts in South Africa' in Hugh Corder (ed) *Essays on Law and Social Practice in South Africa* (1988) 237 at 252; 257; Morton J Horwitz 'Rights' (1988) 23 *Harvard Civil Rights Civil Liberties LR* 393 at 395; 398; 405-406; William H Simon 'Rights and redistribution in the welfare system' (1986) 38 *Stanford LR* 1431 at 1432-1435; Robin West 'Rights, Capabilities and the Good Society' (2001) 69 *Fordham LR* 1901 at 1904-1907; 1914-1915.

[2]See, for instance, the arguments of Frank I Michelman 'The Supreme Court 1968 term: Foreword: On protecting the poor through the Fourteenth Amendment' (1969) 83 *Harvard LR* 7 at 7-8; 13-14; 33-39 in relation to the use of equal protection doctrine in poverty-alleviation cases before the United States Supreme Court in the late 1960s. Michelman argued that the success of legal measures aimed at alleviating social hardship would depend on their ability to address the actual, physical needs of the people that they aim to protect and advance. He showed that courts run the risk of rendering such needs extrinsic by demanding their incorporation in abstract and relational legal standards. Unless an approach was adopted that identified certain core social needs and attempted directly to satisfy them, he warned, legal tools aimed at alleviating social hardship would be only partially successful. This argument is appropriated in the South African context by Danie Brand 'The proceduralisation of South African socio-economic rights jurisprudence, or "what are socio-economic rights for?"' in Henk Botha et al (eds) *Rights and Democracy in a Transformative Constitution* (2003) 33 at 35-37; Andre van der Walt 'A South African reading of Frank Michelman's theory of social justice' in Botha et al (ibid) 163 at 178; 182-183; 193; 196; 198-199.

more effective in securing discernible social benefits for poor and marginalised sectors of society.[3]

But, in response, it has been shown that a mere articulation of need would more often than not be powerless to satisfy such need, in the absence of an effective political tool through which denial of need may be confronted.[4] Since the objects of rights may (unlike the satisfaction of 'mere' needs) typically be demanded through the legal process, rights discourse presents one of the only viable political tools in this respect.[5] Articulating claims to social goods as rights clothes the interests that the claims represent in a measure of political significance that is lacking in other interests which have not similarly been elevated to the status of right.[6] Rights entail enforceable obligations for those against whom they are claimed and demand justification for their non-fulfilment.[7] Rights-terminology is accordingly instrumental in reconceptualising needs as entitlements rather than aspirations and in ensuring that the satisfaction of such needs becomes a societal priority.[8]

In particular, socio-economic rights (which award entitlements to goods and services that are essential for human survival and flourishing) appear capable of effectively reconciling notions of right and need and accordingly of

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[3]See especially Mark Tushnet 'An essay on rights' (1984) 62 *Texas LR* 1363-1403. See also the summary of the CLS argument by Van der Walt op cit note 2 at 197.

[4]See especially Patricia J Williams 'Alchemical notes: Reconstructing ideals from deconstructed rights' (1987) 22 *Harvard Civil Rights Civil Liberties LR* 401 at 412-413.

[5]'[A] claim which can neither be established as justified by some common decision procedure nor is capable of being enforced or protected as such, does not qualify as a "right" in any serious sense'. Du Toit op cit note 1 at 256. See also Simon op cit note 1 at 1431.

[6]Bruce A Ackerman *Social Justice in the Liberal State* (1980) at 5 conceives of rights as political tools with which to express justified and legitimate claims to social goods within societal dialogues and power struggles. In its Dworkinian formulation, rights are accordingly depicted as 'trumps' over competing social claims. Ronald Dworkin *Taking Rights Seriously* (1977) at 199. See further Du Toit op cit note 1 at 251-255; Horwitz op cit note 1 at 395; Alicia Ely Yamin 'Defining questions: Situating issues of power in the formulation of a right to health under international law' (1996) 18 *Human Rights Quarterly* 398 at 402-403.

[7]Dworkin op cit note 6 at 200; 204; 269. See also generally David Bilchitz 'Towards a reasonable approach to the minimum core: Laying the foundations for future socio-economic rights jurisprudence' (2003) 19 *SAJHR* 1 at 23; Etienne Mureinik 'Beyond a charter of luxuries: Economic rights in the Constitution' (1992) 8 *SAJHR* 464 at 471-473.

[8]Mario Gomez 'Social economic rights and human rights commissions' (1995) 17 *Human Rights Quarterly* 155 at 167; Sheetal B Shah 'Illuminating the possible in the developing world: Guaranteeing the human right to health in India' (1999) 32 *Vanderbilt J of Transnational Law* 435 at 440-441; Van der Walt op cit note 2 at 197; Williams op cit note 4 at 411-412; 416; Yamin op cit note 6 at 398; 401-403.

contributing to the achievement of an ultimately more just society, in which the human dignity of all citizens is equally respected and affirmed. However, the very notion of socio-economic *rights* has through the years encountered much ideological opposition[9] and discursive devaluation. In particular, socio-economic rights have often been characterised by opponents of their enforcement as moral aspirations rather than enforceable human rights[10] - the latter term typically being reserved for civil and political rights. This has historically been justified with reference to perceived differences between these two 'categories' of rights. It has for instance been argued that civil and political rights are ideologically neutral and conceptually certain, impose only duties of non-interference on states and do not entail any significant state expenses, whereas socio-economic rights embody vague, ideologically loaded and resource-intensive claims that require positive state action for their fulfillment.[11]

These differences are, of course, for the most part fallacious. It has authoritatively been illustrated that both civil and political and socio-economic rights engender a mixture of positive and negative state-obligations and involve different degrees of policy-interference, budgetary priority-setting and cost-

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[9]The notion of socio-economic rights was initially associated with socialist political ideology. Socio-economic rights are accordingly depicted by opponents of socialism as inimical to the value of individual liberty and to respect for civil and political rights. This opposition resonates with contemporary depictions of socio-economic rights in neo-liberal discourse as opposed to the structures of the free market, frustrative of economic growth and devaluing of civil liberties. For critical discussion of these arguments see, for example, Philip Alston 'Economic and social rights in the international arena' (1998) 1(2) *ESR Review* 2; AC Basson 'Die ontwikkeling van ekonomiese regte' (1994) 9 *SA Public Law* 94 at 97; 106-108; Matthew CR Craven *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development* (1995) at 11; Asbjørn Eide 'Freedom from want: Taking economic and social rights seriously' in Barend van der Heijden & Bahia Tahzib-Lie (eds) *Reflections on the Universal Declaration of Human Rights: A Fiftieth Anniversary Anthology* (1998) 121 at 126; Gomez op cit note 8 at 161; Marius Pieterse 'Beyond the welfare state: Globalization of neo-liberal culture and the constitutional protection of social and economic rights in South Africa' (2003) 14 *Stellenbosch LR* 3 at 5; 7; 12-13 and authorities cited there.

[10]Critically observed by Rolf Künnemann 'A coherent approach to human rights' (1995) 17 *Human Rights Quarterly* 323 at 333; Shah op cit note 8 at 445; Henry J Steiner & Philip Alston *International Human Rights in Context: Law, Politics, Morals* (2000) at 237.

[11]These distinctions are set out and defended by, for instance, Marc Bossuyt 'International human rights systems: Strengths and weaknesses' in Kathleen E Mahoney & Paul Mahoney *Human Rights in the Twenty-first Century: A Global Challenge* (1993) 47 at 52-55, who concludes from them that it is artificial and counter-productive to view socio-economic aspirations as rights.

implications.[12] More fundamentally, the dichotomisation of the two 'categories' of rights ignores the reality that the theoretical ability to claim civil and political rights offers little practical consolation to those who do not enjoy access to basic social and economic amenities.[13] It has convincingly been argued that a society which values human dignity must not only respect the moral agency of its citizens and safeguard such civil and political liberties as are necessary for their individual and collective pursuit of 'the good life', but should also 'ensure some minimal level of well-being because such a threshold is necessary if citizens are to live fully human lives and have the dignity to which their humanity entitles them'.[14]

In international human rights law and scholarship, this notion has found expression in the normative principle that all human rights (ie civil and political rights as well as social, economic and cultural rights) are 'interdependent and indivisible', in that they are incapable of being realised in isolation and that the values associated with their protection are indistinct.[15] Respect for and

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[12]See Bertus De Villiers 'Socio-economic rights in a new constitution: Critical evaluation of the recommendations of the South African Law Commission' (1992) *TSAR* 421at 425-426; Pierre De Vos 'The economic and social rights of children and South Africa's transitional Constitution' (1995) 10 *SA Public Law* 233 at 236-244; Pierre De Vos 'Pious wishes or directly enforceable human rights?: Social and economic rights in South Africa's 1996 Constitution' (1997) 13 *SAJHR* 67 at 68-71; Asbjørn Eide 'Economic, social and cultural rights as human rights' in Asbjørn Eide et al (eds) *Economic, Social and Cultural Rights: A Textbook* (1995) at 22-23; Maria Green 'What we talk about when we talk about indicators: Current approaches to human rights measurement' (2001) 23 *Human Rights Quarterly* 1062 at 1076; Nicholas Haysom 'Constitutionalism, majoritarian democracy and socio-economic rights' (1992) 8 *SAJHR* 451 at 457-458; Stephen Holmes & Cass R Sunstein *The Cost of Rights* (2000); Künnemann op cit note 10 at 333; Sandra Liebenberg 'Social and economic rights: A critical challenge' in Sandra Liebenberg (ed) *The Constitution of South Africa from a Gender Perspective* (1995) 79 at 83-85; Mureinik op cit note 7 at 465-468; Geraldine Van Bueren 'Alleviating poverty through the Constitutional Court' (1999) 15 *SAJHR* 52 at 61; GJH Van Hoof 'The legal nature of economic, social and cultural rights: A rebuttal of some traditional views' in P Alston & K Tomasevski (eds) *The Right to Food* (1984) 97 at 103-105.

[13]See Haysom op cit note 12 at 452; Christof Heyns & Danie Brand 'Introduction to socio-economic rights in the South African Constitution' (1998) 2 *Law, Democracy & Development* 153 at 154; Mureinik op cit note 7 at 465; Craig Scott 'The interdependence and permeability of human rights norms: Towards a partial fusion of the international covenants on human rights' (1989) 27 *Osgoode Hall LJ* 769 at 789-790; 798-799.

[14]West op cit note 1 at 1902. See also Michelman op cit note 2 at 13-15 and Sandra Liebenberg 'The value of human dignity in interpreting socio-economic rights' (2005) 21 *SAJHR* 1 at 2-3; 7.

[15]This principle and its foundations in the value of human dignity are affirmed by the preambles of both the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant of Economic, Social and Cultural Rights (ICESCR), which state that all

affirmation of inherent human dignity accordingly requires the actualisation of civil and political rights as well as of socio-economic rights:

> 'If human rights represent deeply held values about the nature of human persons and their social interaction, the term "interdependence" attempts to capture the idea that values seen as directly related to the full development of personhood cannot be protected and nurtured in isolation. [Interdependence] reflects an appreciation of the intimate connections between the personal, political and socio-economic dimensions of human dignity and well-being'.[16]

However, a mere rhetorical acknowledgment of the material dimensions of human dignity and personhood is ultimately as inimical to the value of interdependence as an exclusive focus on the enforcement of civil and political rights. In order to achieve the ideals associated with the value of interdependence, it is necessary that socio-economic rights are capable of realisation in practice as well as in theory.

Furthermore, if socio-economic rights are effectively to function as legal tools through which denial of need may be confronted and remedied, their appropriation in particular factual circumstances must connect concretely to the needs and experiences of their subjects.[17] The formulation of abstract legal standards measuring compliance with socio-economic obligations and the institutional settings within which these standards are conceived and implemented is at most of indirect and secondary importance to the beneficiaries of socio-economic rights, for whom the actual alleviation of their hardship carries

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human rights 'derive from the inherent dignity of the human person' and that 'the ideal of human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights'.

[16]Sandra Liebenberg 'Socio-economic rights' in Matthew Chaskalson et al (eds) *Constitutional Law of South Africa* (RS5, 1999) ch 41 at 1. See also generally Scott op cit note 13 as well as Sandra Liebenberg 'Violations of socio-economic rights: The role of the South African Human Rights Commission' in Penelope Andrews & Stephen Ellmann (eds) *The Post Apartheid Constitutions: Perspectives on South Africa's Basic Law* (2001) 405 at 410; Martin Scheinin 'Economic and social rights as legal rights' in Eide et al op cit note 12, 41 at 44; Craig Scott & Patrick Macklem 'Constitutional ropes of sand or justiciable guarantees? Social rights in a new South African constitution' (1992) 141 *Univ Pennsylvania LR* 1 at 86-87; Steiner & Alston op cit note 10 at 247.

[17]Argued also by Mark Heywood 'Debunking "Conglomo-talk": A case study of the amicus curiae as an instrument for advocacy, investigation and mobilisation' (2001) 5 *Law, Democracy & Development* 133 at 147; Liebenberg op cit note 14 at 18; Dikgang Moseneke 'The fourth Bram Fischer memorial lecture: Transformative adjudication' (2002) 18 *SAJHR* 309 at 318.

priority.[18] Legal tools which fail to acknowledge and reflect this priority will not easily succeed in their aim to correct for the diminution of human dignity suffered as a result of such hardship.

Moreover, socio-economic rights will be useful to rights-bearers only to the extent that the rights have the potential to tangibly improve the physical conditions of their lives - '[i]f ... socio-economic rights ... are to amount to more than paper promises, they must serve as useful tools in enabling people to gain access to the basic social services and resources needed to live a life consistent with human dignity'.[19] Accordingly, individuals may be expected to rely on socio-economic rights and the legal process for the alleviation of their personal hardship only if there is a distinct possibility that they will concretely benefit, either directly or indirectly, from the exercise.[20] If this is not the case, socio-economic rights (and, by implication, rights-discourse as a whole) will have failed in their purpose of effectively confronting the denial of need,[21] and additional or alternative political tools for this purpose will have to be sought.

(b) The inclusion of justiciable socio-economic rights in the South African Constitution

Much academic debate surrounded the political decision to include justiciable

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[18]Brand op cit note 2 at 35-36, drawing from Michelman op cit note 2. See also Sandra Liebenberg 'The right to social assistance: The implications of *Grootboom* for policy reform in South Africa' (2001) 17 *SAJHR* 232 at 235.

[19]Sandra Liebenberg 'South Africa's evolving jurisprudence on socio-economic rights: An effective tool in challenging poverty?' (2002) 6 *Law, Democracy & Development* 159. See also Thomas J Bollyky 'R if C > B + P: A paradigm for judicial remedies of socio-economic rights violations' (2002) 18 *SAJHR* 161 at 164; Dennis Davis 'Socio-economic rights in South Africa: The record of the Constitutional Court after ten years' (2004) 5(5) *ESR Review* 3 at 5; Liebenberg op cit note 18 at 233; JC Mubangizi 'Protection of human rights in South Africa: Public awareness and perceptions' (2004) 29(1) *Journal for Juridical Science* 62 at 80.

[20]Mark Heywood 'Preventing mother-to-child HIV transmission in South Africa: Background, strategies and outcomes of the Treatment Action Campaign case against the Minister of Health' (2003) 19 *SAJHR* 278 at 300; Liebenberg op cit note 19 at 176; Craig Scott & Philip Alston 'Adjudicating constitutional priorities in a transnational context: A comment on *Soobramoney*'s legacy and *Grootboom*'s promise' (2000) 16 *SAJHR* 206 at 254-255. In essence, this argument holds also for socio-economic rights litigation brought by NGOs and other public interest litigators, who will more often than not be motivated by the desire to secure tangible benefits for the groups of beneficiaries whose interests they represent.

[21]Liebenberg op cit note 19 at 160.

socio-economic rights in the text of the Constitution of the Republic of South Africa, Act 108 of 1996 ('the Constitution'). One the one hand, it was readily acknowledged that a new South African constitution had to embody an unwavering commitment to the eradication of the inequalities occasioned by apartheid and to the socio-economic upliftment of the greater majority of the population. The only way in which a constitutional text could meaningfully reflect such a commitment, many felt, was for its Bill of Rights to include socio-economic rights alongside civil liberties.[22] But, others argued, to include socio-economic rights in a Constitution would raise unrealistic expectations that these rights could immediately be enforced. Were such expectations to be shattered (as, it was argued, was inevitable), the legitimacy of not only the socio-economic rights in the Bill of Rights, but of the Bill of Rights as a whole and of the entire constitutional enterprise of which it formed part, would be severely tarnished.[23]

One possible solution to the above problem, strongly mooted at the time, was that the South African Constitution should only give limited recognition to socio-economic rights, in the form of 'directive principles of state policy'. Such principles require ongoing political commitment to social upliftment and inform the content of legislative and policy initiatives, but do not grant any enforceable entitlements to citizens. Formulating socio-economic rights thus, it was contended, would not only leave intact the legitimacy of the Bill of Rights, but would also safeguard the institutional legitimacy of the judiciary, who would otherwise face significant separation of powers and counter-majoritarian tensions in having to decide on matters of socio-economic delivery.[24]

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[22]As Nicholas Haysom wrote at the time: 'for a constitution to have a meaningful place in the hearts and minds of the citizenry, it must address the pressing needs of ordinary people. It cannot be seen to institutionalise and guarantee only political/civil rights and ignore the real survival needs of the people - it must promise both bread and freedom. If it does not do so, it will find no lasting resonance amongst the true guardians of the constitution - which are not the courts but the citizens'. Haysom op cit note 12 at 454. See also Mureinik op cit note 7 at 465; Scott & Macklem op cit note 16 at 85.

[23]See DM Davis 'The case against the inclusion of socio-economic demands in a Bill of Rights except as directive principles' (1992) 8 *SAJHR* 475 at 480-481; 484-485; Mureinik op cit note 7 at 465; AJ Rycroft 'The protection of socio-economic rights' in Corder (ed) op cit note 1, 267 at 268.

[24]The directive principles option was strongly contended for, for these and other reasons, by Davis op cit note 23. See also Bertus De Villiers 'Directive principles of state policy and fundamental rights: The Indian experience' (1992) 8 *SAJHR* 29 at 32-33; 39; Erika De Wet 'The

The Constitutional Assembly thought differently and included a significant number of fully justiciable socio-economic rights in the draft text of the 1996 Constitution. This inclusion was opposed during the hearings preceding the certification of the text by the Constitutional Court. It was argued that socio-economic rights should not be justiciable because of the budgetary consequences attached to their vindication, and because the notion of justiciable socio-economic rights would involve the illegitimate judicial encroachment on legislative and executive terrain. The Constitutional Court dismissed these objections, holding that 'it cannot be said that by including socio-economic rights within a bill of rights, a task is conferred upon the Courts so different from that ordinarily conferred upon them by a bill of rights that it results in a breach of the separation of powers'.[25] The Court further pointed out that civil and political rights often have similar budgetary consequences to socio-economic rights, and concluded that 'the fact that socio-economic rights will almost inevitably give rise to such implications does not seem to us to be a bar to their justiciability. At the very minimum, socio-economic rights can be negatively protected from improper invasion'.[26]

When the 1996 Constitution consequently came into operation in February of 1997, its Bill of Rights included both civil and political and socio-economic rights, without in principle differentiating between them on the basis of justiciability. The decision of the constitutional drafters to include justiciable socio-economic rights in the Constitution, rather than non-justiciable directive principles of state policy, is significant. This is because rights, unlike directive principles, entail more than abstract guidelines for judicial review - '[r]ights are

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enforceability of socioeconomic directive principles / legislative commands, with special reference to constitutional principle XI of the South African transitional Constitution' (1995) 112 *SALJ* 462 at 464; 477; Ziyad Motala 'Socioeconomic rights, federalism and the courts: Comparative lessons for South Africa' (1995) 112 *SALJ* 61 at 63; 66; 69; 72; 74; 87.

[25] *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa, 1996* 1996 (4) SA 744 (CC) at para 77.

[26] Ibid para 78. For comment on these dicta, see Iain Currie 'Bill of rights jurisprudence' (2000) *Annual Survey of SA Law* 24 at 51-52; Johan De Waal; Iain Currie & Gerhard Erasmus *The Bill of Rights Handbook* (4th ed 2001) at 434; Liebenberg (in Chaskalson et al) op cit note 16 at 5; Christa Van Wyk 'The enforcement of the right of access to health care in the context of HIV/AIDS and its impact on the separation of powers' (2003) 66 *THRHR* 389 at 395.

morally grounded imperatives, not a list of suggestions for good governance'.[27] As Ronald Dworkin has shown in relation to civil and political rights, the granting of a right implies a societal acceptance of the social costs that will have to be incurred in order to enforce that right.[28] The recognition of a right is accordingly associated with a guarantee that it may be legally enforced.[29]

The clear legislative intent behind the entrenchment of justiciable socio-economic rights in the Constitution therefore appears to be that citizens should in appropriate circumstances be able to enforce these rights against the State, or against others who threaten, disrupt or obstruct their exercise or enjoyment. When considered in light of the common law maxim 'ubi ius ibi remedium' (according to which a remedy forms an inextricable part of a right to the extent that a right would be rendered meaningless in the absence of an effective remedy), the fact that citizens have been awarded socio-economic rights indicates that they are entitled to effective remedies in cases where their rights have unjustifiably been infringed.[30] It also appears, both from the entrenchment of justiciable socio-economic rights by the Constitutional Assembly and from the Constitutional Court's dismissal of objections to this entrenchment, that courts are appropriate and competent fora in which to seek such relief.

(c) Enforcing justiciable socio-economic rights

The South African Constitutional Court's approach to the enforcement of the socio-economic rights contained in the Bill of Rights of the 1996 Constitution has received a fair measure of praise for the manner in which it balances the need for judicial vigilance implied by the constitutional presence of socio-economic rights with the need for deference occasioned by its institutional role within a

[27]West op cit note 1 at 1917.
[28]Dworkin op cit note 6 at 198-199; 269
[29]Davis op cit note 23 at 480; Rycroft op cit note 23 at 268.
[30]On the content of 'ubi ius ibi remedium', see *Minister of the Interior v Harris* 1952 (4) SA 769 (A) at 780-781C; *Administrator, Transvaal v Brydon* 1993 (3) SA 1 (A) at 15G-16B; Jonathan Klaaren 'Judicial Remedies' in Chaskalson et al op cit note 16, ch 9 at 1. On the maxim's application in relation to socio-economic rights, see Rycroft op cit note 23 at 279; Van der Walt op cit note 2 at 167.

constitutional system that reflects the separation of powers.[31] However, the Court's approach, which essentially amounts to a procedural inquiry into the reasonableness of laws and policies aimed at the progressive realisation of socio-economic rights,[32] has also attracted significant criticism.

Certain scholars have expressed concern about the seemingly ad hoc, abstract and context-dependent nature of the inquiry which, it has been argued, fails to award meaningful content to socio-economic rights, to prioritise the satisfaction of certain basic and urgent socio-economic needs over others and to set consistent standards against which the adherence of government policies to constitutional obligations may be measured.[33] Other researchers have shown that the Court's approach is, due to its focus on procedural and technical issues related to the content and implementation of socio-economic policy rather than on the satisfaction of the survival interests of poor and vulnerable sectors of society, at best of limited use to citizens in securing access to those goods and services to which they are entitled by virtue of their inherent human dignity.[34] Yet others have lamented the lack of remedial vigor displayed by the Court's socio-economic rights judgements, which appear to be shying away from awarding mandatory, structural and tangible relief.[35] Finally, concerns have been expressed that the Court is failing to subject state assertions of resource scarcity to sufficiently rigorous scrutiny.[36]

What most of these critiques have in common is a concern that the Court seems to conceive of socio-economic rights not as separately enforceable rights

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[31]See, for instance, Cass R Sunstein 'Social and economic rights? Lessons from South Africa' (2001) 11(4) *Constitutional Forum* 123; Frank I Michelman 'The constitution, social rights, and liberal political justification' (2003) 1 *International J of Constitutional Law* 13.

[32]See chapter 4 below.

[33]The central proponent of this argument is David Bilchitz, who advocates instead for the adoption of a minimum core approach to socio-economic rights adjudication, akin to that followed in international law. See for instance David Bilchitz 'Giving socio-economic rights teeth: The minimum core and its importance' (2002) 119 *SALJ* 484; Bilchitz op cit note 7.

[34]See Brand op cit note 2; Liebenberg op cit note 19; Liebenberg op cit note 14.

[35]See Davis op cit note 19; Kameshni Pillay 'Implementation of Grootboom: Implications for the enforcement of socio-economic rights' (2002) 6 *Law, Democracy & Development* 255; Theunis Roux 'Understanding *Grootboom* - a reply to Cass R Sunstein' (2002) 12(2) *Constitutional Forum* 41 at 50-51; Mia Swart 'Left out in the cold? Crafting constitutional remedies for the poorest of the poor' (2005) 21 *SAJHR* 215.

[36]See Darrel Moellendorf 'Reasoning about resources: *Soobramoney* and the future of socio-economic rights claims' (1998) 14 *SAJHR* 327; Liebenberg op cit note 18 at 255.

to particular goods or services, but rather as a single, overarching guarantee that socio-economic policies may be abstractly reviewed for their adherence to certain principles of good governance. Whereas many of the Court's critics concede that such a guarantee holds important benefits for the policy-driven achievement of social justice in South Africa,[37] the substantive 'emptiness' of the Court's predominantly procedural conception of socio-economic rights[38] reminds most of the warning by Dennis Davis in the pre-constitutional debates that

> '[t]o assert a right is to argue that another party has a duty to provide conditions in terms of which that right can be fulfilled. Once social and economic rights are included in a bill of rights, the constitution trumpets to the society at large that each is entitled to demand enforcement of such rights whether they be rights to housing, to employment, to medical care or to nutrition. To include these rights as being of equivalent status to first-generation rights is to raise expectations within a society that these rights can indeed be enjoyed by all. For members of society to then find that all that is entailed thereby is a process of negative constitutional review is to create a situation where expectations are raised only to be dashed on the rock of a technical legal review. ... Certainly Mr and Ms Citizen will demand more than review from a fully fledged right'.[39]

The text of the Constitution clearly awards justiciable rights to have access to particular socio-economic amenities. It accordingly indicates that it should be possible to enforce these rights in a manner that entails the satisfaction of the material needs that they represent. To consistently interpret and 'enforce' these rights in a manner that denies this possibility, diminishes the potential of rights discourse to contribute meaningfully to the quest for social justice and threatens also to diminish the legitimacy of the Bill of Rights in the eyes of the majority of South Africans.

1.2 PREMISES AND OBJECTIVES OF THIS DISSERTATION

Departing from the premises, first, that the meaningful enforcement of socio-economic rights is of integral importance in a society concerned with the

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[37]See Bilchitz op cit note 7 at 22; Liebenberg op cit note 19 at 162. Michelman op cit note 31 at 17-18; 29; 32-34 regards the indirect, policy-directive effects of the Court's approach as its main advantage.

[38]See Iain Currie 'Bill of Rights jurisprudence' (2002) *Annual Survey of SA Law* 36 at 72. See also chapter 4 note 51 and accompanying text.

[39]Davis op cit note 23 at 484-485.

affirmation and protection of human dignity; secondly, that enforcement of socio-economic rights must respond concretely to the needs of their beneficiaries; and, thirdly, that by virtue of their rights-status, socio-economic rights must be capable of contributing perceptibly to the satisfaction of the needs they represent, this dissertation conducts a benefit-focused analysis of health rights enshrined in the 1996 Constitution. I argue that successful reliance on health rights in litigation must, in appropriate circumstances, produce tangible benefits[40] for individual rights-bearers. This is possible, first, because the relevant constitutional provisions are justiciable rights rather than directive principles of state policy, which means that they are inherently capable of resulting in direct and tangible relief and, secondly, because the Constitution allows courts to give tangible effect to these rights without transgressing institutional boundaries or departing radically from 'traditional' conceptions of the judicial role.

Insofar as it argues for *individual* benefits, the dissertation is somewhat controversial. The Constitutional Court is on record as being opposed to an interpretation of socio-economic rights that confers immediately enforceable, individual socio-economic entitlements. Indeed, rights discourse is often criticised for its tendency to 'atomise' individuals and thereby to divorce rights-claims from their social context, which is considered counterproductive in bringing about large-scale social and economic reform.[41] It is certainly conceivable that vindicating individual socio-economic claims may upset

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[40]By the notion of 'tangible benefit' I mean a perceptible outcome or necessary after effect of litigation in which a health-related right was successfully vindicated, which firstly has a discernible impact on the life of individual rights-bearers (in the sense that they gain something which they did not have before the litigation, such as an item, access to a service, an enforceable claim against a third party, an assurance that future needs will be met, or compensation for losses suffered as a result of the non-satisfaction of past needs) and which secondly contributes at least partially to the satisfaction of a particular health-related need or compensates for the hardship resulting from its non-satisfaction. A particular need is in turn conceived of as being health-related where the satisfaction of the need is capable of leading to an improvement in, or of preventing a deterioration in, individual health status.

[41]See Horwitz op cit note 1 at 399-400; Kevin P Quinn 'Viewing health care as a common good: Looking beyond political liberalism' (2000) 73 *Southern California LR* 277 at 303-304; Simon op cit note 1 at 1433; West op cit note 1 at 1912-1915 and also generally Peter Gabel 'The phenomenology of rights-consciousness and the pact of the withdrawn selves' (1984) 62 *Texas LR* 1563-1599.

carefully crafted programmes aimed at communal social upliftment. It is accordingly necessary when dealing with socio-economic rights to attempt to balance communal and individual interests.[42]

But this should not mean that legitimate individual entitlements are always sacrificed in favour of a vaguely-defined 'common good'.[43] Rights-based terminology is used in relation to social goods precisely to counter the self-defeatism of an 'all-or-nothing' communalist approach to social upliftment. It acknowledges that 'we are diminished as a society to the extent that any of our members are deprived of the opportunities to develop their basic capabilities to function as individual and social beings'.[44] A rights-based approach to health 'sees the welfare of an individual as an object of morality and as a legitimate purpose of a just society'[45] and, unlike a utilitarian approach (seeking to confer the greatest possible aggregate health-related benefit on society in general), paternalistic approach (viewing the distribution of health-related benefits as flowing from the benevolence of bureaucrats and health care professionals who are deemed to have the best interests of society at heart) or market-based approach (according to which health-related benefits are commodities capable of alienation and purchase) undeniably involves the concept of individual entitlement.[46]

This is not to say that individual entitlements must always trump communal interests. Nor am I contending that tangible benefits must necessarily be conferred in every matter where a health-related right has apparently been infringed. There is certainly a significant range of circumstances in which an infringement of a socio-economic right will either be justifiable or where it would be inappropriate to award direct, tangible relief to individual litigants. However, there will also be circumstances in which awarding tangible relief for an unjustifiable infringement for a socio-economic right is both appropriate and

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[42]On the need to find a balance between individual and collective aspects of socio-economic rights claims in South Africa, see Bilchitz op cit note 7 at 22.

[43]See remarks of Scott & Alston op cit note 20 at 252-253.

[44]Liebenberg op cit note 14 at 12. See also ibid at 22.

[45]Virginia Leary 'Implications of a right to health' in Mahoney & Mahoney (eds) op cit note 11, 481 at 482.

[46]Ibid.

possible. In such circumstances, I believe that courts are constitutionally obliged to give effect to the rights-based status of health-related claims and to award such tangible relief as is appropriate in the circumstances.

Moreover, I believe that the structure and content of the Bill of Rights requires of any court tasked with giving effect to a socio-economic right to start from the double premise that the right is in principle enforceable and that the applicant is in principle entitled to the tangible relief she seeks. In circumstances where the interests of justice or some other compelling interest require that the extent of an applicant's entitlement be limited, or where it would for some institutional or other reason be inappropriate to award tangible relief, the court is required to indicate whether, to what extent and for what reasons it should depart from this premise.

I accordingly argue that the Constitutional Court is mistaken in its opposition to an interpretation of socio-economic rights that confers immediately enforceable entitlements upon claimants. This opposition, I believe, unnecessarily restricts the benefit-rendering potential of socio-economic rights. While I concede that there are significant indirect benefits to be derived from the Court's current approach to socio-economic rights, I am of the view that such benefits would also have resulted if socio-economic rights were constitutionally included simply as directive principles of state policy. Given that they have instead been entrenched as justiciable rights, I contend that the benefits resulting from the enforcement of socio-economic rights should, in appropriate circumstances, also be direct and tangible.

The dissertation accordingly explores the extent to which constitutional health rights may realistically be expected to render tangible benefits, examines the degree to which the potential of health rights in this regard is realised through current judicial approaches to their enforcement and suggests ways in which such approaches may be modified and/or supplemented in order for tangible benefits to result more readily from successful rights-vindication.[47]

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[47]Rather than attempting to formulate a single theory for the application, interpretation and limitation of health rights as a group, I contemplate alternative interpretative, evaluative and remedial judicial strategies that could maximise the tangible benefits resulting from different

The focus of my research is predominantly on South African cases and literature pertaining to the interpretation and enforcement of socio-economic rights (and, particularly, of health-related rights) in the Constitution. Given that many of these rights have been modelled on provisions contained in international law treaties, and in light of s 39(1)(b) of the Constitution's determination that international law must be considered when interpreting the Bill of Rights, I also devote some attention to relevant treaty-provisions as well as to local and foreign academic deliberations on their meaning and implications. Furthermore, although a comparative study of the protection of health rights is not undertaken, I also rely occasionally on foreign (predominantly Anglo-American) sources that illuminate concepts which I regard as relevant to the protection and enforcement of health-related rights.

My focus is further limited to benefits resulting from asserting constitutionally-based rights-claims within the judicial process. This is not to underplay the importance of rights awarded and enforcement mechanisms created by legislation and/or executive policy, but I will refer to these only to the extent that they supplement and/or illuminate the benefit-rendering potential of relevant constitutional rights in the litigation setting. Furthermore, at least one other institution, the South African Human Rights Commission (SAHRC), is constitutionally implicated in the actualisation of socio-economic rights. Relevant SAHRC processes may therefore also produce tangible benefits for the beneficiaries of socio-economic rights, but these are beyond the scope of the dissertation.[48]

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health-related rights in different settings. On the need for such a 'multistranded' or 'pluriform' theoretical approach to the interests implicated by socio-economic rights, see Van der Walt op cit note 2 at 204-205.

[48]On the role of the SAHRC in this regard, see s 184 of the Constitution and also Kenneth Creamer 'Finance and the realisation of socio-economic rights: Analysing the Human Rights Commission's s 184(3) review of the financial authorities' in Centre for Human Rights *Report on the Realisation of Socio-Economic Rights* (2000) 13-28; Christof Heyns 'Taking socio-economic rights seriously: The "domestic reporting procedure" and the role of the South African Human Rights Commission in terms of the new Constitution' (1999) 32 *De Jure* 195-226; Liebenberg (in Andrews & Ellmann) op cit note 16 at 405-443; Dwight G Newman 'Institutional monitoring of social and economic rights: A South African case study and a new research agenda' (2003) 19 *SAJHR* 189-216; Karrisha Pillay 'An interpretation of "relevant organs of state" in section 184(3) of the Constitution and their duty to provide information on socio-economic rights to the South African Human Rights Commission' (1998) 2 *Law, Democracy &*

It is necessary to acknowledge at the outset that the judicial process does not always present an ideal institutional setting for the actualisation of benefits implied by socio-economic rights. Socio-economic rights matters often involve choice-sensitive and polycentric issues and often have significant resource implications. They are accordingly often depicted as falling predominantly within the realm of legislatures and policy-makers. Real or perceived counter-majoritarian and separation of powers-based concerns are therefore bound to impact on the effectiveness of the enforcement of socio-economic rights through the judicial process. Difficulties experienced by courts in this regard will likely further be compounded by the essentially formalist undertones of South African legal culture, as well as by individual judges' discomfort with using rights-based terminology to vindicate social claims.[49] Moreover, health rights matters are likely to involve the technically specialist field of medicine, which is typically perceived as being beyond judicial expertise and as accordingly requiring respect for the decisions of health care professionals in a variety of contexts.[50]

However, whereas the problems of institutional legitimacy and competence listed here must necessarily impact on the manner in which courts give effect to health-related rights, I will argue that the obstacles posed by them in this regard are not insurmountable, and that courts can give effect to health rights in a manner that holds tangible benefits for their subjects without radically departing from 'traditional' conceptions of their role or disrupting the functioning of the modern-day democratic state.

When confronted with a claim that a health-related right has been

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Development 179-196.

[49]I have discussed all of these obstacles in detail in Marius Pieterse 'Coming to terms with judicial enforcement of socio-economic rights' (2004) 20 *SAJHR* 383-417. See also the various authorities cited there. To the extent that these factors impact on South African courts' ability to interpret and enforce health rights in a manner that produces tangible benefits for beneficiaries, they will be considered in chapter 4 below.

[50]See for instance Gregg M Bloche 'The invention of health law' (2003) 91 *California LR* 249 at 270-271; Paul Gertler & Jacques Van der Gaag *The Willingness to Pay for Medical Care: Evidence from Two Developing Countries* (1990) at 17; Mark A Hall & Gerard F Anderson 'Health insurers' assessment of medical necessity' (1992) 140 *Univ Pennsylvania LR* 1637 at 1650; 1675; 1698-1700; David Mechanic 'Professional judgment and the rationing of medical care' (1992) 140 *Univ Pennsylvania LR* 1713 at 1724-1725; 1727; John A Siliciano 'Wealth, equity, and the unitary medical malpractice standard' (1991) 77 *Virginia LR* 439 at 480.

infringed by the State or a private entity,[51] a court may be expected, first, to ascertain the ambit and scope of the right in question, thereafter to evaluate the challenged law or conduct in an attempt to establish whether the right has been unjustifiably infringed in the circumstances, and, if that is found to have been the case, to order that the infringement be remedied. Whereas the question of whether tangible benefits will result from an applicant's victory in such a case would appear most obviously to be contingent on the nature of the remedy awarded, my focus extends beyond judicial remedial practices to contemplate the interpretation of health-related rights as well as the evaluation of respondents' compliance with the obligations imposed by such rights.[52] Indeed, I will show that the manner in which courts carry out their interpretative and evaluative functions constrains the exercise of their remedial function to the extent that the failure of health-rights cases to produce tangible benefits is as often ascribable to restrictive interpretative and evaluative practices, as to lack of remedial vigour.

I devote a significant portion of the dissertation to clarifying the content of the various health-related rights that form the object of my study. By doing this, I hope, in the first instance, to illustrate how a group of seemingly disparate rights operate together to further a particular social goal (in this case, individual and collective health-maximisation). More importantly, I believe it to be necessary to ground any critique of current adjudicative practices in relation to socio-economic rights in a detailed and integrated understanding of the content of the rights in question. An unintended feature of the academic response to the Constitutional Court's socio-economic rights judgments has been a disproportionate focus on institutional and procedural aspects of the judicial enforcement of socio-economic rights, rather than on their content and

[51]Whereas this dissertation will not engage in a detailed study of the horizontal application of health rights, many of its observations pertain equally to their invocation against private entities. In particular, I will argue that the benefit-rendering potential of health rights may significantly be increased by allowing for their indirect horizontal application in certain circumstances.

[52]In this sense, the benefit-focused approach adopted here is broader than the 'remedy-conscious' approach argued for by Jonathan Klaaren 'A remedial interpretation of the *Treatment Action Campaign* decision' (2003) 19 *SAJHR* 455-468.

implications, even as scholars lament the fact that the Court's current approach sidelines the content of the rights. This is unfortunate, since the Court's reluctance to adopt a more robust approach to enforcing socio-economic rights is at least in part ascribable to a perception among its members that socio-economic rights suffer from a lack of conceptual clarity.[53] Lest South African socio-economic rights jurisprudence and scholarship be caught up in the debilitating chicken-and-egg situation that has for years hindered the effective enforcement of socio-economic rights in international and foreign law (where the supposed lack of conceptual clarity of socio-economic rights has been used to justify their limited enforcement, which conversely has hindered the incremental fleshing out of their content through application in concrete cases[54]), we need to focus anew on the content and practical implications of socio-economic rights and of the obligations that they impose.[55]

My investigation into the benefit-related content and implications of rights relevant to health-maximisation starts with their formulation in international law, which not only functioned as the blueprint for corresponding rights in the South African Constitution, but also remains the premier source of the content and benefit-related implications of socio-economic rights. Chapter 2 below surveys the formulation of the so-called 'right to health' in international human rights treaties, and shows that the right consists of an interrelated 'package of rights' that, exercised together, contribute to the highest attainable standard of human health. The constituent elements of this package includes both socio-economic

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[53]See *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) at para 32; *Minister of Health v Treatment Action Campaign (No 2)* 2002 (5) SA 721 (CC) at paras 37-38.

[54]See, for example, Audrey R Chapman 'A "violations approach" for monitoring the International Covenant on Economic, Social and Cultural Rights' (1996) 18 *Human Rights Quarterly* 23 at 30; Matthew CR Craven 'The domestic application of the International Covenant on Economic, Social and Cultural Rights' (1993) 40 *Netherlands International LR* 367 at 367-368; Künnemann op cit note 10 at 337; Scheinin op cit note 16 at 42; 53; 62; Scott & Macklem op cit note 16 at 72-73; Shah op cit note 8 at 445; Steiner & Alston op cit note 10 at 250; Van Hoof op cit note 12 at 99.

[55]As Geoff Budlender has argued, there needs to be a shift in thinking in South African socio-economic rights scholarship, away from institutional issues, in order to 'find out how social and economic rights can be used to benefit real people in South Africa'. Geoff Budlender 'Socio-economic rights in South Africa: Facing the challenges of implementation' (1999) 1(4) *ESR Review* 15 at 15-16. See also Van der Walt op cit note 2 at 166.

and civil and political elements, illustrating that the enforcement of socio-economic rights is closely connected to, dependent on and an essential prerequisite for the effective protection of civil and political rights. In an attempt to derive a rounded understanding of the various benefits that may realistically be expected to result from successful enforcement of health-related rights, the chapter also considers prominent academic and institutional elaborations on the content of the rights consisting this 'package' as well as of the obligations that they impose.

Chapter 3 then moves the focus of the study to the South African constitutional setting. It commences by illustrating that the Bill of Rights in the 1996 Constitution, in addition to containing justiciable socio-economic rights alongside civil and political rights, enables a benefit-centered approach to health-related rights through awarding courts sufficient interpretative leeway and remedial flexibility to balance the interests served by the rights with the public interest. It is therefore possible, in appropriate circumstances, to enforce health-related rights in a manner that renders tangible benefits. I subsequently show that all constituent elements of the right to health in international law find adequate protection in the South African Bill of Rights. I identify constitutional provisions that correspond to the various constituent elements of the right to health and indicate the extent of their potential to render tangible benefits to a range of persons in a variety of circumstances. In doing so, I propose interpretations of the relevant constitutional provisions that I believe best reflects their purpose and best enables them to adequately respond to the needs they represent, while at the same time remaining true to their textual formulation.

In chapter 4, I evaluate the approach of South African courts to certain of the health-related rights in the 1996 Constitution. Through integrating the various critiques of South African socio-economic rights jurisprudence, I show that, while current judicial approaches are capable of resulting in a measure of tangible benefits for rights-bearers, they often unduly limit the potential of constitutional health rights in this regard. Shortcomings in current judicial practices are identified and possible institutional and other reasons for these are

considered. In the main, I argue that the Constitutional Court's denial that socio-economic rights embody enforceable individual claims, as well as its alternative focus on the reasonableness of socio-economic policies, has served to strip these rights of discernible content and has removed the focus of the Court's inquiry from the needs that the rights aim to satisfy. However, there remain indications in the jurisprudence of the Constitutional Court, supported by a number of High Court judgments, that certain interests served by health-related rights may yet be tangibly vindicated as South African socio-economic rights jurisprudence develops. I also show that, contrary to the assertions of the Constitutional Court and its defenders, the overly restrictive elements of its current approach to health-related rights are not necessitated by the institutional constraints typically associated with the judicial vindication of socio-economic rights.

Building on the conclusions reached in chapter 4, chapter 5 illustrates that there exist viable alternative and supplementary judicial approaches to the enforcement of health-related rights, which would be more conducive to tangible benefits than the Constitutional Court's current approach. Adopting such approaches would neither preclude courts from conducting a 'reasonableness analysis' in appropriate circumstances, nor require of them to depart drastically from the manner in which they typically conduct themselves in socio-economic rights matters. The chapter argues, first, for the identification and enforcement of core-like interests underlying rights to health and, secondly, for the increased indirect application of health rights to a variety of public and private disputes, through the development of the common law in accordance with the spirit, purport and objects of the Constitution.

Finally, chapter 6 situates the enforcement of constitutional health rights within the overarching social and economic transformation 'project' envisaged by the preamble of the 1996 Constitution. I argue that, by virtue of their justiciability, health rights have the potential to contribute to this transformation project not only through their 'directive principle effect', but also through enabling vulnerable sectors of South African society to demand the tangible

satisfaction of their health-related needs. Summarising and integrating the findings of the dissertation, the chapter points out that this potential remains largely unrealised. I argue that courts should acknowledge and affirm the rights-based nature of health rights by adopting interpretative, evaluative and remedial practices that enable the vindication of the claims they represent in appropriate circumstances. I also indicate areas in which further research is required in order to overcome theoretical lacunae which continue to inhibit the potential of health rights to render tangible benefits through the judicial process.

Overall, I aim to illustrate that there are circumstances in which it is not only permissible, but both possible and appropriate to enforce health-related rights (and, by implication, all socio-economic rights) in a manner that confers tangible benefits on their beneficiaries. It is hoped that this dissertation will provide increased clarity on the content and implications of health-related rights and on the manner in which they interact, and also that the benefit-focused perspective adopted here will shed new light on their remedial potential and will suggest useful approaches to their enforcement.

CHAPTER 2
CONTENT AND IMPLICATIONS OF THE INTERNATIONAL LAW RIGHT TO HEALTH

2.1 INTRODUCTION: THE RIGHT TO HEALTH

In this chapter, I provide an overview of the protection of and interaction between various health-related rights in international and regional human rights law. Through this overview, I hope to identify the various health-related interests that must be affirmed and protected in order for a rights-based approach to health-maximisation to be effective. I would also like to draw attention to the existence of a detailed elaboration of the content of health-related rights, the obligations they impose and the benefits they imply on the international law level, which I believe to be instructive for domestic courts tasked with awarding meaningful content to corresponding provisions in the South African Constitution.

It is universally accepted that the pursuit of physical and mental health is a legitimate individual and societal goal[1] and that human dignity is compromised when members of society are denied the means with which to participate in this pursuit. As Michael Walzer has remarked in relation to health care:

> 'Were medical care a luxury, these discrepancies [in access thereto] would not matter much; but as soon as medical care becomes a socially recognized need, and as soon as the community invests in its provision, they matter a great deal. For then deprivation is a double loss - to one's health and to one's social

[1]René Descartes famously claimed that health-preservation is 'chief of all goods' and should be pursued at all cost. R Descartes *Discourse on Method* (trans A Wollaston, 1960) at 85, as quoted and discussed by Michael Walzer 'Welfare, membership and need' in Michael J Sandel (ed) *Liberalism and its Critics* (1984) 200 at 200-201. Walzer himself argues that pursuit of health belongs to 'a separate sphere of justice' and that community efforts and goods aimed at health preservation should be equally distributed. Ibid at 213-217. Whereas these observations do not necessarily hold true for all health-related needs and the goods and services with which they may be satisfied (as convincingly shown by Ronald Dworkin 'Justice in the distribution of health care' (1993) 38 *McGill LJ* 883 at 885-888), they appear to indicate significant consensus on the notion that human health is a highly valued social good and that its preservation relates intricately to respect for individual and communal dignity. See also Kevin P Quinn 'Viewing health care as a common good: Looking beyond political liberalism' (2000) 73 *Southern California LR* 277 at 286; 289; 325; 357.

> standing. Doctors and hospitals have become such massively important features of contemporary life that to be cut off from the help they provide is not only dangerous but also degrading'.[2]

It would thus appear that the intrinsic importance of human health and its close connection to the value of human dignity justifies adopting a rights-based approach in relation to claims for equal participation in the quest for health-maximisation, as well as claims to such social goods and services that may assist in this quest.

Of course, the main problem with adopting a rights-based approach towards health-maximisation is that a state of 'perfect' (or 'sufficient', or 'good', or 'acceptable') human health, in addition to defying exact and universal definition, is incapable of complete and lasting achievement.[3] The success of exercising a right to health-maximisation will accordingly always only be partial. It will also vary from individual to individual and will depend on the particular circumstances in which the right is asserted. Individual health status is impacted by a complex interaction of several variable factors, such as genetics, the operation of social power structures, individual lifestyle and behaviour, the physical environment, age, gender, the state of science and technology, the state of the health system and, beyond all of these, coincidence.[4] Exercising a right (or rights) to health-maximisation will impact at most partially on certain of these determinants and may have no influence whatsoever on others.

To the extent that health status is impacted by socio-economic

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[2]Walzer op cit note 1 at 214-215.

[3]See remarks of Alicia Ely Yamin 'Defining questions: Situating issues of power in the formulation of a right to health under international law' (1996) 18 *Human Rights Quarterly* 398 at 407-408. The goal of health-maximisation is also largely incapable of self-fulfillment. Population health necessarily depends, at least in part, on sustained, state-driven, community-wide efforts, which explains why the safeguarding and protection of public health is a central goal of all modern states. See Rene Bowser & Lawrence O Gostin 'Managed care and the health of a nation' (1999) 72 *Southern Californian LR* 1209 at 1210-1211; Knut Erik Tranoy 'Vital needs, human rights, health care law' (1996) 15 *Medicine & Law* 183 at 186.

[4]Apart from the latter, these are usually referred to as 'determinants of health', which are typically sub-classified into biological, behavioural (ie lifestyle related), structural (ie health-system-related), socio-economic, socio-cultural and (physical, biological, social and economic) environmental determinants of health. See for instance Carol Barker *The Health Care Policy Process* (1996) at 108-116; Sundrasagaran Nadasen *Public Health Law in South Africa: An Introduction* (2000) at 3-8.

vulnerability and the operation of social power structures,[5] the success or otherwise of exercising right(s) to health-maximisation is further contingent on the dismantling of such structures in the quest for substantive equality and on the simultaneous satisfaction of other, equally compelling, socio-economic needs. Accordingly, the ability to exercise right(s) to health may be but one of several capacities required for the effective maximisation of individual and collective health.

A wide array of 'goods', which differ significantly in nature, contribute in different ways to the various needs associated with health-maximisation and may all be required in order for an individual to enjoy the maximum attainable level of health. It would be virtually impossible to formulate a single, specific right that simultaneously and practicably caters for all of these needs. Rather, achievement of the 'right to health' (as the conglomeration of these needs is often referred to) requires the exercise of a variety of complementing rights to the various social goods that contribute to the highest attainable standard of health.

One of the earliest conceptualisations of a 'right to health' in international law is found in the 1946 Constitution of the World Health Organisation (WHO), the preamble of which proclaims that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. The preamble further defines 'health' as 'a state of complete physical, mental and

[5]On the 'matrix of vulnerability' occasioned by the intersection of vulnerabilities associated with determinants such as gender, race, age and social status, and its impact on and interaction with individual and communal health status, see, for example, Cathi Albertyn 'Using rights and the law to reduce women's vulnerability to HIV/AIDS' (2001) 5 *Law, Democracy & Development* 179 at 179-184; Barker op cit note 4 at 104; 112-113; Lynn P Freedman 'Reflections on emerging frameworks of health and human rights' in Jonathan M Mann et al (eds) *Health and Human Rights: A Reader* (1999) 227-252; Linda J Jones *The Social Context of Health and Health Work* (1994) at 24; 27; 230; 251-253; 306; 313-316; Barbara Klugman 'Mainstreaming gender equality in health policy' (1999) *Agenda Monologue* 48-70; L Walker & L Gilbert 'HIV/AIDS: South African women at risk' (2002) 1 *African J of AIDS Research* 75 at 75; 77; Susan L Waysdorf 'Fighting for their lives: Women, poverty, and the historical role of United States law in shaping access to women's health care' (1995-96) 84 *Kentucky LJ* 745; Lisa K Whittle & Marcia C Inhorn 'Rethinking difference: A feminist reframing of gender/race/class for the improvement of women's health research' (2001) 31 *International J of Health Services* 147-165; Yamin op cit note 3 at 409-411; 415.

social well-being and not merely the absence of disease and infirmity'. This definition has been criticised for its essentially idealist and unworkable nature, given that a 'state of complete physical, mental and social well-being' is unattainable by most persons and that its achievement would certainly seem beyond the reach of law.[6] However, given that it is not a human right to this state of well-being that is proclaimed, but rather one to the 'highest attainable' degree of such a state, the WHO definition of health, as well as its concomitant understanding of a right to health, may be regarded as sufficiently flexible to incorporate diverse health-related concerns. This said, the relative vagueness of the standard clearly calls for further clarification.[7]

In its General Comment on the content of the right to health as enshrined in the International Covenant on Economic, Social and Cultural Rights (ICESCR), the UN Committee on Economic Social and Cultural Rights (UNCESCR) emphasised that the phrase 'right to health' should not be read as implying a right to be healthy, since health status is influenced by various personal and environmental factors. Rather, it determined that the right may best be understood as encompassing a package of interrelated and mutually supporting rights, that operate jointly to enable the achievement of the highest attainable standard of physical and mental health.[8]

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[6]See Audrey R Chapman 'Core obligations related to the right to health and their relevance for South Africa' in Danie Brand & Sage Russell (eds) *Exploring the Core Content of Socio-economic Rights: South African and International Perspectives* (2002) 35 at 39-40; Danwood Mzikenge Chirwa 'The right to health in international law: Its implications for the obligations of state and non-state actors in ensuring access to essential medicine' (2003) 19 *SAJHR* 541 at 545; Jones op cit note 5 at 6; Virginia Leary 'Implications of a right to health' in Kathleen E Mahoney & Paul Mahoney *Human Rights in the Twenty-first Century: A Global Challenge* (1993) 481 at 481; 484; Charles Ngwena 'Access to antiretroviral therapy to prevent mother-to-child transmission of HIV as a socio-economic right: An application of section 27 of the Constitution' (2003) 18 *SA Public Law* 83 at 97; Brigit Toebes 'Towards an improved understanding of the international human right to health' (1999) 21 *Human Rights Quarterly* 661 at 662.

[7]See Chirwa op cit note 6 at 545; Aart Hendriks & Brigit Toebes 'Towards a universal definition of the right to health?' (1998) 17 *Medicine & Law* 319 at 321; Paul Hunt *Reclaiming Social Rights: International and Comparative Perspectives* (1996) 108; Toebes op cit note 6 at 663.

[8]UNCESCR General Comment 14 *The Right to the Highest Attainable Standard of Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* (2000) at paras 1; 3-4; 7-9. See also Hendriks & Toebes op cit note 7 at 325; Ngwena op cit note 6 at 97; Brigit Toebes *The Right to Health as a Human Right in International Law* (1999) at 19; Geraldine Van Bueren 'Health' in MH Cheadle et al (eds) *South African Constitutional Law: The*

Section 2.2 below aims to tease out the constituent elements of this package through a cursory survey of the formulation of the right to health and related entitlements in leading international and regional human rights instruments. My predominant focus is on the formulation of the right in article 12 of the ICESCR, since that is the most authoritative international treaty on socio-economic rights and since its provisions have been the subject of several high-profile and authoritative institutional attempts at norm-clarification.[9] In particular, I rely heavily on UNCESCR's elaboration of the content of the ICESCR's formulation of the right to health, in its 14th General Comment. In addition, I will engage with the formulations of the right to health and related aspects in several other prominent UN treaties as well as in the prime regional human rights instruments.[10] These all bind different states in different ways and are all enforced differently, but these technical and procedural aspects of international health rights protection and enforcement do not concern me here. My intention is merely to identify certain common elements evident from these formulations, in order to arrive at a fairly tangible 'package of rights' that may be said to constitute, or at least to contribute to, achievement of the right to health.

Furthermore, an important feature of international human rights law is the demarcation of state responsibility under relevant treaties and the concomitant development of workable and realistic standards according to which state compliance with rights may be ascertained, monitored and ensured. While I do not intend to elaborate on the procedural aspects of these obligations or their

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Bill of Rights (2002) 491 at 494.

[9]See for instance the *Limburg Principles on the Implementation of the ICESCR* UN Doc. E/CN.4/1987/17/Annex (1987) ('Limburg Principles'); the *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* (1997) reprinted in (1998) 20 *Human Rights Quarterly* 691-704 ('Maastricht Guidelines') as well as the various General Comments by the UNCESCR.

[10]Provisions surveyed, in addition to art 12 of the ICESCR, are: Article 12 of the Convention on Elimination of all forms of Discrimination Against Women (CEDAW); art 5(e)(iv) of the Convention on the Elimination of all forms of Racial Discrimination (CERD); art 24 of the UN Convention on the Rights of the Child (CRC); arts 11 and 13(1) of the European Social Charter (ESC); art 11 of the American Declaration on the Rights and Duties of Man ('American Declaration'); art 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ('San Salvador Protocol'), art 16 of the African Charter on Human and Peoples' Rights ('African Charter') and art 14 of the African Charter on the Rights and Welfare of the Child (ACRWC). All provisions surveyed are quoted in full in Annexure A to this dissertation.

various associated compliance-measuring standards, it is necessary for a proper understanding of the content of the 'health rights package' to contemplate also some of the institutional elaborations on the content of obligations flowing from health rights. These are relevant especially insofar as they shed light on the extent to which the entitlements implied by the health rights package may realistically be enforced against states at any given time.[11] Section 2.3 below briefly examines the terms of article 2.1 of the ICESCR (which determines in essence that states must take appropriate steps to facilitate progressively the full realisation of socio-economic rights within the maximum of their available resources), as well as two of the theoretical approaches aimed at clarifying various aspects of this generic obligation, namely the 'tripartite typology of interdependent duties' and the 'minimum core obligation' approach, both of which are of particular relevance to the content of the right to health.

2.2 CONTENT OF THE HEALTH RIGHTS PACKAGE

Acknowledging the multi-dimensional nature of health as a social good, UNCESCR understands the right to health as encompassing both health-related freedoms and health-related entitlements that afford citizens 'the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health'.[12] It further affirms that, like most other human rights, the right to health is underscored by a guarantee of equality and non-discrimination which, substantively conceived, also requires a policy commitment to prioritising the health rights of socially and economically vulnerable sectors of society.[13] It is accordingly clear that the pursuit of the

[11]Of course, the international human rights framework does not currently provide for the direct enforcement of socio-economic rights by individuals against states. Instead, compliance with relevant treaty-obligations is typically monitored through complex reporting mechanisms. The various weaknesses of these, as well as the prominent institutional attempts to overcome them (and hence to make the rights more effectively enforceable at international level) do not concern me here. For my purposes, it is sufficient to note the extent to which these instruments regard the relevant obligations as binding on states.

[12]UNCESCR General Comment 14 op cit note 8 at para 9. See also para 8.

[13]Ibid at paras 18-19.

highest attainable standard of health requires the concurrent exercise of civil liberties and social rights. The right to health, thus conceived, affirms and embodies the principle that human rights are interdependent and indivisible. UNCESCR's typology of the constituent elements of the right to health presents a useful starting point for an investigation into the content of the right. Following this typology, this section now elaborates on the content of each of the central components of the 'right to health'.

(a) Health-related freedoms

Just as 'individuals require a minimum level of health and physical well-being in order to develop autonomously their life-styles and to fulfill their goals in accordance with their value-commitments',[14] individuals must possess sufficient autonomy to pursue optimal health through exercising informed choices relating to their lifestyle and their exposure to the risk of disease, to seek medical attention in the event of sickness and to participate meaningfully in medical and other decisions that concern their health and well-being. Therefore, 'a right to health must refer to a right to gain control over one's sense of physical and psychological well-being'.[15]

The package of rights constituting the right to health accordingly includes a number of autonomy-related rights. In General Comment 14, UNCESCR lists the following freedoms as forming part of the right to health: 'The right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation'.[16] These liberty-interests broadly correspond to those protected by rights to security of the person and to freedom from degrading treatment (including freedom from medical experimentation without consent) under the International Covenant on Civil and

[14]Dieter Giesen 'A right to health care? A comparative perspective' (1994) 4(2) *Health Matrix* 277 at 280.

[15]Yamin op cit note 3 at 415.

[16]UNCESCR General Comment 14 op cit note 8 at para 8.

Political Rights (ICCPR).[17] Given its importance for the pursuit of substantive gender equality, reproductive freedom further finds explicit protection under the Convention on the Elimination of all forms of Discrimination against Women (CEDAW).[18]

However, meaningful exercise of these liberties not only requires that people have access to sufficient health-related information,[19] but also depends almost entirely on their material ability to exercise the choices to which their autonomy entitles them. If people lack access to goods and services that facilitate the exercise of autonomous, health-conducive choices, the choices are for all practical purposes beyond their reach.[20] Accordingly, the exercise of health-related freedoms is closely related to the objects of health-related entitlements, to which I now turn.

(b) Health-related entitlements

Since the societal goal of health-maximisation is best achieved through structured, community-wide efforts, General Comment 14 regards the existence of a national system of health protection, within which the achievement of various constituent elements of the right to health may be facilitated, as the primary entitlement to flow from the right.[21] Accordingly, the right to health may be understood as mandating at least the existence of a health system, an overarching legislative and policy framework facilitating health protection and

[17]See arts 7 and 9 of the ICCPR. On the freedom to control health and body, see Maria Green 'What we talk about when we talk about indicators: Current approaches to human rights measurement' (2001) 23 *Human Rights Quarterly* 1062 at 1074. On the overlap between protection of the right to health and protection of physical integrity in international law, see Toebes op cit note 8 at 264-269.

[18]See art 16(1)(e) of CEDAW.

[19]On the importance of such information for the autonomous pursuit of good health, see Barker op cit note 4 at 112-113.

[20]See Albertyn op cit note 5 at 187; Barker op cit note 4 at 113; Aart C Hendriks 'Patients' rights and access to health care' (2001) 20 *Medicine & Law* 371 at 375; Jones op cit note 5 at 27; Sheetal B Shah 'Illuminating the possible in the developing world: Guaranteeing the human right to health in India' (1999) 32 *Vanderbilt J of Transnational Law* 435 at 461; Walker & Gilbert op cit note 5 at 76; Yamin op cit note 3 at 407; 411; 417.

[21]UNCESCR General Comment 14 op cit note 8 at para 8.

promotion, as well as a national health strategy and plan of action.[22]

More tangible individual entitlements to health-conducive social amenities (which may be viewed as legitimate claims against particular health systems and their functionaries) may be derived from further engagement with the formulation of the right to health in international and regional human rights instruments. Most of these proclaim the right in broad terms similar to that of the WHO definition,[23] but then proceed to award more tangible content to the right by listing a variety of sub-rights or sub-obligations that are understood to flow from it. For instance, whereas article 12(1) of the ICESCR emulates the WHO's idealistic formulation of the right, article 12(2) prescribes an open-ended list of steps to be taken in pursuit of the 'highest attainable standard of physical and mental health'. These are:

> '(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> (b) The improvement of all aspects of environmental and industrial hygiene;
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness'.

General Comment 14 emphasises that this list is not exhaustive, and may be viewed as representing a list of separate, subservient 'rights' to particular aspects of health, which form part of the overarching right to health.[24]

The first of these is a right to adequate maternal, child and reproductive health services and information derived from article 12(2)(a).[25] This may be understood as an elaboration on a more general right to health care services (to

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[22]General Comment 14 (ibid) at paras 53-56 acknowledges that it is not feasible to dictate the contents of such systems, legislation, policy, frameworks and plans, since these must respond to the specific health needs of every population and will necessarily depend on the economic, structural and social realities of each society. Broad policy guidelines, including principles of non-discrimination, community participation in health policy formulation, transparency and accountability, are however listed.

[23]See art 12(1) of the ICESCR; art 24(1) of the CRC; art 10(1) of the San Salvador Protocol; art 16(1) of the African Charter.

[24]UNCESCR General Comment 14 op cit note 8 at paras 7; 13.

[25]Ibid para 14. Similarly, art 12(2) of the CEDAW requires 'appropriate services in connection with pregnancy, confinement and the post-natal period', whereas art 24(2)(a) of the CRC mandates measures aimed at diminishing infant and child mortality and at ensuring that mothers receive appropriate pre- and post-natal care. See also art 24(2)(d) of the CRC.

be discussed below), that entitles pregnant women and new-born children to the context-specific care necessitated by their peculiar health-related vulnerabilities. A right to have access to adequate reproductive health care services may further be justified by virtue of the fact that such access is essential for the effective exercise of reproductive freedom and for the achievement of substantive gender equality.

According to General Comment 14, article 12(2)(b) may be understood as implying two broad entitlements - firstly, a right to occupational health, safety and hygiene, and secondly a right to environmental determinants of health including a healthy physical environment, safe drinking water and adequate sanitation services.[26] This resonates with General Comment 14's assertion that the phrase 'state of complete physical, mental and social well-being' encompasses 'a wide range of socio-economic factors that promote conditions whereby people can lead a healthy life', which also implies protection of underlying determinants of health such as adequate nutrition, access to safe drinking water, adequate housing conditions as well as health-conducive working and environmental conditions.[27] Such entitlements are also recognised, with greater or lesser specificity, in most of the other human rights documents surveyed here.[28] Viewed together, these seem to represent essential

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[26]UNCESCR General Comment 14 op cit note 8 at para 15.

[27]Ibid paras 4; 11. See also Chapman op cit note 6 at 36; Chirwa op cit note 6 at 547; Green op cit note 17 at 1074; Hunt op cit note 7 at 111; Toebes op cit note 6 at 676. These are discussed in more detail in Toebes op cit note 8 at 254-259.

[28]On occupational health, see art 3 of the ESC; art 7(e) of the San Salvador Protocol, as well as the myriad of standards contained in the conventions of the International Labour Organisation (ILO) (see for example ILO Convention 155 on Occupational Safety and Health and the Working Environment (1983); ILO Convention 161 on Occupational Health Services (1988). For an overview of relevant ILO treaties, see Nadasen op cit note 4 at 107-110). Environmental health and social goods that impact on health status are viewed as flowing from the 'right to health' by for instance art 24 of the CRC (adequate nutrition; clean drinking water; healthy environment), art 12 of the American Declaration (food, clothing, housing), arts 11 and 12(1) of the San Salvador Protocol (healthy environment; adequate nutrition); art 14 of the ACRWC (adequate nutrition; safe drinking water) and art 11(1) of the ESC. While not directly included in art 16 of the African Charter, the African Commission on Human and Peoples' Rights has held that failure to provide 'basic services' (such as safe drinking water) and shortage of medicine amounts to a violation of art 16 (see *Union Inter-africaines des Droits de 'l'Homme v Zaire* Communication No. 100/93; discussed by Vincent O Orlu Nmehielle *The African Human Rights System: Its Laws, Practice, and Institutions* (2001) at 127) and that the deliberate pollution of water, soil and air violates art 16, which was found to bar governments from deliberately engaging in health-harming activities (see *Social and Economic Rights Action*

components of the right to a standard of living conducive to health and well-being enshrined in the 1945 UN Charter and in the Universal Declaration of Human Rights.[29] For my purposes, they may be grouped together as elements of an overarching right to determinants of health, which may be understood as consisting of rights to occupational health, environmental health and to have access to non-medicinal, health-enhancing social goods.

Article 12(2)(c) of the ICESCR, according to General Comment 14, implies a right to disease prevention, treatment and control and requires the establishment and maintainance of disease-prevention and health-education programmes, as well as of a responsive public health system that effectively combats the spread of infectious epidemic and endemic diseases.[30] As such, it corresponds to the right of health promotion and protection in article 11 of the ESC and seems to reflect the WHO's understanding of 'health promotion' as a broad policy objective encompassing the conception and implementation of health-enhancing public policy measures, as well as the encouragement and empowerment of individuals and communities to lead healthy lives.[31] From a benefit-focused perspective, the only tangible entitlements that may conceivably flow from a right to health promotion and protection would seem to be to those goods, facilities or services (such as immunisation services, quarantine facilities or medicines specifically required to combat particular epidemics) that form part of a responsive public health system.

Finally, a right to have access to health care facilities, goods and services is implied by article 12(2)(d) of the ICESCR.[32] This right may be viewed as an elaboration on the more vague entitlement to medical attention in the event of

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Centre and the Centre for Economic and Social Rights v Nigeria Communication No. 55 of 1996, discussed by Danwood Mzikenge Chirwa 'A fresh commitment to implementing economic, social and cultural rights in Africa' (2002) 3(2) *ESR Review* 19-21).

[29]See arts 55(b) and 62(1) of the UN Charter; art 25 of the Universal Declaration.

[30]UNCESCR General Comment 14 op cit note 8 at para 16.

[31]See for instance WHO *Ottawa Charter for Health Promotion* (1986). The provisions of the Ottawa Charter and the WHO's approach to health promotion are discussed by Nadasen op cit note 4 at 8-9. Health promotion and health protection initiatives measures are similarly viewed as mandated by the right to health by arts 24(2)(c) and (e)-(f) of the CRC, arts 10(2)(c)-(e) of the San Salvador Protocol and art 16 of the African Charter.

[32]See also art 24(1) of the CRC; art 2(1)(c) of CERD and art 12 of the American Declaration.

illness guaranteed by several other human rights instruments.[33] The treaty provisions surveyed here typically do not themselves define what is meant by 'health care goods and services', save for indicating that these relate both to physical and mental health. Several of the provisions however emphasise the provision of primary health care services, goods and facilities, in line with the WHO's distinction between primary, secondary and tertiary health care.[34] The extent of the article 12(2)(d) entitlement has been clarified by General Comment 14, which understands it to require 'the provision of equal and timely access to basic preventative, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care'.[35]

General Comment 14 further determines that compliance with the right to have access to health care facilities, goods and services should be assessed with reference to the availability, accessibility, acceptability and quality of the facilities, goods, and services. Each of these determinants seemingly represents an essential element of the right to have access to health care

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[33]See arts 55(b) and 62(1) of the UN Charter; art 25 of the Universal Declaration; art 24(2)(b) of the CRC; art 13(1) of the ESC; art 16 of the African Charter.

[34]See art 24(2)(b) of the CRC, art 10(2)(a) of the San Salvador Protocol and arts 14(2)(b) and (d) of the ACRWC. Primary health care aims to satisfy basic health needs through prevention and treatment services for commonly encountered medical conditions. Secondary health care involves prevention and treatment of less common conditions that require more specialised treatment, whereas tertiary health care refers to highly specialised medical interventions requiring advanced facilities, drugs and knowledge. See WHO *Glossary of Terms* (1984) paras 2-30, as well as discussions of the typology by Gina Bekker 'Introduction to the rights concerning health care in the South African Constitution' in Gina Bekker (ed) *A Compilation of Essential Documents on the Rights to Health Care* (2000) 1 at 9; Nadasen op cit note 4 at 13; Karrisha Pillay 'Tracking South Africa's progress on health care rights: Are we any closer to achieving the goal?' (2003) 7 *Law, Democracy & Development* 55 at 61; Toebes op cit note 8 at 247; HJ Van Rensburg 'Primary health care in disadvantaged communities in South Africa' (1994) 13 *Medicine & Law* 133 at 134. The importance of the provision of primary health care services is further discussed under 2.3(b) below.

[35]UNCESCR General Comment 14 op cit note 8 at para 17. The reference to 'essential drugs' is best understood as referring to the WHO's list of 'essential drugs', a term which it has through time defined as medicines 'of utmost importance, basic, indispensable and necessary for the health needs of the population' that 'should be available within the functioning health systems at all times in adequate amounts, in appropriate dosage forms, with assured quality and at a price that individuals and the community can afford', and which have been selected 'with due regard to disease prevalence, evidence on efficacy and safety, and comparative cost-effectiveness'. This is a conglomeration of various definitions of the term to be found in WHO Technical Reports through the years, set out by Chirwa op cit note 6 at 554-555.

services and it therefore makes sense to view them as separately enforceable entitlements. An entitlement to the availability of services, goods and facilities would accordingly require that particular treatment options as well as the personnel, facilities and medicines required to effect these are physically available, in sufficient quantities, in the health sector concerned. The standard of accessibility in turn demands that health care facilities, goods and services are physically and geographically accessible to all citizens and are within the financial means of all (implying an additional standard of affordability), whereas the standard of acceptability requires that health care facilities, goods and services are culturally appropriate and adhere to relevant medical ethics and standards. Finally, an entitlement to care of adequate quality requires that health services, goods and facilities are 'scientifically and medically appropriate', and implies further entitlements to access to trained medical professionals, scientifically approved and safe medication and medical equipment, as well as of safe drinking water and adequate sanitation at health care facilities.[36]

To summarise, the entitlements implied by the right to health may be subdivided into two categories. The first is a right to determinants of health, which implies entitlements to occupational health, environmental health and to various non-medicinal, health-enhancing social goods. The second is a right to available, accessible, and acceptable health care goods, services and facilities of sufficient quality. The latter right pertains to a large range of health care services, facilities and products, but specifically includes at least primary health care services, maternal and reproductive health care services and health protection services.

(c) Equality

[36]UNCESCR General Comment 14 op cit note 8 at para 12. See further Chapman op cit note 6 at 45; Green op cit note 17 at 1073; Toebes op cit note 8 at 287-288. Similarly, the Council of Europe's Committee of Ministers has indicated that ESC art 11 implies an obligation to ensure that health care services are 'financially accessible'. Council of Europe, Recommendation R (86)5 of the Committee of Ministers (1986), quoted and discussed by Katarina Tomasevski 'Health rights' in Asbjørn Eide et al (eds) *Economic, Social and Cultural Rights: A Textbook* (1995) 125 at 133.

The egalitarian undertones of the right to health are evident firstly from its phrasing in the preamble of the WHO Constitution (which explicitly determines that its enjoyment may not be impeded by discrimination) and secondly from the WHO's policy of equity in health care provision (which is aimed at reducing 'avoidable gaps in health status and health services between groups with different levels of social privilege').[37] The implementation of all rights in the ICESCR is similarly underscored by a guarantee of equality. Article 2(2) of the ICESCR determines that 'the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'. A further emphasis on gender equality is to be found in article 3, which requires states to 'ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights...'. Measures taken in pursuit of the right to health may therefore not be discriminatory and should emphasise the need to target gender-discrepancies in the enjoyment of the right.[38]

The equality component of the right to health may accordingly be said to entail an uncompromising guarantee against unfair discrimination from public or private sources, in the provision of health-related goods and services, where such discrimination 'has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health'.[39] In slightly broader terms, the core entitlement conferred by the equality-component of the right to health is one against arbitrary or discriminatory exclusion from the ambit of laws, policies or programmes which confer health-related benefits. Successfully enforcing this right would thus entitle the beneficiary to share equally in the benefits conferred

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[37]WHO *Equity in Health and Health Care* (1996) 1, quoted from Bekker op cit note 34 at 10.

[38]Clair Apodaca 'Measuring women's economic and social rights achievement' (1998) 20 *Human Rights Quarterly* 139 at 144; Alicia Ely Yamin & Deborah P Maine 'Maternal mortality as a human rights issue: Measuring compliance with international treaty obligations' (1999) 21 *Human Rights Quarterly* 563 at 601.

[39]UNCESCR General Comment 14 op cit note 8 at para 18, which lists the following grounds upon which such discrimination is prohibited: 'race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status'.

by the law, programme or policy.

On a somewhat more abstract level, General Comment 14 further determines that the ICESCR's anti-discrimination provisions must be understood as endeavouring to ensure substantively equal access to health care services, goods and facilities. Beyond an obligation immediately to abolish all instances of de jure discrimination in health care policy and/or practices and to refrain from such discrimination, this also requires a commitment on the part of states to eradicate de facto discrimination, occasioned by unequal enjoyment of health rights. States must therefore endeavour to bring about the substantively equal enjoyment of relevant goods and services.[40] This necessitates the active targeting and dismantling of those social structures and associated vulnerabilities that impact perniciously on the health status of particular groups in society. One way of achieving this is through the adoption of special measures that aim to address the specific health needs of socially vulnerable and/or marginalised groups, such as women (especially rural women), children (especially girl children), members of minority or historically oppressed racial groups, the elderly, the disabled and indigenous communities.[41] Beyond sharing in the benefits implied by health-related laws, policies and programmes aimed at the general population, the equality-component of the right to health thus entitles members of such vulnerable groups to special consideration for their

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[40]Ibid paras 18-19. A right of substantive equality of access is also evident from art 2(1)(c) of CERD; art 12 of CEDAW; art 2 of the CRC; art 13(2) of the ESC and art 3 read with arts 10(2)(b) and (f) of the San Salvador Protocol. See also UNCESCR General Comment 3 *The Nature of State Parties' Obligations (Art. 2, para. 1 of the Covenant)* (1990) at para 1; Limburg Principles 14; 37-39; Matthew CR Craven *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development* (1995) at 117; Brigitte I Hamm 'A human rights approach to development' (2001) 23 *Human Rights Quarterly* 1005 at 1024; Hunt op cit note 7 at 119; Leary op cit note 6 at 489; Sandra Liebenberg 'The International Covenant on Economic, Social and Cultural Rights and its implications for South Africa' (1995) 11 *SAJHR* 359 at 364.

[41]UNCESCR General Comment 14 op cit note 8 at paras 20-21 (mandating special attention for the specific health needs of women); 22 (requiring special measures aimed at addressing children's health needs as represented by art 24 of the CRC); 25 (special measures aimed at satisfying health needs of older persons); 26 (need for measures aimed at eradicating de facto discrimination against persons with disabilities); 27 (need for appropriate measures responding to specific health needs of indigenous peoples). Article 5(e)(iv) of CERD emphasises the need for substantive racial equality in relation to enjoyment of the right to health, whereas women's health needs are emphasised by arts 12 and 14(2)(b) of CEDAW (the latter of which requires specific attention for the health needs of rural women).

particular health-related needs and vulnerabilities.

Non-compliance with both the formal and more substantive obligations implied by the equality component of the right to health may be depicted not only as a violation of the right to health but also as an infringement of the right to equality. As such, the interaction between articles 2(2) and 3 of the ICESCR and the right to equality in article 26 of the ICCPR is one of the most typically cited examples of the 'related interdependence' of civil and political and socio-economic rights.[42] Although the right to equality would often be incapable of directly remedying hardship occasioned by substantial deprivation of health-related needs, due to the relational nature of an inquiry into compliance with the right,[43] it could usefully be appropriated in circumstances where a 'typical' infringement thereof coincides with non-compliance with the right to health. This is so especially since the right to equality typically enjoys stronger and more immediate protection in most societies than do more direct rights to health-related goods, services or facilities.

2.3 OBLIGATIONS IMPOSED BY THE RIGHT TO HEALTH

The international community has recognised the unfortunate reality that, due firstly to the extent of socio-economic need and secondly to the significant resource implications of satisfying such need, expecting of states immediately to comply with all the obligations imposed by socio-economic rights would simply

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[42] 'Related interdependence' involves viewing rights as 'mutually reinforcing or mutually dependant, but distinct'. Craig Scott 'The interdependence and permeability of human rights norms: Towards a partial fusion of the international covenants on human rights' (1989) 27 *Osgoode Hall LJ* 769 at 782-783. The UN Human Rights Committee has, in considering individual complaints under the ICCPR, showed a willingness to apply the ICCPR's equal protection clause also to legislation awarding benefits associated with ICESCR rights. See Scott (ibid) at 851-859 and the authorities cited there; also Scott Leckie 'Another step towards indivisibility: Identifying the key features of violations of economic, social and cultural rights' (1998) 20 *Human Rights Quarterly* 81 at 104-105; Henry J Steiner & Philip Alston *International Human Rights in Context: Law, Politics, Morals* (2000) at 247.

[43] As shown by Frank I Michelman 'The Supreme Court 1968 term: Foreword: On protecting the poor through the Fourteenth Amendment' (1969) 83 *Harvard LR* 7-59. For example, the right to equality is of little assistance in circumstances where all groups in society are equally deprived of access to health-related goods or services, or where benefits are equally conferred by relevant laws, policies or programmes but are inadequate to satisfy urgent health-related needs.

be unrealistic.[44] Accordingly, like several other international and regional human rights instruments, article 2.1 of the ICESCR affirms that there are limits on the extent to which socio-economic rights may be enforced at any given time. It determines that states must take deliberate steps, through all appropriate measures and to the maximum of their available resources, in order to achieve progressively the full enjoyment of all socio-economic rights.[45]

Despite purporting to capture the urgency with which states must pursue the socio-economic upliftment of their populations, article 2.1 (and particularly the progressive realisation standard and resource-limitation it contains) has been criticised for failing to articulate sufficiently concrete standards against which state compliance with the obligations imposed by socio-economic rights may be measured.[46] Accordingly, its terms have often been appropriated to fuel perceptions that socio-economic rights amount to perpetually unachievable ideals, rather than to enforceable rights.

Much institutional and academic energy has been spent on countering such perceptions. As UNCESCR stated in its third General Comment:

> 'the fact that realisation over time, or in other words progressively, is foreseen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realisation of economic, social and cultural rights. On

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[44]See Pierre De Vos 'Pious wishes or directly enforceable human rights?: Social and economic rights in South Africa's 1996 Constitution' (1997) 13 *SAJHR* 67 at 96; Johan De Waal; Iain Currie & Gerhard Erasmus *The Bill of Rights Handbook* (4th ed 2001) at 441; Andrea Gabriel 'Socio-economic rights in the Bill of Rights: Comparative lessons from India' (1997) 1(6) *Human Rights and Constitutional LJ of Southern Africa* 8 at 10; Sandra Liebenberg 'Socio-economic rights' in Matthew Chaskalson et al (eds) *Constitutional Law of South Africa* (RS5, 1999) ch 41 at 39-40.

[45]See also for instance art 4 of the CRC and art 1 of the San Salvador Protocol. The terms of art 2.1 of the ICESCR are discussed in detail by Craven op cit note 40 at 114-116; 125-144. Chapter 3 below will further engage with the meaning of the progressive realisation standard and the resource limitation, as they are phrased in the South African Constitution.

[46]See for instance the critical discussions of the art 2.1 standards by Audrey R Chapman 'A "violations approach" for monitoring the International Covenant on Economic, Social and Cultural Rights' (1996) 18 *Human Rights Quarterly* 23 at 31; 36-39; Audrey R Chapman 'Monitoring socio-economic rights: A "violations approach"' (1998) 1(3) *ESR Review* 2-4; Craven op cit note 40 at 130-131; Robert E Robertson 'Measuring state compliance with the obligation to devote the "maximum available resources" to realizing economic, social and cultural rights' (1994) 16 *Human Rights Quarterly* 693 at 694; Geraldine van Bueren 'Alleviating poverty through the Constitutional Court' (1999) 15 *SAJHR* 52 at 60; Geraldine van Bueren 'Combating child poverty - human rights approaches' (1999) 21 *Human Rights Quarterly* 680 at 690-691.

> the other hand, the phrase must be read in the light of the overall objective, indeed the *raison d'etre*, of the Covenant which is to establish clear obligations for State parties in respect of the full realisation of the rights in question'.[47]

There have been several attempts to clarify the obligations imposed by socio-economic rights and to show that certain of their elements are capable of immediate enforcement, notwithstanding the limits imposed by the progressive realisation standard and the resource limitation.

It has for instance been shown that the equality-guarantee underlying protection of rights such as the right to health is immediately enforceable and accordingly operates unaffected by resource-availability or progressive realisation.[48] Due to their resonance with autonomy rights protected under the ICCPR (which does not contain a clause equivalent to article 2.1 of the ICESCR), the same may be said for the health-related freedoms discussed above. As to health-related entitlements, this section of the chapter briefly considers two theoretical approaches to rights in the ICESCR which distinguish between different categories of obligations flowing from socio-economic rights. I attempt here to indicate the extent to which these obligations (and their correlative entitlements) are capable of immediate enforcement and thereby to illuminate and further clarify the content of several of the entitlements forming part of the health rights package.

(a) The 'tripartite typology of interdependent duties'

The 'tripartite typology of interdependent duties' was first conceived of by Henry Shue, who argued that all rights impose obligations on states, first, to avoid depriving citizens of existing enjoyment of rights, secondly, to protect them from violations of their rights by third parties and, thirdly, to aid the deprived. These have since been recast as duties to respect, protect and fulfill all human rights.[49]

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[47]UNCESCR General Comment 3 op cit note 40 at para 9.

[48]See Limburg Principle 35; Maastricht Guideline 11; UNCESCR General Comment 14 op cit note 8 at para 30.

[49]Shue first developed the typology in *Basic Rights: Subsistence, Affluence and U.S Foreign Policy* (1980). I rely here on his subsequent elaboration on the typology in Henry Shue

In relation to socio-economic rights, the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights describe the 'duty to respect' as entailing an immediately enforceable obligation on states to refrain from interfering with existing enjoyment of socio-economic rights, the 'duty to protect' as requiring states to act immediately in order to prevent third parties from infringing socio-economic rights and the duty to fulfill as requiring the adoption of 'appropriate legislative, administrative, budgetary, judicial and other measures towards the full realization of [socio-economic] rights'.[50]

In General Comment 14, UNCESCR adopted the tripartite typology in relation to the obligations imposed by article 12 of the ICESCR, and has elaborated on the 'right to health'-specific content of each of the obligations. The obligation to respect the right, according to UNCESCR, 'requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health'.[51] This means that citizens are awarded immediately enforceable entitlements to non-disruption of existing access to health-related goods, services and facilities and to the removal of arbitrary barriers to access. In addition, UNCESCR's understanding of the obligation to respect the right to health affirms the right to autonomy in health-related decisionmaking (by forbidding coercive treatment and the withholding of vital health information), as well as rights to equality of access and not to be discriminated against in health

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'The interdependence of duties' in P Alston & K Tomasevski (eds) *The Right to Food* (1984) at 83-95. The typology indicates unequivocally that socio-economic rights are capable of imposing concrete standards against which compliance may be measured. Hunt op cit note 7 at 133; Craig Scott & Patrick Macklem 'Constitutional ropes of sand or justiciable guarantees? Social rights in a new South African Constitution' (1992) 141 *Univ Pennsylvania LR* 1 at 73. Whereas a degree of vagueness still hampers effective monitoring of the obligation to fulfill socio-economic rights, the typology indicates a tangible theoretical basis for enforcing the obligations to respect and protect them. Second, the typology counteracts the distinction between socio-economic and civil and political rights by showing that both entail 'positive' and 'negative' state obligations. Craven op cit note 40 at 110; Hunt op cit note 7 at 133; Toebes op cit note 6 at 677; GJH Van Hoof 'The legal nature of economic, social and cultural rights: A rebuttal of some traditional views' in Alston & Tomasevski (this note) 97 at 107.

[50]Maastricht Guideline 6. See further Craven op cit note 40 at 109-114; Victor Dankwa, Cees Flinterman & Scott Leckie 'Commentary to the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights' (1998) 20 *Human Rights Quarterly* 705 at 713-715; Hendriks & Toebes op cit note 7 at 330; Rolf Künnemann 'A coherent approach to human rights' (1995) 17 *Human Rights Quarterly* 323 at 327-328; Scott & Macklem op cit note 49 at 73-77; Van Hoof op cit note 49 at 106.

[51]UNCESCR General Comment 14 op cit note 8 at para 33.

care provision (by requiring of states to abstain from various discriminatory practices and from impeding equal access to care). It also illuminates rights to quality of care (by mandating that states refrain from marketing unsafe drugs), to reproductive health care services (by mandating that states refrain from limiting access to contraceptives and other reproductive health services) and to environmental health (by forbidding willful pollution).[52]

The obligation to protect the right to health is understood by UNCESCR as requiring the adoption of measures that prevent third parties from infringing upon article 12.[53] This immediately entitles citizens to demand the availability of effective remedies that protect them against private violations of their health-related rights. UNCESCR's understanding of the 'obligation to protect' also further clarifies the quality-dimension of the right to access health care, by requiring measures that ensure the acceptability and quality of privately available health care products and services, as well as measures ensuring that health care professionals act ethically and that their conduct meets appropriate standards of competence and skill.[54]

Apart from affirming the rights to health protection and equal access to determinants of health, few directly enforceable entitlements may be derived from General Comment 14's elaboration on the obligation to fulfill the right to health. This is in line with predominant academic opinion that the obligation to fulfill represents mainly those aspects of the right that are to be realised progressively.[55] Accordingly, General Comment 14 elaborates on the progressive elements of rights to determinants of health (by mandating measures that ensure increased population access to non-medicinal, health-

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[52]Ibid paras 34; 50. See also Limburg Principle 72; Maastricht Guidelines 14(a); 15(g). For further deliberation on the obligation to respect implied by the right to health, see Toebes op cit note 8 at 312-313; 316-326.

[53]UNCESCR General Comment 14 op cit note 8 at para 33.

[54]Ibid paras 35; 51. See also Maastricht Guideline 15(d). The obligation to protect the right to health is further contemplated by Toebes op cit note 8 at 326-332.

[55]See Bekker op cit note 34 at 14; Craven op cit note 40 at 113-114; Christof Heyns & Danie Brand 'Introduction to socio-economic rights in the South African Constitution' (1998) 2 *Law, Democracy & Development* 153 at 158; Karrisha Pillay 'South Africa's commitment to health rights in the spotlight: Do we meet the international standard?' in Brand & Russell op cit note 6, 61 at 64; Sage Russell 'Minimum state obligations: International dimensions' in Brand & Russell (ibid) 11 at 19.

conducive social amenities), the availability and quality of health services (by requiring ongoing efforts to increase the number of health care facilities, especially in rural areas, as well as ongoing training of medical professionals) and affordable care (by requiring the provision of a public or private health insurance system). UNCESCR's understanding of the 'obligation to fulfill' also includes a programmatic (ie not directly benefit-related) element in that it obliges states to attempt the realisation of the right to health through adopting measures aimed at health care provision and health promotion. It also requires states to adopt benchmarks and timeframes with which to measure progress towards full realisation of the right to health.[56]

(b) Minimum core obligations

The development of a 'minimum core approach' to the substantive rights enshrined in the ICESCR has served both to clarify the content of these rights and to expound the standard of progressive realisation, through prioritising certain basic needs over others (thereby indicating both a logical starting point and a temporal framework for progressive realisation). In line with the premise that human dignity is denied those who are forced to subsist without access to even the most basic of socio-economic amenities, the concept of 'minimum core obligation' entails that there are minimum levels of socio-economic subsistence below which no-one should be allowed to exist, regardless of state-resource constraints. Aimed at protecting the most vulnerable members of society, the minimum core approach involves identifying such subsistence levels in respect of each socio-economic right and insisting that the provision of 'minimum core' goods and services enjoys immediate priority. The minimum core of a right thus represents a 'floor' of immediately enforceable entitlements from which progressive realisation should proceed.[57]

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[56]UNCESCR General Comment 14 op cit note 8 at paras 33; 36-37; 52. See also Toebes op cit note 8 at 332-336.

[57]These aspects of minimum core are explained by David Bilchitz 'Towards a reasonable approach to the minimum core: Laying the foundations for future socio-economic rights jurisprudence' (2003) 19 *SAJHR* 1 at 11-18; Thomas J Bollyky 'R if C > B + P: A paradigm for

The moral and practical importance of a minimum core approach to the obligations imposed by socio-economic rights lies in its acknowledgement that certain socio-economic needs are of extreme vitalness and urgency, and that their satisfaction should accordingly be prioritised over the satisfaction of other, less urgent and vital, needs.[58] This distinction is especially useful in relation to the right to health, due to the substantial variations in urgency and vitalness of health-related needs and in the cost and effectiveness with which such needs may be satisfied.[59]

UNCESCR embraced the minimum core concept in its third general comment, where it stated that

> 'a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant'.[60]

Of course, this affirmation of the existence and implications of minimum core obligations sheds little light on their content in relation to specific rights. For instance, all that is said about the right to health is that deprivation of 'essential primary health care' would amount to non-compliance therewith.[61]

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judicial remedies of socio-economic rights violations' (2002) 18 *SAJHR* 161 at 184; Chapman op cit note 6 at 37; Iain Currie 'Bill of Rights jurisprudence' (2000) *Annual Survey of SA Law* 24 at 57; Dankwa; Flinterman & Leckie op cit note 50 at 717-718; Pierre De Vos 'The economic and social rights of children and South Africa's transitional Constitution' (1995) 10 *SA Public Law* 233 at 251; Leckie op cit note 42 at 101-102; Liebenberg op cit note 44 at 43; Caroline MA Nicholson 'The right to health care, the best interests of the child and AIDS in South Africa and Malawi' (2002) 35 *CILSA* 351 at 360; Russell op cit note 55 at 15; Craig Scott & Philip Alston 'Adjudicating constitutional priorities in a transnational context: A comment on *Soobramoney*'s legacy and *Grootboom*'s promise' (2000) 16 *SAJHR* 206 at 250; Scott & Macklem op cit note 49 at 77; Toebes op cit note 6 at 676-677; Geraldine van Bueren 'On floors and ceilings: Minimum core obligations and children' in Brand & Russel op cit note 6, 183 at 185.

[58]Bilchitz op cit note 57 at 11-12; Sandra Liebenberg 'The value of human dignity in interpreting socio-economic rights' (2005) 21 *SAJHR* 1 at 18; Sandra Liebenberg 'The interpretation of socio-economic rights' in Stuart Woolman (ed) *Constitutional Law of South Africa* (2ed; 2003) ch 33 at 28-29.

[59]See Dworkin op cit note 1 at 886; 888-894, who argues for a Rawlsian exercise of public deliberation through which society determines which health-related needs are most vital and accordingly prioritises their satisfaction over other, less vital, health-related needs.

[60]UNCESCR General Comment 3 op cit note 40 at para 10. See also Limburg Principle 72; Maastricht Guideline 15(i).

[61]That states must emphasise the provision of primary health care is also echoed by art 24 of the CRC and art 10(2)(b) of the San Salvador Protocol.

Accordingly, greater clarity on the core content of the right to health may be gained by engaging with the WHO's understanding of the concept of primary health care, defined in its Declaration of Alma-Ata as 'essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally available to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination'.[62] Essential elements of primary health care identified at Alma-Ata include 'promotion of food supply and proper nutrition; basic sanitation and safe water; provision of essential drugs and maternal and child care, including family planning; education regarding prevailing health problems; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and immunization against major infectious diseases'.[63]

Much-needed further clarity on the minimum core content of the right to health has been provided by UNCESCR, which in General Comment 14 provided a list of obligations comprising the core content of article 12 of the ICESCR. These are:

> '(1) to ensure the right of access to health facilities, goods and services on a non-discriminatory basis especially for vulnerable or marginalized groups;
> (2) to ensure access to the minimum essential food which is sufficient, nutritionally adequate and safe, to ensure freedom from hunger to everyone;
> (3) to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
> (4) to provide essential drugs, as from time to time defined by the WHO's Action Programme on Essential Drugs;
> (5) to ensure equitable distribution of all health facilities, goods and services;
> (6) to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the

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[62]WHO *Declaration of Alma-Ata* (1978) para VI. Primary health care forms the crux of the WHO's 'Health for All' strategy, and its importance is also emphasised by arts 24(2)(b)-(c) of the CRC and art 10(2)(a) of the San Salvador Protocol. On the usefulness of the 'primary health care' concept in fleshing out the mimimum core content of the right to health, see Hendriks & Toebes op cit note 7 at 326; Nicholson op cit note 57 at 360-361; Toebes op cit note 6 at 676; Toebes op cit note 8 at 283-284. On viewing provision of essential medicines as part of the minimum core of the right to health, see Chirwa op cit note 6 at 542; 549; 565.

[63]Bekker op cit note 34 at 9. See also Nadasen op cit note 4 at 12-14; Nicholson op cit note 57 at 360-361.

whole population...'.[64]

An additional list of obligations, considered by UNCESCR as being 'of comparable priority' to minimum core obligations, is also furnished, namely:

> '(1) to ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
> (2) to provide immunization against the community's major infectious diseases;
> (3) to take measures to prevent, treat and control epidemic and endemic diseases;
> (4) to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
> (5) to provide appropriate training for health personnel, including education on health and human rights'.[65]

It would thus seem that the minimum core of the right to health, rather than adding entitlements and/or obligations to those already identified above, affirms the importance of certain of those entitlements (such as that to equality and non-discrimination and the adoption of a public health strategy) while indicating essential elements of others. In particular, the core of the right to health care services, goods and facilities encompasses the provision of essential drugs, reproductive health care services, child health care and immunisation against infectious diseases, whereas core aspects of non-medicinal determinants of health (illuminated elsewhere in relation to specific rights to housing, food, etc) should similarly be prioritised.

In principle, a minimum core approach to the obligations imposed by socio-economic rights entails that citizens should generally be able to demand to be provided with the goods, facilities and services that comprise the minimum core of a right such as the right to health. This is the case notwithstanding the dictates of progressive realisation and despite the resource implications of providing minimum core goods and services, although states may nevertheless justify non-provision of core goods and services by showing that complying with

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[64]UNCESCR General Comment 14 op cit note 8 at para 43, which also contains a list of minimum characteristics to which public health strategies should adhere.

[65]Ibid para 44. These lists of core and comparable obligations are discussed in more detail by Bekker op cit note 34 at 15-16; Chapman op cit note 6 at 49-50; 54; Karrisha Pillay 'South Africa's commitment to health rights in the spotlight' (2000) 2(3) *ESR Review* 1 at 2-3; Pillay op cit note 55 at 65-66.

their core obligations is objectively impossible, or demonstrably outside of their resource capacity.[66]

2.4 SUMMARY: ENTITLEMENTS IMPLIED BY THE HEALTH RIGHTS PACKAGE

It is clear that the right to health, in addition to representing 'an aspirational ethical ideal for the international community, which is intrinsically valuable',[67] also encompasses tangible human rights standards and imposes a network of enforceable obligations on states. These derive from an interrelated package of rights that together ensure maximum possible enjoyment of the right to health. This chapter has identified the contributing elements to this package from authoritative formulations of health-related rights in several international human rights instruments. Understandings of health rights emerging from this survey were integrated with institutional and academic elaborations on their content as well as on the content of the obligations they generate.

Three strands of rights emerged from the survey. The right to health, it may be said, consists first of a group of freedom rights (such as freedom from coercive treatment, the right to bodily integrity, the right to reproductive freedom and the right not to be treated without consent), which may immediately be enforced in the same way as other civil liberties. Second, there is an immediately enforceable entitlement to equal enjoyment of the right to health. This in turn implies an entitlement not to be arbitrarily or unfairly excluded from health-related services and/or benefits. Citizens should thus be able to demand

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[66] According to Maastricht Guideline 9, minimum core obligations generally apply 'irrespective of the availability of resources ... or any other factors and difficulties'. UNCESCR nevertheless indicated that non-fulfillment of core obligations could be justified by resource scarcity, but only where states can demonstrate that 'every effort has been made' to use all available resources in order to satisfy the core obligations 'as a matter of priority'. UNCESCR General Comment 3 op cit note 40 at para 10. It further emphasised that, even in times of economic crisis, states must do all in their power to ensure that rights are afforded the 'widest possible enjoyment ... under the circumstances' and should prioritise meeting the needs of the most vulnerable sectors of society. Ibid at paras 11-12. See also Limburg Principles 25-28; 72 as well as discussions on limitation of core interests in international law by Chapman op cit note 6 at 37; Craven op cit note 40 at 143; Liebenberg op cit note 40 at 366-367; Robertson op cit note 46 at 701-702.

[67] Philip W Bates 'Health law, ethics and policy: Challenges and new avenues for the 21st century and new millennium' (1999) 18 *Medicine & Law* 13 at 21.

that their health-related liberties are respected in a variety of settings, to be included in the ambit of laws, policies and programmes that confer health-related benefits and to receive such benefits where these are being withheld arbitrarily or due to unfair discrimination.

Third, the right to health awards a number of entitlements to health-conducive social goods and services. These may be subdivided into two groups: On the one hand, the right to health encompasses rights to determinants of health (in turn consisting of rights to occupational health, to environmental health and to non-medicinal, health-conducive social goods such as housing, food, water and sanitation that are typically the subjects of separate socio-economic rights). These all consist of immediately enforceable core elements (which may be derived from literature relating specifically to the separate rights they represent) and of non-core elements which are to be realised progressively. On the other hand, the right to health implies a right to available, accessible and acceptable health care services, products and facilities of adequate quality. The immediately enforceable core of this right consists of the provision of essential medicines, primary health care, reproductive health care and services necessary for health protection (such as immunisation services). In relation to other (non-core) services, products and facilities, citizens at least possess enforceable entitlements to non-disruption of existing access and to have arbitrary barriers in the way of access removed.

There are of course important institutional differences between the international human rights framework upon which the survey conducted in this chapter has been based and the domestic legal setting.[68] In particular, the possibility of individuals actually enforcing their rights against their state, and therefore of deriving tangible benefit from the exercise of their rights, is real on the domestic level. The focus of the remainder of this dissertation is therefore on the extent to which the elements of the health rights package identified in this chapter find recognition and protection in the South African Constitution and on

[68]For a discussion of some of these, see Fons Coomans 'Reviewing implementation of social and economic rights: An assessment of the "reasonableness" test as developed by the South African Constitutional Court' (2005) 65 *Heidelberg J of International Law* 167 at 185.

the extent to which the benefits that they imply have in fact accrued from their invocation in South African constitutional litigation.

CHAPTER 3

HEALTH RIGHTS IN THE 1996 CONSTITUTION

3.1 BASIC FEATURES OF THE BILL OF RIGHTS AND A BENEFIT-FOCUSED APPROACH TO HEALTH RIGHTS

By including justiciable socio-economic rights alongside civil and political rights, the Bill of Rights in chapter 2 of the 1996 Constitution affirms the principle of interdependence and indivisibility of human rights.[1] The apparent equal justiciability of socio-economic rights and civil and political rights means that, unlike constitutional systems where socio-economic rights are not included in a bill of rights or are included as non-enforceable directive principles of state policy, there is no textual impediment in the South African Bill of Rights to tangible benefits being claimed in, and resulting from, litigation involving socio-economic rights. This chapter first discusses basic features of the Bill of Rights that facilitate and impact on a benefit-centered approach to health rights. Thereafter, I engage with the formulation of substantive health rights in the Bill of Rights and illustrate that the benefits implied by the health rights package in international law are also capable of resulting from South African Bill of Rights litigation.

According to s 39(1) of the Constitution, courts must promote the underlying values of an open and democratic society, must take international law into account and may also have regard to foreign law when interpreting rights in the Bill of Rights. This provision appears to mandate consideration of interpretations of the right to health in international law when interpreting rights

[1]Thomas J Bollyky 'R if C > B + P: A paradigm for judicial remedies of socio-economic rights violations' (2002) 18 *SAJHR* 161 at 180-181; Pierre De Vos 'Pious wishes or directly enforceable human rights?: Social and economic rights in South Africa's 1996 Constitution' (1997) 13 *SAJHR* 67 at 70; Christof Heyns & Danie Brand 'Introduction to socio-economic rights in the South African Constitution' (1998) 2 *Law, Democracy & Development* 153 at 157; Marius Olivier 'Constitutional perspectives on the enforcement of socio-economic rights: Recent South African experiences' (2002) 33 *Victoria Univ of Wellington LR* 117 at 135; Craig Scott & Philip Alston 'Adjudicating constitutional priorities in a transnational context: A comment on *Soobramoney*'s legacy and *Grootboom*'s promise' (2000) 16 *SAJHR* 206 at 214.

in the Bill of Rights that correspond to elements of the health rights package. While not requiring that such interpretations be followed regardless of differences between the domestic and international formulation of rights or in the institutional setting within which these are translated into reality, s 39(1) allows courts to rely on an extensive body of theory which considers the content and implications of relevant rights and standards in detail.[2]

For example, s 7(2) of the Constitution determines that '[t]he state must respect, protect, promote and fulfil the rights in the Bill of Rights'. Clearly a domestic recasting of the 'tripartite typology of interdependent duties',[3] this subsection opens the door for UNCESCR's deliberation of the obligations derived from the right to health to enter South African courts' interpretations of constitutional health rights. For example, South African courts may recognise that the obligation to respect health rights implies entitlements to the continuation and non-disruption of their existing enjoyment, whereas the obligation to protect health rights requires that individuals have access to effective remedies that prevent or compensate for private infringements of their rights.[4]

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[2]See Audrey R Chapman 'Core obligations related to the right to health and their relevance for South Africa' in Danie Brand & Sage Russell (eds) *Exploring the Core Content of Socio-economic Rights: South African and International Perspectives* (2002) 35 at 50-51; Chrystal Chetty 'The right to health care services: Interpreting section 27 of the Constitution' (2002) 17 *SA Public Law* 453 at 454; Olivier op cit note 1 at 123-124; Karrisha Pillay 'South Africa's commitment to health rights in the spotlight: Do we meet the international standard?' in Brand & Russell (this note) 61 at 62-63; Sage Russell 'Minimum state obligations: International dimensions' in Brand & Russell (this note) 11 at 14; Scott & Alston op cit note 1 at 222. Notwithstanding the fact that South Africa has not ratified the ICESCR, its provisions and the various deliberations on the meaning thereof remain important in terms of s 39(1), especially since many socio-economic rights in the 1996 Constitution were clearly modeled on provisions of the ICESCR. See Sandra Liebenberg 'The interpretation of socio-economic rights' in Stuart Woolman (ed) *Constitutional Law of South Africa* (2ed; 2003) ch 33 at 11. In any event, while not incurring any obligations in terms of the ICESCR, South Africa indicated its agreement with the substantive terms thereof by signing the treaty, and has ratified several of the treaties that recognise the right to health in terms not dissimilar to that of art 12 of the ICESCR, such as the CEDAW, the CERD, the CRC, the African Charter and the ACRWC.

[3]With the exception that s 7(2) adds a separate obligation to promote rights, which in international law is viewed as part of the obligation to fulfill. See UNCESCR General Comment 14 *The Right to the Highest Attainable Standard of Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* (2000) at paras 33; 37.

[4]See Gina Bekker 'Introduction to the rights concerning health care in the South African Constitution' in Gina Bekker (ed) *A Compilation of Essential Documents on the Rights to Health Care* (2000) 1 at 14; Danwood Mzikenge Chirwa 'The right to health in international law: Its implications for the obligations of state and non-state actors in ensuring access to essential

The duty to protect socio-economic rights further clearly requires the recognition, regulation and enforcement of private socio-economic obligations.[5] This appears to imply at least a measure of horizontal application of socio-economic rights, the possibility of which is often denied or overlooked by courts and academic commentators alike.[6] Whereas the constitutional text seems to indicate that only the State bears the duty to progressively realise socio-economic rights, this need not mean that it is the only actor implicated in socio-economic rights matters, nor that socio-economic rights are inherently incapable of horizontal application. Certainly, private entities appear as capable of harming the enjoyment of socio-economic rights as the State. Given that the satisfaction of many health-related needs is often frustrated through the conduct of private entities, health rights will frequently be meaningless to their beneficiaries unless they are capable of invocation also against such entities.[7]

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medicine' (2003) 19 *SAJHR* 541 at 559-560; De Vos op cit note 1 at 79-80; 83; Pierre De Vos '*Grootboom*, the right of access to housing and substantive equality as contextual fairness' (2001) 17 *SAJHR* 258 at 273; Stephen Ellmann 'A constitutional confluence: American "State-action" law and the application of South Africa's socio-economic rights guarantees to private actors' in Penelope Andrews & Stephen Ellmann (eds) *The Post-Apartheid Constitutions: Perspectives on South Africa's Basic Law* (2001) 444 at 448; Heyns & Brand op cit note 1 at 158; Sandra Liebenberg 'Socio-economic rights' in Matthew Chaskalson et al (eds) *Constitutional Law of South Africa* (RS5, 1999) ch 41 at 27-28; 31-32; Sandra Liebenberg 'Violations of socio-economic rights: The role of the South African Human Rights Commission' in Andrews & Ellmann (this note) 405 at 411; 414-415; Olivier op cit note 1 at 137-138; Kate O'Regan 'Introducing socio-economic rights' (1999) 1(4) *ESR Review* 2; Pillay op cit note 2 at 64; 67; Karrisha Pillay 'Rights concerning health' in Centre for Human Rights *Report on the Realisation of Socio-economic Rights* (2000) 51 at 54; Russell op cit note 2 at 18-19; Craig Scott & Patrick Macklem 'Constitutional ropes of sand or justiciable guarantees? Social rights in a new South African constitution' (1992) 141 *Univ Pennsylvania LR* 1 at 74.

[5]See UNCESCR General Comment 14 op cit note 3 at paras 35; 42.

[6]See for instance *Jooste v Botha* 2000 (2) BCLR 187 (T) at 196I-197D re s 28(1)(b) of the Constitution; *Modderklip Boerdery v Modder East Squatters* 2001 (4) SA 385 (W) at 394G-395(B) and *Theewaterskloof Holdings v Jacobs* 2002 (3) SA 401 (LCC) at para 18 re s 26(1) of the Constitution; also Halton Cheadle & Dennis Davis 'The application of the 1996 Constitution in the private sphere' (1997) 13 *SAJHR* 44 at 59-60; Alfred Cockrell 'Private Law and the Bill of Rights: A threshold issue of "horizontality"' in *Butterworths Bill of Rights Compendium* (RS13 October 2003) ch 3A at 13; Rolf Künnemann 'A coherent approach to human rights' (1995) 17 *Human Rights Quarterly* 323 at 339-340.

[7]On the capacity of private entities to infringe socio-economic rights and the need to hold them responsible for such infringements, see Maastricht Guideline 18; Danwood Mzikenge Chirwa 'Non-state actors' responsibility for socio-economic rights: The nature of their obligations under the South African Constitution' (2002) 3(3) *ESR Review* 2 at 4; Chirwa op cit note 4 at 561-562; KD Ewing 'Social rights and constitutional law' (1999) *Public Law* 104 at 119; Mark Heywood 'Debunking "Conglomo-talk": A case study of the amicus curiae as an instrument for advocacy, investigation and mobilisation' (2001) 5 *Law, Democracy & Development* 133 at 134-135; Scott Leckie 'Another step towards indivisibility: Identifying the key features of violations

Application of the Bill of Rights is regulated by s 8 of the Constitution, which determines in relevant part:

> '(1) The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.
> (2) A provision of the Bill of Rights binds a natural or juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.
> (3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court -
>
> (a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and
> (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36(1)'.

Socio-economic rights are nowhere excluded from horizontal application. What is acknowledged by s 8, however, is that application of a right to a private dispute will depend on the nature of the right and on the nature of the duties it imposes - indicating that not every right, and not all duties imposed by a particular right, will find horizontal application.[8] In addition, it may be argued that a third factor, namely the nature or identity of the actor against whom/which the right is applied, is significant, since not all actors have equal capacity to comply with the various obligations imposed by a socio-economic right. It may accordingly be argued that s 8(2) 'proceeds on the assumption that constitutional rights might be agent-relative and context-sensitive, inasmuch as their direct application against private agencies will depend on the circumstances of the case and the characteristics of the particular person'.[9]

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of economic, social and cultural rights' (1998) 20 *Human Rights Quarterly* 81 at 108; 111; Liebenberg (in Andrews & Ellmann) op cit note 4 at 414; Jordan J Paust 'Human rights responsibilities of private corporations' (2002) 35 *Vanderbilt J of Transnational Law* 801 at 802; Marius Pieterse 'Beyond the welfare state: Globalization of neo-liberal culture and the constitutional protection of social and economic rights in South Africa' (2003) 14 *Stellenbosch LR* 3 at 25-26; Steven R Ratner 'Corporations and human rights: A theory of legal responsibility' (2001) 111 *Yale LJ* 443 at 462; Johan van der Walt '*Progressive* indirect horizontal application of the Bill of Rights: Towards a co-operative relation between common-law and constitutional jurisprudence' (2001) 17 *SAJHR* 341 at 353.

[8] Johan De Waal; Iain Currie & Gerhard Erasmus *The Bill of Rights Handbook* (4th ed 2001) at 55; Ellmann op cit note 4 at 451-452; 461; Liebenberg (in Chaskalson et al) op cit note 4 at 45.

[9] Cockrell op cit note 6 at 13. In determining the extent to which a private entity should be bound by a particular socio-economic obligation, it is useful to consider the nature and extent of the power exercised by the entity, the degree to which it emulates state power and the manner in which exercising the power impacts on the enjoyment of socio-economic rights. Examples

Section 8(3) proceeds to indicate that rights would seldom directly apply to a private dispute. The preferred manner to vindicate them in the private sphere would be by way of legislative enactment or through developing the common law, which would generate more effective remedies for private rights-infringements.[10] Given the plethora of relevant legislative provisions regulating social service delivery and the vast body of common law that may be developed to give effect to socio-economic rights, direct reliance on socio-economic rights in a private dispute will likely be a rare occurrence. Fears of overzealous private application are further allayed by the determination that rules of common law may be developed to limit the private application of a right.[11]

Notwithstanding the manner in which the Bill of Rights is applied to a particular dispute, all rights can be limited by the State in accordance with the general limitations provision contained in s 36 of the Constitution, which reads:

> '(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including -
>
> (a) the nature of the right;
> (b) the importance of the purpose of the limitation;
> (c) the nature and extent of the limitation;
> (d) the relation between the limitation and its purpose; and
> (e) less restrictive means to achieve the purpose.
>
> (2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights'.

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of private entities that may be considered bound by health rights because of the nature and impact of the power they wield include private hospitals, pharmaceutical companies and private health care practitioners. Otherwise, it may be argued that private entities should be regarded as socio-economic duty-bearers in contexts where a 'special relationship' may be said to exist between them and the relevant rights-bearers. Examples include the doctor-patient relationship, the employer-employee relationship, the parent-child relationship, spousal relationships and a variety of contractual relationships such as that between individuals and their medical aid schemes. See Ellmann op cit note 4 at 444; 446; 462-467; also Chirwa op cit note 7 at 4; 6; James W Nickel 'How human rights generate duties to protect and provide' (1993) 15 *Human Rights Quarterly* 76 at 78; 81-82; Ratner op cit note 7 at 497-511; 524-525; Henry Shue 'The interdependence of duties' in P Alston & K Tomasevski (eds) *The Right to Food* (1984) 83 at 90.

[10] See De Waal; Currie & Erasmus op cit note 8 at 37 and also the separate concurring remarks of Sachs J in *Du Plessis v De Klerk* 1996 (3) SA 850 (CC) at para 187.

[11] Liebenberg (in Chaskalson et al) op cit note 4 at 46. On possibilities in this regard, see generally Pieter Carstens & Anton Kok 'An assessment of the use of disclaimers by South African hospitals in view of constitutional demands, foreign law and medico-legal considerations' (2003) 18 *SA Public Law* 430 at 441; De Vos op cit note 1 at 100-101; Pieterse op cit note 7 at 26.

Given that s 36 affords the State an opportunity to show that there are valid reasons why a limitation on the enforcement of a particular right should be upheld in particular circumstances, courts have adopted a so-called 'two stage' approach to Bill of Rights adjudication. This involves broadly that a court, first, determines whether an infringement of a right has occurred by defining the ambit and scope of that right and, thereafter, if an infringement is indeed found, that the respondent is called upon to justify such infringement in terms of s 36.[12] In addition to promoting accountability by insisting that the State publicly define and justify the extent to which it seeks to limit rights,[13] the two-stage approach affords courts the luxury of being able to generously and permissively award content to a particular right through the process of interpretation without being hindered by the fact that there must inevitably be limits to the extent of its enforcement, since these may properly be deliberated in the limitation-stage of proceedings.[14]

Section 36 is of significance to a benefit-centered approach to health rights not only because it facilitates the unfettered development of their content in this manner but specifically because, through essentially mandating that a proportionality analysis be conducted in deciding whether or not to allow a particular limitation, it allows courts to perform the inevitable balancing act of weighing individual interests in obtaining tangible benefit from a particular health-related right against competing individual or societal interests. Through its consistent invocation on a case-by-case basis, s 36 can therefore assist in the development of a coherent theory on the circumstances in which health rights may legitimately render the benefits that they promise.

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[12]For a more detailed exposition of the 'two-stage' approach, see De Waal; Currie & Erasmus op cit note 8 at 145-147.

[13]See Liebenberg op cit note 2 at 55 and authorities there cited.

[14]Accordingly, the Constitutional Court has on several occasions indicated that it would adopt a generous and purposive approach to interpretation of rights in the Bill of Rights. A generous approach to Bill of Rights interpretation involves preferring as wide and inclusive an interpretation of a right as is possible within the parameters of the constitutional text. De Waal; Currie & Erasmus op cit note 8 at 132-133. Purposive interpretation 'aims to tease out the core values underpinning listed fundamental rights in an open and democratic society based on human dignity, equality and freedom and then to prefer the interpretation of a provision that best supports and protects those values'. Ibid at 130-131.

Finally, s 38 of the Constitution, which is simultaneously the Bill of Rights' standing provision and its primary remedial clause, is of particular importance for a benefit-focused analysis of health rights. It determines:

> 'Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights. The persons who may approach a court are-
>
> a) anyone acting in their own interest;
> b) anyone acting on behalf of another person who cannot act in their own name;
> c) anyone acting as a member of, or in the interest of, a group or class of persons;
> d) anyone acting in the public interest; and
> e) an association acting in the interest of its members'.

Section 38 drastically relaxed standing rules in South Africa, where previously litigants had to prove that they had a personal interest in a matter before they could bring it before a court. Its scope furthers the cause of social justice by enabling socio-economic rights-based litigation on behalf of poor and otherwise marginalised persons who would ordinarily not be in a position to assert their rights themselves.[15] Even more significant for a benefit-focused approach is that s 38 clearly allows *individuals* to approach a court for *individual* relief where their socio-economic rights have been infringed or threatened. Arguments that socio-economic rights should only function as group rights and should generally not result in the granting of individual relief due to their polycentric nature are thus without constitutional foundation.

As to its remedial aspect, s 38's affirmation that courts may grant 'appropriate relief' in the event of an infringement of a right in the Bill of Rights is augmented by s 172(1) of the Constitution's determination that courts '(a) must declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of its inconsistency; and (b) may make any order that is just and equitable...'. Appropriateness, justness and equity are thus the only constitutionally derived limits on the remedial power of the judiciary in Bill of

[15]See John C Mubangizi 'Public health, the South Arican Bill of Rights and the socio-economic polemic' (2002) *TSAR* 343 at 349 and in general Tembeka Ngcukaitobi 'The evolution of standing rules in South Africa and their significance in promoting social justice' (2002) 18 *SAJHR* 590-613.

Rights cases.[16]

An inquiry into the justness and appropriateness of a particular remedy in the circumstances of a particular case is necessarily a context-specific one and is impacted by various practical, legal, institutional and moral considerations. These pertinently include that relief must sufficiently address the wrong caused by the constitutional infringement and must be effective, fair, flexible and capable of being enforced.[17] Courts should further take account of the principles that successful litigants must generally obtain the relief that they seek and that relief should generally not be confined only to such litigants, but should extend also to all others who are similarly situated, unless this would be inappropriate or unjust.[18]

I have argued in chapter 1 that the justiciable nature of socio-economic rights, read with the common law maxim of 'ubi ius ibi remedium', entitles citizens to effective relief for infringements of their socio-economic rights.[19] Similarly, UNCESCR has stated that '[a]ny person or group who is a victim of a violation of the right to health should have access to effective judicial or other appropriate remedies ... [and] should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition'.[20] In order for an applicant in a health rights matter to derive tangible benefit from the successful invocation of her right, it is necessary that

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[16]See *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC) at paras 18-19; *National Coalition for Gay and Lesbian Equality v Minister of Home Affairs* 2000 (2) SA 1 (CC) at para 165; *Hoffmann v South African Airways* 2001 (1) SA 1 (CC) at para 42; Jonathan Klaaren 'Structures of government in the 1996 Constitution: Putting democracy back into human rights' (1997) 13 *SAJHR* 3 at 11; Jonathan Klaaren 'Judicial Remedies' in Chaskalson et al op cit note 4, ch 9 at 2-4; 29; Liebenberg (in Chaskalson et al) op cit note 4 at 10; 52; Olivier op cit note 1 at 132; 146-147; Kameshni Pillay 'Implementation of *Grootboom*: Implications for the enforcement of socio-economic rights' (2002) 6 *Law, Democracy & Development* 255 at 257-258; Scott & Alston op cit note 1 at 224; Wim Trengove 'Judicial remedies for violations of socio-economic rights' (1999) 1(4) *ESR Review* 8.

[17]These are considered for instance in *Fose* op cit note 16 at paras 19; 96; *Hoffmann* op cit note 16 at para 45 and by Howard Varney 'Forging new tools: A note on *Fose v Minister of Safety and Security* CCT 14/96' (1998) 14 *SAJHR* 336 at 340-343.

[18]See for instance *S v Bhulwana* 1996 (1) SA 388 (CC) at para 32; *Mistry v Interim Medical and Dental Council of South Africa* 1998 (4) SA 1127 (CC) at para 35; *National Coalition for Gay and Lesbian Equality* op cit note 16 at paras 82; 94 as well as discussion of these principles by De Waal, Currie & Erasmus op cit note 8 at 174; 183.

[19]See chapter 1 note 30 and accompanying text.

[20]UNCESCR General Comment 14 op cit note 3 at para 59.

relief awarded to prevent or compensate for the unjustifiable infringement of her right is both effective and amounts to 'adequate reparation'.

A wide range of remedies may constitute appropriate, just, equitable and effective relief for unjustifiable infringements of health-related rights, depending on the nature of the right, the nature of the infringement and the unique circumstances of each case. These include, for instance, an order declaring that a challenged law, policy or conduct is invalid, an order suspending a declaration of invalidity of legislation or policy and allowing the legislature or executive to correct the defect, an order that words be read into legislation or policy, a declaration of rights, a prohibitive interdict, a mandamus, a structural interdict, an order of specific performance or reparations in kind, the development of the substantive or remedial provisions of the common law, an award of damages or compensation as well as various forms of interim relief.[21]

Of course, tangible benefits will result more readily from some of these remedies than from others. So for instance will purely declaratory relief, while it may indirectly benefit individual rights-bearers, often be of little use to them -

> '[t]he benefits of moral condemnation ... seem rather abstract for those whose rights have been violated, such as the thousands of South Africans living with HIV/AIDS and dying without access to effective treatment. ... Effective relief for these individuals must be more than declaratory, it must be mandatory in form and structural in purpose, addressing the underlying conditions that threaten constitutional values as well as the private and public acts that create and perpetuate those conditions'.[22]

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[21]The appropriateness of various of these remedies for violations of socio-economic rights and in other related contexts is considered for instance by David Bilchitz 'Towards a reasonable approach to the minimum core: Laying the foundations for future socio-economic rights jurisprudence' (2003) 19 *SAJHR* 1 at 18; 25-26; Bollyky op cit note 1 at 177; 184-186; De Waal, Currie & Erasmus op cit note 8 at 175-190; 451-452; Klaaren (1999) op cit note 16 at 7-8A; 11-16; 22; 28; Jonathan Klaaren 'A remedial interpretation of the *Treatment Action Campaign* decision' (2003) 19 *SAJHR* 455 at 461; 465; Leckie op cit note 7 at 120; Liebenberg (in Chaskalson et al) op cit note 4 at 52-54; Liebenberg op cit note 2 at 62-63; Sandra Liebenberg 'Basic rights claims: How responsive is reasonableness review?' (2004) 5(5) *ESR Review* 7 at 11; Kent Roach & Geoff Budlender 'Mandatory relief and supervisory jurisdiction: When is it appropriate, just and equitable?' (2005) 122 *SALJ* 325; Theunis Roux 'Understanding *Grootboom* - A Response to Cass R Sunstein' (2002) 12(2) *Constitutional Forum* 41, 51; Scott & Alston op cit note 1 at 224-25; Mia Swart 'Left out in the cold? Crafting constitutional remedies for the poorest of the poor' (2005) 21 *SAJHR* 215 at 225-228; Trengove op cit note 16 at 8-11; Varney op cit note 17 at 337-338; 344-345. See also *Fose* op cit note 16 paras 19-20; 58-61; 67; 72; 99; 104.

[22]Bollyky op cit note 1 at 163-164.

Nevertheless, circumstances may well arise in which the interests of justice and equity dictate that a declaratory order is the only appropriate one.[23] What is required in every case is for courts to weigh the applicant's interest in an effective remedy that amounts to adequate reparation for the harm threatened or suffered against competing individual or societal interests and to award a tangible remedy unless doing so would be unjust, inequitable or inappropriate.

The extent of courts' remedial flexibility enables them to strike an appropriate balance between individual and communal interests in socio-economic rights cases and further to delineate the circumstances in which the interests of justice permit tangible benefits to result from a finding that a socio-economic right has unjustifiably been infringed. Accordingly, it facilitates a more explicitly benefit-focused approach to the interpretation and limitation of health rights, by allowing courts to avoid potentially unjust consequences of a permissive and benefit-focused interpretation of health rights or a finding that a (permissively interpreted) health right has unjustifiably been infringed, through tailoring a remedy that is appropriate in light of the specific circumstances of every case.[24]

Overall, the provisions governing the structure of Bill of Rights litigation appear to encourage a benefit-focused approach to socio-economic rights. Not only are socio-economic rights fully justiciable and enforceable by a wide range of individuals and groups against the State or certain private entities, but their enforcement may also, in appropriate circumstances, result in the granting of tangible and effective relief which amounts to adequate reparation for their infringement. Courts are empowered firstly to ascertain the extent of the benefits implied by various socio-economic rights through a generous and purposive approach to their interpretation, secondly to ascertain whether law or conduct has infringed a particular right by balancing the interests served by any limitation on its ambit against the applicant's interests in obtaining relief that satisfies the needs it represents, and thirdly to delineate the circumstances in

[23]See De Waal, Currie & Erasmus op cit note 8 at 194.
[24]Remarked in a more general sense by De Waal, Currie & Erasmus (ibid) at 169.

which the benefits implied by a right should result by deliberating the appropriateness of a range of orders through which to remedy the infringement. It is thus possible for the socio-economic rights in the Bill of Rights, including the various health-related rights to be discussed in the following section, to directly and tangibly compensate for the denial of the needs they represent, and hence to contribute to the affirmation and protection of the inherent dignity of their subjects.

3.2 THE HEALTH RIGHTS PACKAGE IN THE BILL OF RIGHTS

There is no single provision in the Constitution that simultaneously protects all aspects of the right to 'the enjoyment of the highest attainable standard of physical and mental health'. Rather, chapter 2 of the Constitution contains several scattered provisions aimed at promoting the realisation of the right to health, which ought to be read together when ascertaining the extent of health-related protection awarded by the Bill of Rights.[25] This section identifies the rights in the Bill of Rights that guarantee interests similar to those that enjoy protection as part of the health rights package in international law, and illustrates that the benefits implied by these constitutional provisions are virtually identical to those conferred by the right to health. I accordingly propose an interpretation of these rights that corresponds to the interpretation of the relevant constituent elements of the health rights package advanced in chapter 2, and consider the extent to which these rights are capable of rendering the benefits they promise (and, accordingly, of satisfying the needs they affirm) within the structural framework of South African Bill of Rights litigation.

(a) Health-related freedoms

Control over physical and mental health status may be seen as an integral aspect of human autonomy, and the pursuit of health through the exercise of

[25]Bekker op cit note 4 at 1-2; Chapman op cit note 2 at 35-36; 51.

personal choices as an expression of that autonomy.[26] As shown in 2.2(a) above, the health rights package accordingly includes a number of autonomy-based freedoms. In South Africa, these are located in s 12(2) of the Constitution, which determines:

> 'Everyone has the right to bodily and psychological integrity, which includes the right -
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> (a) to make decisions concerning reproduction;
> (b) to security in and control over their body; and
> (c) not to be subjected to medical or scientific experiments without their informed consent.'

Regarded also as an important instrument for the achievement of substantive gender equality, s 12(2)(a) enshrines the control of women over their reproductive capacity. As such, it is most often equated to choices to use contraception or to terminate a pregnancy, and requires firstly that legal and other obstacles to exercising such choices be removed and secondly that women are not to be refused access to reproductive health care facilities, goods and services when they request it.[27]

Given that the availability and accessibility of such facilities, goods and services are logical and essential prerequisites for the meaningful exercise of this right,[28] s 12(2)(a) should further be interpreted as affording additional weight to any claims to such access that women have in terms of other constitutional provisions. For example, Jonathan Berger argues that lack of access to

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[26]RS Downie; Carol Tannahill & Andrew Tannahill *Health Promotion: Models and Values* (1996) at 176; Dieter Giesen 'A right to health care? A comparative perspective' (1994) 4(2) *Health Matrix* 277 at 280; Sheetal B Shah 'Illuminating the possible in the developing world: Guaranteeing the human right to health in India' (1999) 32 *Vanderbilt J of Transnational Law* 435 at 457; 460-461; Alicia Ely Yamin 'Defining questions: Situating issues of power in the formulation of a right to health under international law' (1996) 18 *Human Rights Quarterly* 398 at 404; 422.

[27]In the context of abortion, the exercise of this right is facilitated by s 5 of the Choice on Termination of Pregnancy Act 92 of 1996, which determines that no consent other than that of a pregnant woman is required for the termination of a pregnancy. The reverberance of this provision with s 12(2)(a) of the Constitution influenced a finding that the limits occasioned by it on the rights of parents to consent to medical treatment received by their daughters were not unjustifiable in *Christian Lawyers Association v Minister of Health* 2004 (10) BCLR 1086 (T). See 1092H-1095J.

[28]Joanna Birenbaum 'Contextualising choice: Abortion, equality and the right to make decisions concerning reproduction' (1996) 12 *SAJHR* 485 at 485-486; 489-490; 502; Charles Ngwena 'Access to health care as a fundamental right: The scope and limits of section 27 of the Constitution' (2000) 25(1) *Journal for Juridical Science* 1 at 9. See also *Christian Lawyers Association of SA v Minister of Health* 1998 (4) SA 1113 (T) at 1123E-G.

treatment preventing the transmission of the HIV virus from mother to child could effectively negate reproductive freedom through indirectly coercing poor, HIV-positive, pregnant women to opt for termination of pregnancy. Berger accordingly views s 12(2)(a) as obliging the State to ensure that women have access to such health care services as would enable them freely to exercise their choice whether or not to continue with a pregnancy.[29]

Other than in relation to reproductive autonomy, the context in which health-related freedoms are most at issue is that of the doctor-patient relationship. The inherent imbalances in medical knowledge between patients and health care professionals, combined with the remnants of a culture of medical paternalism within the medical profession, complicates the ability to exercise informed choices in relation to medical treatment options. It is therefore necessary that patients are afforded rights to have full facts regarding their own medical status, diagnosis, prognosis and treatment options disclosed to them by health care practitioners and that they are not subjected to medical interventions without their informed consent.[30]

Section 12(2)(c) of the Constitution entrenches a right not to be treated without consent, albeit in the context of medical or scientific experimentation. In addition, the phrase 'security in and control over [the] body' in s 12(2)(b) is arguably aimed at protecting individual interests in 'bodily autonomy and self-determination' from undue interference.[31] If interpreted in accordance with the South African common law understanding of physical integrity, this phrase would encompass protection of individual control over physical and mental health status, as well as protection of independent and informed decision-making in pursuit of health.[32] To administer medical treatment without a patient's consent

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[29]Jonathan M Berger 'Taking responsibilities seriously: The role of the state in preventing transmission of HIV from mother to child' (2001) 5 *Law, Democracy & Development* 163 at 166-168.

[30]See Dieter Giesen 'Health care as a right: Some practical implications' (1994) 13 *Medicine & Law* 285 at 292-293; Aart C Hendriks 'Patients' rights and access to health care' (2001) 20 *Medicine & Law* 371 at 373-374; Ngwena op cit note 28 at 15; SA Strauss 'Geneesheer, pasient en die reg: 'n Delikate driehoek' (1987) *TSAR* 1 at 3.

[31]De Waal; Currie & Erasmus op cit note 8 at 262-264.

[32]The extent to which the ss 12(2)(b) and (c) rights are protected by the current state of common law is discussed under 5.3(a) below. Patients' right not to be treated without their

would therefore likely amount to a breach of ss 12(2)(b) and/or (c).

As s 12(2) does not contain an internal limitation, non-compliance with the obligations it imposes would be capable of justification only under circumstances allowed for by laws which satisfy the criteria laid down by s 36 of the Constitution.[33] Where an unjustifiable infringement of a s 12(2) right is occasioned by the terms of some law or policy, such law or policy would be invalid to the extent of its inconsistency with s 12(2). Furthermore, it is conceivable that rights-bearers may attempt to prevent infringement of their s 12(2) rights by applying for interdicts or similar orders against health care professionals or others who threaten to interfere with their exercise of the s 12(2) rights, or that they may seek compensation in circumstances where they suffered damages due to an infringement of their health-related autonomy rights.

(b) Equality

The eradication of socio-economic inequalities is a primary aim of South Africa's constitutional order. The inclusion of socio-economic rights in the Bill of Rights is particularly indicative of this aim. As such, the socio-economic rights in the Constitution may be said to be egalitarian in orientation while the aims of the right to equality include addressing the inequalities resulting from decades of social deprivation.[34] Section 9 of the Constitution determines:

> '(1) Everyone is equal before the law and has the right to equal protection and benefit of the law.

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informed consent also finds expression in ss 7-9 of the National Health Act 61 of 2003, which require that a patient's informed consent be obtained before the administering of any medical treatment and which provide for patients' participation in all decisions affecting their health.

[33]For instance, s 7 of the National Health Act determines that treatment without the consent of a patient may proceed where the patient is unable to consent and consent is instead obtained from another person who has been authorised by the patient to consent to treatment on her behalf or, in appropriate circumstances, from a spouse, parent or close family member of the patient; where failure to treat the patient would pose serious risks for the public health or, in circumstances where the patient has not expressly refused consent, where failure to treat would pose serious risk to the life or health of the patient; provided that in all of these instances a health care provider has taken all reasonable steps to obtain the patient's consent.

[34]See De Vos op cit note 4 at 265; Pierre De Vos 'Substantive Equality after *Grootboom*: The emergence of social and economic context as a guiding value in equality jurisprudence' (2001) *Acta Juridica* 52 at 53; Caroline MA Nicholson 'The right to health care, the best interests of the child and AIDS in South Africa and Malawi' (2002) 35 *CILSA* 351 at 359.

> (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
> (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
> (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
> (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair'.

The guarantee of 'equal protection and benefit of the law' in s 9(1), as well as s 9(2)'s determination that the right to equality encompasses the 'full and equal enjoyment of all rights and freedoms', indicates that equal access and enjoyment of socio-economic amenities is envisaged. The State is accordingly tasked with the programmatic eradication of lingering inequalities in such access and enjoyment.

Many of these inequalities are occasioned by the operation of patriarchal social power-structures and their interaction with the remnants of the structural racial oppression of apartheid, which continue to lend definite racial and gender dimensions to discrepancies in access to health-conducive social amenities and to health care facilities, goods and services. For instance, the lack of availability and comparatively poorer quality of health care services in rural areas coincides with the fact that rural areas are predominantly populated by black people and women.[35] Another example is the virtual exclusion of poor South Africans (the overwhelming majority of whom are black and female) from the high quality care that is available at considerable expense in the private health care sector, and their concomitant relegation to the over-burdened and under-resourced public

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[35]See Eric Buch 'Discrimination in the area of health and health care' in Christof Heyns et al (eds) *Discrimination and the Law in South Africa Volume 1* (1994) 152; Barbara Klugman 'Mainstreaming gender equality in health policy' (1999) *Agenda Monologue* 48 at 50-51; Charles Ngwena 'Accessing abortion services under the Choice on Termination of Pregnancy Act: Realising substantive equality' (2000) 25 *Journal for Juridical Science* 19 at 35; Ngwena op cit note 28 at 6; Edgar Pieterse & Mirjam van Donk 'Incomplete ruptures: The political economy of realising socio-economic rights in South Africa' (2002) 6 *Law, Democracy & Development* 193 at 203; Jeremy Sarkin 'Health' (1997/8) *SA Human Rights Yearbook* 97 at 131; HCJ van Rensburg et al *Health Care in South Africa: Structure and Dynamics* (1992) at 30-31.

health sector.[36] The right to equality demands that the amelioration of these discrepancies in enjoyment of health-related rights receives urgent attention in a variety of policy-formulation and -implementation processes.

But the right to equality also holds more immediately enforceable benefits for its subjects. Read with the Constitutional Court's test for establishing violations of the right,[37] it would seem that s 9(1) may be used to attain the benefit of inclusion in programs conferring health-related benefits from which an applicant has arbitrarily and/or irrationally been excluded, or to attain access to health care services where such access is arbitrarily or irrationally being denied, unless the exclusion or refusal can be justified under s 36. Similarly, where denial, exclusion or inequitable provision of health-related benefits results from unfair discrimination on one or more of the grounds listed in s 9(3) or on another ground where discrimination on that ground 'is based on attributes and characteristics which have the potential to impair the fundamental human dignity of persons or to affect them adversely in a comparably serious manner',[38] such

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[36]Only approximately 18% of South Africans (most of whom have medical insurance and belong to the White and Indian population groups) are treated in the private health care sector. However, approximately 80% of health care expenditure takes place in the private sector, which also employs by far the greatest number of health care professionals. For these figures and for discussion of problems relating to quality discrepancies between private and public sector health care in South Africa see Buch op cit note 35 at 156; Chapman op cit note 2 at 52; MA Christianson 'Health care' in EML Strydom (ed) *Social Security Law* (2001) 122 at 138; Herma Forgey et al *South Africa Survey 2000/01* (2001) at 229; 237-239; Heywood op cit note 7 at 136-138; Heinz Klug 'Five years on: How relevant is the Constitution to the new South Africa?' (2002) 26 *Vermont LR* 803 at 806; Bruce E Leech 'The right of the HIV-positive patient to medical care: An analysis of the costs of providing medical treatment' (1993) 9 *SAJHR* 39 at 43; Ngwena op cit note 28 at 7; Sarkin op cit note 35 at 97; Jeremy Sarkin 'A review of health and human rights after five years of democracy in South Africa' (2000) 19 *Medicine & Law* 287 at 288; Van Rensburg et al op cit note 35 at 28.

[37]Laid down in *Harksen v Lane* 1998 (1) SA 300 (CC) at paras 42-54.

[38]Ibid para 54(b)(i). One non-listed ground upon which discrimination in health service provision is especially rife is that of health status (see for example Mahendra Chetty 'Human rights, access to health care and AIDS' (1993) 9 *SAJHR* 71-76; Mary A Crossley 'Of diagnoses and discrimination: Discriminatory nontreatment of infants with HIV infection' (1993) 93 *Columbia LR* 1581-1667; David Orentlicher 'Destructuring disability: Rationing of health care and unfair discrimination against the sick' (1996) 31 *Harvard Civil Rights Civil Liberties LR* 49 at 50-51; 61; Marelise Richter 'Aiding intolerance and fear: The nature and extent of AIDS discrimination in South Africa' (2001) 5 *Law, Democracy & Development* 195 at 205-208). In *Hoffmann* op cit note 16, the Constitutional Court determined that unfair discrimination in employment practices, on the ground of HIV status, infringes s 9. It would seem both logical and necessary to extend protection in this regard also to the provision of health-related benefits. Other non-listed grounds which could conceivably come into play in this context include citizenship, geographical location, and socio-economic status.

denial, exclusion or inequitable provision will be unconstitutional unless it is found to be justifiable under s 36.[39]

A wide array of potential remedies, ranging from orders that policy or laws be modified to comply with the dictates of the right to equality to declaratory orders that particular applicants are entitled to receive certain benefits, may compensate for unjustifiable infringements of s 9. These may be considered effective from a benefit-focused perspective where they result in the inclusion of the applicant in the ambit of the health-related policy or program from which she was previously excluded, or in the conferring of the health-related benefit which she was previously denied.

According to s 9(4), the right to equality may also be asserted horizontally. The subsection further indicates the need for legislation in order to provide effective remedies for unfair discrimination in the private sector. In relation to health, three legislative enactments augment s 9(4). First, s 6 of the Employment Equity Act 55 of 1998 prohibits unfair discrimination in the workplace on grounds similar to those in s 9(3), but significantly including also HIV status. The prohibition explicitly extends to the provision of employment benefits, which would include health-related benefits such as contributions to medical aid schemes, sick leave etc.[40]

Second, s 24(2)(e) the Medical Schemes Act 131 of 1998 prohibits registration of a medical scheme which discriminates on a list of grounds similar to those in s 9 of the Constitution but prominently including 'state of health'. This provision is augmented by s 29(1)(n) of the Act's determination that terms and conditions applicable to a person's admission to a medical scheme may not relate in any manner to similar grounds. Together, these provisions constitute a prohibition on the exclusion of membership from a medical scheme based on

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[39]See De Vos op cit note 34 at 64-65; Liebenberg (in Chaskalson et al) op cit note 4 at 30; Liebenberg (in Andrews & Ellmann) op cit note 4 at 412-414; Mubangizi op cit note 15 at 346.

[40]On the ambit, scope and impact of s 6 see Charles Ngwena 'HIV in the workplace: Protecting rights to equality and privacy' (1999) 15 *SAJHR* 513 at 532; Charles Ngwena 'HIV/AIDS and equal opportunities in the workplace: The implications of the Employment Equity Act' (2000) 33 *CILSA* 96 at 102-106.

health status or any ground listed in the Constitution.[41]

Third, several health-related provisions are contained in the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000. Augmenting s 6's general prohibition on unfair discrimination, are determinations outlawing the provision of inferior services to any racial group (s 7(d)) and the limiting of women's access to health benefits (s 8 (g)). Section 34 urges that inclusion of HIV status as an explicitly enumerated prohibited ground of discrimination should be considered, whereas item 3 of the Schedule to the Act contains an illustrative list of unfair practices in the health sector, which include the unfair denial or refusal of access to health care facilities and the discriminatory refusal to provide emergency medical treatment to particular people or groups of people. A wide array of remedies for victims of unfair discrimination is allowed for by s 21 of the Act. These include declaratory orders, orders for payment of damages, prohibitive interdicts, orders for the implementation of special measures that aim to address unfair discrimination, orders requiring an unconditional apology and the suspension or revocation of a health care practitioner's licence.[42]

Overall, it would seem that the immediate protection afforded by s 9 of the Constitution and its detailed elaboration in a variety of legislative provisions serve adequately to vindicate the equality-element of the right to health. Combining challenges based on more 'conventional' health rights with a challenge based on the right to equality in circumstances where a deprivation of health-related benefits also falls foul of the latter right, would give practical effect to the principle that rights are interdependent and indivisible. Indeed, where a challenge to the non-provision of or denial of access to a social good or service may be brought under the ambit of s 9, adequate reparation for such

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[41]For a discussion of the impact of these provisions, see Ngwena (2000) (ibid) at 106-107.

[42]Relevant provisions of the Act are discussed by Cathi Albertyn, Beth Goldblatt & Chris Roederer (eds) *Introduction to the Promotion of Equality and Prevention of Unfair Discrimination Act* (2001) 84-86; 112-114; Sandra Liebenberg & Michelle O'Sullivan 'South Africa's new equality legislation: A tool for advancing women's socio-economic equality?' (2001) *Acta Juridica* 70 at 92-96.

non-provision or non-access may result more readily from basing a constitutional challenge on s 9 than from relying on another right which guarantees provision of the good or service more generally.[43]

(c) Health-related entitlements: Rights to determinants of health

Section 2.2(b) above has shown that rights to a variety of determinants of health, including rights to environmental and occupational health as well as to several non-medicinal, health-conducive social goods, form part of the health rights package in international law. Rights to the majority of these amenities are also contained in the 1996 Constitution.

Section 24(a) of the Constitution determines that '[e]veryone has the right ... to an environment that is not harmful to their health or well-being'. This open-ended right obviously guarantees environmental health and is phrased broadly enough to serve as a constitutional basis for a right to occupational health (working environment not harmful to health or well-being) and for rights to a variety of other non-medicinal, health-conducive social goods.[44] In addition to requiring that the State adopt measures aimed at ensuring that environmental conditions do not harm citizens' health (from which tangible health-related benefits will flow indirectly),[45] infringements of s 24(a) may also be directly remedied through, for instance, an interdict prohibiting health-damaging actions by public or private entities (such as dumping toxic waste in a residential area) or an award of compensation where such actions have adversely affected health.[46]

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[43]De Vos op cit note 4 at 270-271; 273-274; De Vos op cit note 34 at 65-66; 68. Note, however, the drawbacks of using the right to equality to ameliorate social hardship discussed in chapter 2 note 43 and accompanying text.

[44]Erika De Wet *The Constitutional Enforceability of Economic and Social Rights: The Meaning of the German Constitutional Model for South Africa* (1996) at 119; Jan Glazewski *Environmental Law in South Africa* (2000) at 85; Mubangizi op cit note 15 at 345.

[45]UNCESCR General Comment 14 op cit note 3 at para 43 views the adoption of a public and environmental health strategy as part of the minimum core of the right to health. See also Brigit Toebes 'Towards an improved understanding of the international human right to health' (1999) 21 *Human Rights Quarterly* 661 at 668; Yamin op cit note 26 at 410-411.

[46]See *Minister of Health and Welfare v Woodcarb* 1996 (3) SA 155 (N); Jan Glazewski 'Environment' in MH Cheadle et al (eds) *South African Constitutional Law: The Bill of Rights*

With the exception of a right to sanitation (which I would argue nevertheless finds residual protection under s 24(a)), rights to most non-medicinal, health-conducive social goods are also enshrined separately by the Bill of Rights. A right to have access to adequate housing is guaranteed by s 26, whereas ss 27(1)(b) and (c) award rights to have access to sufficient food and water and to social security respectively.[47] Children's rights to shelter and basic social services find further protection under s 28(1)(c), whereas s 29(1)(a) confers a right to basic education. With the exception of the latter two, these rights are all guaranteed subject to the proviso that the State must take reasonable measures to achieve their progressive realisation within its available resources. As reflected in the constitutional text, these social goods are all subjects of rights-based protection regardless of their impact on individual or communal health status. Indeed, reported South African court decisions in which these constitutional provisions have come into play typically do not involve the right to health.

While such court decisions remain relevant to an analysis of the potential of health rights to render tangible benefits (due to the textual similarities between these rights and the various rights to health care services, goods and facilities discussed below), I will not conduct a separate benefit-focused analysis of these rights. However, the majority of observations pertaining to health-care related entitlements discussed below pertain equally to entitlements flowing from rights to non-medicinal, health-conducive social amenities.

(2002) 409 at 422; Cheryl Loots 'The impact of the Constitution on environmental law' (1997) 1 *SAJELP* 57 at 58-59. Environmental law has, through standards such as the 'polluter pays principle', long acknowledged that not only states are responsible for environmental preservation. See Paust op cit note 7 at 818; Ratner op cit note 7 at 479-481. Indeed, a multitude of statutory standards of environmental and occupational health have through the years been enforced against public and private entities. See for instance the Atmospheric Pollution Act 45 of 1965; the Occupational Health and Safety Act 85 of 1993 and ss 83 and 89 of the National Health Act 61 of 2003.

[47] On the impact of these amenities on individual health status, see UNCESCR General Comment 14 op cit note 3 at para 44; David Abbott 'AIDS and the homeless' (1994) 144 *New LJ* 1726-1727; Cathi Albertyn 'Using rights and the law to reduce women's vulnerability to HIV/AIDS' (2001) 5 *Law, Democracy & Development* 179 at 185; Sundrasagaran Nadasen *Public Health Law in South Africa: An Introduction* (2000) at 8-12; David R Phillips *Health and Health Care in the Third World* (1990) 13-16; Toebes op cit note 45 at 668.

(d) Health-related entitlements: Rights to health care goods, services and facilities

To complete the health rights package, the 1996 Constitution appears broadly to recognise two distinct categories of rights to health care services, goods and facilities. First, a generic right to have access to such amenities, which is limited in the extent to which it may be enforced at any given time, is guaranteed by s 27(1)(a) read with s 27(2) of the Constitution. Apart from this generic provision, more direct and seemingly unlimited priority entitlements to certain specific forms of health care are found elsewhere in the Constitution.[48] This section discusses the ambit, scope and enforceability of the entitlements implied by these respective categories of rights.

(i) The generic right of access to health care services

Section 27(1)(a) of the Constitution determines:

> 'Everyone has the right to have access to ... health care services, including reproductive health care'.

By determining that 'everyone' is entitled to have access to health care services, s 27(1)(a) clearly has an equality-threshold that forbids any group-based distinctions in the provision of health care services. This aspect of s 27(1)(a) supplements the right to equality by embodying an entitlement not to be arbitrarily or unfairly excluded from the ambit of policies, laws and programmes which confer health care-related benefits and by forbidding the inequitable provision of health care services.[49] The equality-component of s 27(1)(a) is

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[48]On the categorisation of socio-economic rights in the 1996 Constitution as generic 'access' rights on the one hand and fully enforceable, priority rights on the other, see De Vos op cit note 1 at 87-91.

[49]See De Vos op cit note 4 at 265-266; Liebenberg op cit note 4 at 26-27; Ngwena op cit note 28 at 3; 7-9; 27; Charles Ngwena 'Aids in Africa: Access to health care as a human right' (2000) 15 *SA Public Law* 1 at 13; Marius Pieterse 'Foreigners and socio-economic rights: Legal entitlements or wishful thinking?' (2000) 63 *THRHR* 51 at 54; 56; SAHRC *Third Economic and Social Rights Report* (1999) at 189.

further considered to be horizontally enforceable in conjunction with s 9(4).[50] This means that it can be used by citizens to demand medical treatment from public or private sources where such treatment is being withheld arbitrarily or unfairly.

Beyond this threshold, s 27(1)(a) is unclear as to the kinds of 'health care services' it envisages, save for indicating explicitly that such services include reproductive health care.[51] Specific definitional issues to consider include which health needs are addressed by s 27(1)(a), what kinds of services the subsection envisages and on which levels such services need to be rendered.[52]

It may be argued that, in line with a generous approach to constitutional interpretation and in order to resonate with international law standards, s 27(1)(a) should be interpreted as encompassing entitlements to all services, goods and facilities aimed at securing the greatest attainable standard of physical and mental well-being. Section 27(1)(a) should thus be read as addressing more than the need for physical medical treatment to encompass also services aimed at satisfying mental health needs, and as extending beyond medical treatment to include services aimed at health protection and promotion, as well as the prevention and diagnosis of illness. The concept of 'medical treatment' should in turn be understood as implying all services aimed at alleviating, curing or rehabilitating the causes or symptoms of disease and as including entitlements to access ambulance and hospital services, access to care by general and specialist medical practitioners and access to beneficial pharmaceutical products.[53] A similar broad reading of 'reproductive health care'

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[50]See Chirwa op cit note 7 at 4; Chirwa op cit note 4 at 559; 564-565.

[51]The inclusion of reproductive health care services aligns s 27(1)(a) with South Africa's obligations to ensure 'appropriate services in connection with pregnancy, confinement and the post-natal period' under art 12 of CEDAW. See Berger op cit note 29 at 167-168; Ngwena op cit note 28 at 8; Ngwena op cit note 35 at 32.

[52]These issues are identified by Karrisha Pillay 'Tracking South Africa's progress on health care rights: Are we any closer to achieving the goal?' (2003) 7 *Law, Democracy & Development* 55 at 60. Unfortunately, the National Health Act does not provide any clarity on these issues. Instead, its definition of 'health care services' merely refers back to s 27(1)(a) and related provisions whereas other concepts such as 'essential health services' and 'primary health services' are left to be defined by the Minister.

[53]Including all such services within the ambit of s 27(1)(a) accords with UNCESCR General Comment 14 op cit note 3 at para 17 and is reflected also by s 1 of the Medical Schemes Act 131 of 1998. See further Christianson op cit note 36 at 123-126; 132; De Waal,

may be advanced to include access to reproductive education and counselling services, contraceptive services and products, termination of pregnancy services as well as pre- and post-natal care.[54] A generous and purposive interpretation of the phrase 'health care services' in s 27(1)(a) would further imply that access to the services outlined here should in principle be guaranteed at primary, secondary as well as tertiary levels of care.

Much is often made of the fact that it is not a right to health care services that is guaranteed, but merely a right to have *access* to such services. This is said to mean that s 27(1)(a) does not enable anyone directly to demand particular health care services, but rather envisages that people should be capable of securing such services for themselves. On such a reading of s 27(1)(a), the State is depicted as being responsible only for providing an 'enabling environment' within which citizens may realise the right for themselves, by providing conditions necessary to make health care services accessible to all.[55]

From a benefit-focused perspective, however, this argument holds only for those who are already in the material position to access health care services for themselves. Beyond such people, the right of access to health care services must imply more than simply an equal ability to seek care. A theoretical ability to access care is of no significance if such access does not translate into actually obtaining the relevant health care service or product, or physical access to the relevant health care facility. Indeed, in order to be meaningful, a right of access to care must imply the ability to obtain, rather than to seek, treatment.[56]

Currie & Erasmus op cit note 8 at 448; Nicholson op cit note 34 at 359; Pillay op cit note 4 at 52-53; Pillay op cit note 52 at 60-62; Karrisha Pillay 'Testing for HIV/AIDS: The constitutional standard' (2001) 5 *Law, Democracy & Development* 213 at 214; SAHRC op cit note 49 at 185; Geraldine Van Bueren 'Health' in Cheadle et al op cit note 46, 491 at 495.

[54]This understanding is reflected by the preamble to the Choice on Termination of Pregnancy Act 92 of 1996. See also Ngwena op cit note 28 at 8; Ngwena op cit note 35 at 21; 32; Van Bueren op cit note 53 at 497-498; Ferdinand Van Oosten 'The Choice on Termination of Pregnancy Act: Some comments' (1999) 116 *SALJ* 60 at 61-62.

[55]See P Carstens et al 'Health care' in MP Olivier et al (eds) *Social Security Law: General Principles* (1999) 213 at 216; De Vos op cit note 1 at 87; Andrea Gabriel 'Socio-economic rights in the Bill of Rights: Comparative lessons from India' (1997) 1(6) *Human Rights and Constitutional LJ of SA* 8 at 9; Heyns & Brand op cit note 1 at 159; Liebenberg op cit note 4 at 26; Pillay op cit note 4 at 53; Pillay op cit note 53 at 214.

[56]See M Geldenhuys 'The rights to health care and housing: Some aspects of

I would argue that the only limiting function fulfilled by the access standard in s 27(1)(a) is to indicate that health care services need not be made available free of charge to everyone. Where people do have the means and capacity to access health care services themselves, their s 27(1)(a) right is satisfied and capable of infringement only where such access is subsequently deprived, denied, obstructed or otherwise interfered with.[57] The State, however, incurs significantly more responsibility towards those groups or individuals who, through social or financial vulnerability, geographical isolation, the consequences of unfair discrimination or some other reason, lack the means or capacities to access health care services themselves.[58] In relation to such individuals, it may be argued that access to health care services has to be meaningful or adequate in order to comply with s 27(1)(a).

In a different context, American courts have held that access to health care services cannot be said to have been meaningful where vulnerable groups are excluded from such access, where limits on eligibility for treatment are based on criteria that vulnerable groups are objectively incapable of meeting and where recipients of treatment are unable to benefit meaningfully from it.[59] An even more useful assessment of meaningful access is provided in relation to the international law right to health by UNCESCR, which determined in General Comment 14 that health care services, goods and facilities must be accessible, available, affordable, culturally acceptable as well as 'medically

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constitutional interpretation' (2005) 17 *SA Mercantile LJ* 182 at 193; Giesen op cit note 30 at 290; Hendriks op cit note 30 at 374; Knut Erik Tranoy 'Vital needs, human rights, health care law' (1996) 15 *Medicine & Law* 183 at 186-188. Such an understanding of access is reflected by the SA Department of Health's recent *Draft Charter of the Private and Public Health Sectors of the Republic of South Africa* (2005) at 6, which defines 'access' to mean 'having the capacity and means to *obtain* and *use* an affordable package of health care services in South Africa in a manner that is equitable' (my emphasis).

[57]See Bekker op cit note 4 at 15; Liebenberg (in Chaskalson et al) op cit note 4 at 28-30.

[58]See Department of Health *Draft Charter* op cit note 56 at 13; Chapman op cit note 2 at 52; De Vos op cit note 1 at 87; Gabriel op cit note 55 at 9; Liebenberg (in Chaskalson et al) op cit note 4 at 26; Olivier op cit note 1 at 144-145.

[59]The 'meaningful access' standard was first developed in relation to the capping of medical aid benefits in *Alexander v Choate* 469 US 287 (1985) at 301 and followed in a line of subsequent similar cases. For discussion, see Alexander Abbe '"Meaningful access" to health care and the remedies available to Medicaid managed care recipients under the ADA and the Rehabilitation Act' (1999) 147 *Univ Pennsylvania LR* 1161-1203; Orentlicher op cit note 38 at 79-82.

appropriate and of good quality' for the meaningful enjoyment of the right to health.[60]

Access to health care services should therefore not be regarded as meaningful where such services are geographically or physically inaccessible, unavailable or unattainable within a reasonable time after the need for them arises. Similarly, a person should be regarded as having been precluded from exercising his right to meaningfully access health care services where care is unaffordable or not rendered by adequately skilled medical professionals.[61] As to quality, most commentators agree that s 27(1)(a) implies some kind of 'appropriateness', 'adequacy' or 'reasonableness' standard against which the quality of health care services may be measured.[62] Access to care is accordingly considered to be inhibited where services rendered are of an inferior quality. Defining what level of services would qualify as 'adequate', 'reasonable' or 'appropriate' may be difficult, not least because quality of treatment is necessarily influenced by the financial resources of both the patient and the health care facility, the nature of the medical condition, medical-technological progress, and the circumstances in which care is rendered.[63] However, it must at least be acknowledged that access to health care services is impaired where substandard or negligent care is rendered, and that the duty to protect health rights implies the creation and/or sustenance of remedies for damage suffered as a result of substandard or negligent care.[64]

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[60]See UNCESCR General Comment 14 op cit note 3 at para 12; also chapter 2 note 36 and accompanying text.

[61]See further Chapman op cit note 2 at 45; Pillay op cit note 52 at 64; Pillay op cit note 2 at 63-64; Toebes op cit note 45 at 666-667; 669; Van Rensburg et al op cit note 35 at 30-32.

[62]See Carstens & Kok op cit note 11 at 442 ('professional health care services ... provided in a non-negligent manner'); Christianson op cit note 36 at 133 ('basic minimum standards' of care); De Waal; Currie & Erasmus op cit note 8 at 448 ('proper' care); Ngwena op cit note 49 at 5-6 ('adequate' care).

[63]On these and other variables complicating the development of a unitary standard of 'adequacy' in the American context, see generally Einer Elhauge 'Allocating health care morally' (1994) 82 *California LR* 1451 at 1455; 1466-1472; Paul E Kalb 'Defining an adequate package of health care benefits' (1992) 140 *Univ Pennsylvania LR* 1987-1998; John A Siliciano 'Wealth, equity and the unitary medical malpractice standard' (1991) 77 *Virginia LR* 439-487. On resource discrepancies and quality of care in the context of s 27, see Neil Van Dokkum 'The evolution of medical malpractice law in South Africa' (1997) 41 *J of African Law* 175 at 189.

[64]See Department of Health *Draft Charter* op cit note 56 at 19 ('access to health services of unacceptable quality is not access'); Carstens & Kok op cit note 11 at 442; Hendriks op cit note 30 at 377.

Section 27(1)(a) may thus be understood as conferring an entitlement to the availability, accessibility, and acceptability of preventative, diagnostic and curative health care services of adequate quality on primary, secondary and tertiary levels. Such a permissive interpretation of the right accords with the premise that a generous and purposive approach to constitutional interpretation requires that the initial interpretation of the ambit and scope of a right should be as wide as is textually and contextually permissible. Only after the ambit of the right has been identified in this manner, should an inquiry into potential justifications for restrictions or limitations on the right be launched.[65] Given that there are great variations in the cost and effectiveness of various forms of medical treatment, and also that there are many competing health-related needs in society (not all of which are equally urgent and vital), it comes as no surprise that the Bill of Rights envisages the limitation of s 27(1)(a) both through an internal textual limitation on the extent to which it may be enforced and in accordance with s 36.

The internal limitation on s 27(1)(a)'s ambit and scope is contained in s 27(2), which determines:

> 'The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights [guaranteed in s 27(1)]'.[66]

While clearly modeled on article 2.1 of the ICESCR, s 27(2) differs in certain respects from its international law counterpart. First, there are semantic differences in the framing of the provisions' respective resource-specifications and standards of progressive realisation.[67] Second, s 27(2) imports a standard of reasonableness that is absent from article 2.1, which instead prescribes a standard of appropriateness. These differences notwithstanding, the terms

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[65]See De Waal, Currie & Erasmus op cit note 8 at 133-135.

[66]Since s 27(2) is identical to s 26(2), which delineates the right to have access to adequate housing, I rely also on literature pertaining to s 26(2).

[67]Article 2.1 requires states parties to take steps *to the maximum of* their available resources whereas s 27(2) requires measures to be taken *within* the state's available resources. Whereas s 27(2) requires measures to be aimed at achieving the 'progressive realisation' of s 27(1)(a), art 2.1 employs the phrase 'with a view to achieving progressively the full realisation' of relevant rights.

employed by s 27(2) cannot be understood entirely in isolation from the meaning of corresponding international law provisions, especially given the dictates of s 39(1) of the Constitution.

It appears that s 27(2) fulfills two distinct functions. First, it amplifies the rights guaranteed in s 27(1) through indicating the extent of the positive duties they impose on the State. Second, it limits s 27(1) by indicating that not all benefits implied by it may immediately be claimed.[68] As to its amplifying function, the various terms employed in s 27(2) may all be interpreted as indicating specific obligations on the State. First, the duty to take legislative or other appropriate measures constitutes an immediate obligation of conduct, notwithstanding the margin of discretion awarded in relation to the form and content of measures.[69] This margin of discretion is simultaneously preserved and qualified by s 27(2)'s determination that measures adopted must be reasonable.[70] Second, if the resource-specification in s 27(2) is understood as implying similar obligations to those in article 2.1 of the ICESCR, it would indicate that the State infringes s 27(2) where it fails to fulfill an aspect of s 27(1) despite resources for the purpose indeed being available. It also requires that the State prioritise expenditure aimed at satisfying the needs of the most vulnerable sectors of society.[71] Third, the standard of progressive realisation requires that the State incrementally make relevant socio-economic amenities

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[68]The 'dual' nature of s 27(2) is acknowledged by Sandra Liebenberg 'The right to social assistance: The implications of *Grootboom* for policy reform in South Africa' (2001) 17 *SAJHR* 232 at 238; Frank Michelman 'The Constitution, social rights and reason: A tribute to Etienne Mureinik' (1998) 14 *SAJHR* 499 at 503. Its 'amplifying' nature is emphasised by Carstens et al op cit note 55 at 217; De Vos op cit note 4 at 262; Gabriel op cit note 55 at 9-10; Sandra Liebenberg 'Health' in Dennis Davis et al (eds) *Fundamental Rights in the Constitution: Commentary and Cases* (1997) 354 at 358; Ngwena op cit note 28 at 23-24, whereas its 'limiting' character is highlighted by De Vos op cit note 1 at 93; Liebenberg (in Chaskalson et al) op cit note 4 at 48; Darrel Moellendorf 'Reasoning about resources: *Soobramoney* and the future of socio-economic rights claims' (1998) 14 *SAJHR* 327 at 330; Mubangizi op cit note 15 at 345.

[69]See, in relation to art 2.1 of the ICESCR, Limburg Principle 16; Matthew CR Craven *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development* (1995) at 114-116; Ngwena op cit note 28 at 22.

[70]David Bilchitz 'Giving socio-economic rights teeth: The minimum core and its importance' (2002) 119 *SALJ* 484 at 495; Liebenberg (in Chaskalson et al) op cit note 4 at 38.

[71]UNCESCR General Comment 3 *The Nature of State Parties' Obligations (Art. 2, para. 1 of the Covenant)* (1990) at paras 11-12. See also Craven op cit note 69 at 132-133; De Vos op cit note 1 at 98; De Waal; Currie & Erasmus op cit note 8 at 443; Pillay op cit note 53 at 215.

available both to a larger number and a wider range of people, and must show that it is moving 'effectively and expeditiously', through concrete and deliberate steps, towards full realisation of the right. Deliberately retrogressive measures (resulting in lesser enjoyment of the right) are regarded as infringing the right unless they are necessitated by extreme resource scarcity or are in the interest of the progressive realisation of the totality of socio-economic rights. The same would apply where the State does not take any measures aimed at progressive realisation, halts progressive realisation or delays the adoption of appropriate measures unreasonably.[72]

Section 27(2)'s limiting function is far more significant from a benefit-focused perspective, since it directly impacts on the extent to which tangible individual benefits may be claimed under s 27(1)(a). In particular, the resource specification in s 27(2) indicates that the State will not fall foul of s 27(1)(a) where it does not have the resources to give effect to all of the entitlements implied by the provision.[73] Particularly in the health care sector, the reality is that not all medically beneficial treatment is affordable and that, while resource scarcity persists, certain treatment will be unavailable to those who cannot finance it for themselves.[74] It is, however, important to view resource scarcity

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[72]UNCESCR General Comment 3 op cit note 71 at paras 2; 9; Limburg Principles 16; 21; Maastricht Guideline 14(e)-(f). See also Audrey R Chapman 'A "violations approach" for monitoring the International Covenant on Economic, Social and Cultural Rights' (1996) 18 *Human Rights Quarterly* 23 at 42-43; Chapman op cit note 2 at 37; Craven op cit note 69 at 131-132; Pierre De Vos 'So much to do, so little done: The right of access to anti-retroviral drugs post-*Grootboom*' (2003) 7 *Law, Democracy & Development* 83 at 90-91; Gabriel op cit note 55 at 10; Maria Green 'What we talk about when we talk about indicators: Current approaches to human rights measurement' (2001) 23 *Human Rights Quarterly* 1062 at 1070-1071; Heyns & Brand op cit note 1 at 160; Leckie op cit note 7 at 93; 98-100; Sandra Liebenberg 'The International Covenant on Economic, Social and Cultural Rights and its implications for South Africa' (1995) 11 *SAJHR* 359 at 365; Liebenberg (in Chaskalson et al) op cit note 4 at 39-41; Liebenberg (in Andrews & Ellmann) op cit note 4 at 421-422; Ngwena op cit note 28 at 223; Olivier op cit note 1 at 149; Pillay op cit note 53 at 214; Pillay op cit note 2 at 64; Toebes op cit note 45 at 677.

[73]Iain Currie 'Bill of rights jurisprudence' (2000) *Annual Survey of SA Law* 24 at 56; Liebenberg op cit note 4 at 41; Olivier op cit note 1 at 142.

[74]Demand for health services typically exceeds the availability of resources, since technological progress has led to an increasing number of serious ailments becoming treatable (often at high expense) and since even routine health care services are ordinarily often expensive, especially at secondary and tertiary levels. See Elhauge op cit note 63 at 1459; Richard D Lamm 'Rationing health care: Inevitable and desirable' (1992) 140 *Univ Pennsylvania LR* 1511 at 1512; Moellendorf op cit note 68 at 332; Ngwena op cit note 28 at 19.

not as qualifying the ambit of s 27(1)(a) but rather as limiting the extent to which its implied benefits may be demanded at a given time.[75] In this sense, the resource specification links to the concept of progressive realisation which, by conceding that certain aspects of socio-economic rights are only capable of realisation over time, limits the extent to which they are immediately enforceable.[76]

The progressive realisation standard and the resource limitation in s 27(2) accordingly allow courts to approach the task of ascertaining the State's compliance with the obligations imposed by s 27(1)(a) realistically and within the context of every specific matter. However, there remains a real risk, as in international law, that the terms of s 27(2) can be used to deflate the content of s 27(1)(a) to such an extent that they strip the right of most of its remedial capacity. This would defeat the intention of the drafters of the Constitution and would diminish the right's impact on the lives of those it was designed to protect:

> '[n]o provision should be interpreted in a way that makes its enforcement practically impossible. If section 27(2) is interpreted to be exhaustive of the State's positive duties, individual right holders have no direct right to claim anything specific from the state'.[77]

It is accordingly necessary to acknowledge that not all obligations engendered by s 27(1)(a) are rendered unenforceable by the limiting effect of s 27(2).

As in international law, greater clarity on the extent to which obligations engendered by the right of access to health care services survive the limiting effect of the progressive realisation standard and the resource limitation may be gained through considering the extent to which the 'tripartite typology of interdependent duties' finds application in relation to s 27(1)(a) of the Constitution. In line with the Constitutional Court's acknowledgment in its *First*

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[75]See Bilchitz op cit note 21 at 18; 21; Fons Coomans 'Reviewing implementation of social and economic rights: An assessment of the reasonableness test as developed by the South African Constitutional Court' (2005) 65 *Heidelberg J of International Law* 167 at 191-192; Currie op cit note 73 at 56; Scott & Alston op cit note 1 at 255.

[76]De Vos op cit note 1 at 96; De Waal; Currie & Erasmus op cit note 8 at 441; Gabriel op cit note 55 at 10; Liebenberg op cit note 4 at 39.

[77]Liebenberg op cit note 2 at 25. See also Bilchitz op cit note 21 at 21; Gabriel op cit note 55 at 11; Nicholas Haysom 'Giving effect to socio-economic rights: The role of the judiciary' (1999) 1(4) *ESR Review* 11 at 12; Michelman op cit note 68 at 504-505; Scott & Alston op cit note 1 at 239; 249.

Certification judgment that socio-economic rights may at least negatively be protected against improper invasion,[78] it may be argued that entitlements implied by the obligation to respect s 27(1)(a) should be immediately enforceable against public and private entities notwithstanding resource availability or the limits inherent to progressive realisation.[79] Infringements of the obligation to respect s 27(1)(a) would typically occur where law or conduct intentionally deprives existing access to or enjoyment of health rights (by, for example, closing existing health care facilities or discontinuing the provision of particular services in State hospitals) or has the effect of denying or obstructing existing access or enjoyment. The obligation could further be infringed by health-harming conduct (such as pollution or the marketing of unsafe pharmaceuticals), by the adoption of deliberately retrogressive measures or by non-compliance with the guarantee of equal access to health care services.[80]

It may further be argued that the obligation to protect s 27(1)(a) requires that some of the standards inherent in the concept of 'meaningful access' to health care services should be capable of enforcement against third parties without reference to s 27(2). For instance, claimants should generally be able to avail themselves of remedies where health care services to which they have had access were not acceptable or of a reasonable quality.

The elements of s s 27(1)(a) identified here as being capable of immediate enforcement when read with the domestic recasting of the 'tripartite typology of interdependent duties' in s 7(2) of the 1996 Constitution, correspond with certain of the obligations identified by UNCESCR as constituting the

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[78] *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa, 1996* 1996 (4) SA 744 (CC) at para 78.

[79] See Chirwa op cit note 7 at 5-6; Chirwa op cit note 4 at 559; 564; De Vos op cit note 1 at 92-94; 100; Ellmann op cit note 4 at 460-461; Liebenberg (in Chaskalson et al) op cit note 4 at 46-48; Sandra Liebenberg 'South Africa's evolving jurisprudence on socio-economic rights: An effective tool in challenging poverty?' (2002) 6 *Law, Democracy & Development* 159 at 178; Liebenberg op cit note 2 at 19; 58; Michelman op cit note 68 at 504; Pieterse op cit note 7 at 26.

[80] See UNCESCR General Comment 14 op cit note 3 at paras 34; 50; Chapman op cit note 2 at 46; Chetty op cit note 2 at 453; De Vos op cit note 1 at 81; De Vos op cit note 72 at 88-89; De Waal; Currie & Erasmus op cit note 8 at 435; Liebenberg (in Chaskalson et al) op cit note 4 at 28-30; Liebenberg (in Andrews & Ellmann) op cit note 4 at 411-414; 421; Liebenberg op cit note 79 at 163; Pillay op cit note 4 at 54; Pillay op cit note 2 at 67; Richter op cit note 38 at 202; Toebes op cit note 45 at 677.

minimum core of the right to health or as being of similar priority. UNCESCR's list of core and comparable obligations flowing from the right to health also extends beyond these obligations, to include obligations to provide primary health care services, essential reproductive health care services, essential medicines and immunisation against major infectious diseases. In international law, access to these core amenities is viewed as the immediately enforceable baseline of protection awarded by the right to health, from which the State must progressively facilitate increased enjoyment of non-core amenities, with the goal of ultimately ensuring full enjoyment thereof. It would be useful to adopt a similar minimum core approach in relation to s 27(1)(a), which would mean that rights to access such core services, together with other, non-core services to which universal access has already been established through progressive realisation, are viewed as immediately enforceable, notwithstanding the dictates of s 27(2).[81]

A minimum core approach to the interpretation of s 27(1)(a) would be useful firstly because it would determine a concrete starting point for the process of progressive realisation.[82] Acknowledging that s 27(1)(a) entails a core of claimable entitlements would further enable the right to make a concrete difference to the lives of its beneficiaries and would counter perceptions of socio-economic rights as 'never being capable of being violated, as constantly receding into the future'.[83] Moreover, a minimum core approach would affirm the reality that certain socio-economic needs are more vital and urgent than others, and that the immediate satisfaction of the most urgent and vital of these needs is essential in a society that values and protects human dignity. As David Bilchitz argues:

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[81]See Maastricht Guideline 8; David Bilchitz 'Placing basic needs at the centre of socio-economic rights jurisprudence' (2003) 4(1) *ESR Review* 2 at 3; Chapman op cit note 2 at 37; 54; Craven op cit note 69 at 132-133; Currie op cit note 73 at 56; Pierre De Vos 'The economic and social rights of children and South Africa's transitional Constitution' (1995) 10 *SA Public Law* 233 at 251; De Vos op cit note 1 at 97; Gabriel op cit note 55 at 10; Heyns & Brand op cit note 1 at 160; Liebenberg (in Chaskalson et al) op cit note 4 at 43; Liebenberg op cit note 2 at 41; Russell op cit note 2 at 15; Scott & Alston op cit note 1 at 80-81.

[82]See Bilchitz op cit note 81 at 3; Bilchitz op cit note 21 at 11; 13.

[83]Scott & Alston op cit note 1 at 227.

> 'There are two important interests that ss 26 and 27 of the Constitution protect. The first is at a minimum the very basic interest people have in survival and the socio-economic goods required to survive. The second is the interest people have in being provided with the conditions that enable them to pursue their own projects and to live a good life by their own lights. The notion of progressive realisation links these two interests: it recognises that what the government is required to do is to provide core services to everyone without delay that meet their survival needs and then qualitatively to increase these services so as ultimately meet the maximal interests that the state is required to protect. Without protecting people's survival interests, all other interests and rights that they may have - whether civil, political, social or economic - become meaningless. The recognition of a minimum core of social and economic rights that must be realised without delay attempts to take account of the fact that certain interests are of greater relative importance and require a higher degree of protection than other interests'.[84]

Through acknowledging and giving effect to the relative urgency of basic health-related needs by awarding direct claims to their satisfaction, a minimum core approach to s 27(1)(a) would enable the right to connect concretely to the needs and experiences of its subjects by allowing them to demand the immediate satisfaction of the most urgent of the needs it represents.

To hold that certain entitlements implied by s 27(1)(a) are capable of being claimed from the State notwithstanding the terms of s 27(2) is not to say that the State would always be forced to deliver relevant goods and services to all without consideration of the circumstances of delivery, even where delivery would entail severe resource implications for the State, would derail the totality of its social reform efforts or would similarly threaten the interests of justice. It should be remembered that any infringement of s 27(1)(a) may nevertheless be justified as amounting to a reasonable and justifiable limitation of the right in terms of s 36 of the Constitution. Unless a finding that s 27(1)(a) has been infringed is based on a finding that measures adopted towards its progressive realisation were unreasonable (in which case it may be self-defeating to argue that an unreasonable measure in terms of s 27(2) is nevertheless reasonable in terms of s 36[85]), the possibility therefore remains that the State can offer a

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[84]Bilchitz op cit note 21 at 11-12. See also Liebenberg op cit note 2 at 28-29; Sandra Liebenberg 'The value of human dignity in interpreting socio-economic rights' (2005) 21 *SAJHR* 1 at 15; 18; 22.

[85]De Waal; Currie & Erasmus op cit note 8 at 451. See also Christianson op cit note 36 at 131.

satisfactory explanation for non-compliance with a particular obligation.[86] Furthermore, in the event that such explanation is not forthcoming, an order that the good or service in question be provided to the claimant is but one of the myriad ways in which a court can choose to remedy the infringement. A finding that a right to receive a minimum core entitlement had been breached would accordingly still result in tangible benefit for the beneficiary only in circumstances where non-provision of the benefit cannot objectively be justified by the State and where it is appropriate in the circumstances to order that the claimant be provided with the benefit.

(ii) Priority-rights to specific health care services, goods and facilities

Apart from the generic right of access to health care services, three further constitutional provisions award distinct entitlements to particular health care services, goods or facilities. Significantly, not one of these contains an internal modifier subjecting its enforcement to resource availability or progressive realisation. Given this, and in light of the fact that the benefits implied by these provisions relate either to extremely urgent health-related needs or to the health-related needs of particularly vulnerable sectors of society, it appears reasonable to conclude that these benefits are more readily claimable than those awarded by s 27(1)(a).

The first of these provisions, s 27(3), determines that '[n]o-one may be refused emergency medical treatment'. By virtue of its textual separation from s 27(1)(a) and the strong negative language it employs, it may be argued that s 27(3) operates free from the constraints posed by s 27(2). Its unequivocal language and the fact that it identifies no specific duty-bearer further seems to indicate that it will operate horizontally, at least against those entities that are able and qualified to render emergency care (such as paramedics, emergency

[86]See Bilchitz op cit note 21 at 17-18; 23; Liebenberg op cit note 2 at 29-31. Insisting on justification for non-compliance with minimum core obligations in accordance with s 36 seems to accord with the international law standards in relation to non-satisfaction of core interests. See chapter 2 note 66 and accompanying text.

services, private hospitals and health care practitioners).[87]

The scope of the entitlements conferred by s 27(3) primarily depends on the meaning of 'emergency medical treatment'. While clearly not applicable to routine preventative, diagnostic and curative treatment, treatment for a variety of injuries and other physical or physiological symptoms (varying from obvious examples like serious injuries sustained in motor vehicle accidents to less obvious symptoms such as chest pains possibly indicating imminent cardiac arrest) may be viewed as emergency medical treatment.[88] Where a medical emergency exists, s 27(3) seems to demand that relevant medical services are available and are adequate to cope with the demands of the situation. While not guaranteeing a right to free treatment, s 27(3) further seems to require that treatment be rendered regardless of a patient's ability to pay.[89]

Unless an objectively justifiable reason for non-compliance with the positive obligations imposed by s 27(3) is offered in terms of s 36,[90] non-compliance with such obligations may conceivably be remedied either through an order compelling the State to make adequate emergency medical services available or through an award of preventative damages. Given the often severe consequences of non-compliance with s 27(3) for patients in need of emergency

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[87]On these aspects of s 27(3), see Carstens et al op cit note 55 at 217; Chirwa op cit note 7 at 5; Coomans op cit note 75 at 170; De Waal; Currie & Erasmus op cit note 8 at 55; 449-450; De Wet op cit note 44 at 117; Ellmann op cit note 4 at 460; Heyns & Brand op cit note 1 at 158; Liebenberg op cit note 68 at 357-358; Liebenberg (in Andrews & Ellmann) op cit note 4 at 415; Liebenberg op cit note 79 at 163; DJ McQuoid-Mason & SA Strauss 'Medicine, dentistry, pharmacy and other health professions' in WA Joubert & JA Faris (eds) *The Law of South Africa Volume 17* (1st Reissue, 1999) 129 at 193-194; SAHRC op cit note 49 at 186; Scott & Alston op cit note 1 at 247-248; 251; SA Strauss 'Twee mediese regsvrae: Die aanspreeklikheid van private hospitale met ongevalle-afdelings en die aanspreeklikheid van sportpromotors en skeidsregters teenoor beseerde spelers' (2000) *TSAR* 205 at 208-209; Van Bueren op cit note 53 at 505. See further 5.3(c) below.

[88]On the difficulties of defining a medical emergency, see Anna-Katarina S Christakis 'Emergency room gatekeeping: A new twist on patient dumping' (1997) *Wisconsin LR* 295 at 312-315; Erik J Olson 'No room at the inn: A snapshot of an American emergency room' (1994) 46 *Stanford LR* 449 at 455.

[89]See Carstens et al op cit note 55 at 217; Liebenberg op cit note 68 at 358; SAHRC op cit note 49 at 186; Van Bueren op cit note 53 at 504.

[90]That non-compliance with s 27(3) requires immediate remedial action unless it can be justified in terms of s 36, is argued by Carstens et al op cit note 55 at 217; Liebenberg (in Chaskalson et al) op cit note 4 at 37; 42fn1; Liebenberg op cit note 68 at 358; Liebenberg op cit note 79 at 163; Ferdinand Van Oosten 'Financial resources and the patient's right to health care: Myth and reality' (1999) 32 *De Jure* 1 at 13.

care, it is also necessary that patients who were denied emergency treatment are afforded effective ex post facto compensatory remedies against relevant health workers, service providers or establishments.

Under s 28(1)(c), children have the right to 'basic nutrition, shelter, basic health care services and social services'. Section 28(1)(c) is narrower in scope than s 27(1)(a), since only *basic* health care services (which, it may be argued, should at least be understood as entailing an entitlement to primary health care services[91]) are guaranteed. Accordingly, in line with international law, the subsection should be understood as imposing an immediately enforceable obligation upon the State to provide children with primary health care services within the broader framework of progressive realisation.[92] Unless non-compliance with this obligation can be justified under s 36 of the Constitution, an appropriate remedy to correct for the infringement of s 28(1)(c) may well require children to be provided with the treatment they need, notwithstanding the policy or resource-implications of such an order.[93]

Whether the obligations implied by s 28(1)(c) are fit for application against the private health care sector is contested.[94] Interestingly, significantly less controversy seems to surround the question whether parents, who typically command far less resources than private health care establishments, may be bound by s 28(1)(c). This is because parents already bear limited socio-

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[91]Argued also by De Wet op cit note 44 at 107; Pillay op cit note 4 at 56. See further SAHRC op cit note 49 at 186.

[92]See Bekker op cit note 4 at 16-17; De Vos op cit note 81 at 55-56; De Vos op cit note 1 at 88; De Wet op cit note 44 at 106; Heyns & Brand op cit note 1 at 161; Willem A Landman & Lesley D Henley 'Rationing and children's constitutional health-care rights' (2000) 19 *SA Journal of Philosophy* 41 at 42-43; Pillay op cit note 4 at 55; Paula Proudlock 'Children's socio-economic rights: Do they have a right to special protection?' (2002) 3(2) *ESR Review* 6; Geraldine Van Bueren 'Alleviating poverty through the Constitutional Court' (1999) 15 *SAJHR* 52 at 55-59; Frans Viljoen 'Children's rights: A response from a South African perspective' in Brand & Russell (eds) op cit note 2, 201 at 203.

[93]See De Vos op cit note 1 at 87; ME Klinck & DA Louw 'A South African perspective on children's rights: General principles' (2000) 19 *Medicine & Law* 49 at 56-57; Liebenberg op cit note 79 at 162-163.

[94]See De Waal; Currie & Erasmus op cit note 8 at 56 (arguing that these duties are too onerous to be borne by private hospitals); Chris Sprigman & Michael Osborne 'Du Plessis is not dead: South Africa's 1996 Constitution and the application of the Bill of Rights to private disputes' (1999) 15 *SAJHR* 25 at 53fn35 (disputing that these duties are inherently incapable of horizontal application).

economic duties towards their children under international and common law and because they are well-placed to provide for their children's needs (as indicated by the right of children to 'family care or parental care' in s 28(1)(b)).[95] It may however be argued that the duties of parents in relation to their children's health are no more onerous than those of individuals in relation to their own, meaning that the State should provide children with primary health care services where their parents cannot afford to do so.[96]

Finally, among a cluster of rights awarded to detained persons, s 35(2)(e) of the Constitution awards a right 'to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense of adequate ... medical treatment', whereas s 35(2)(f)(iv) awards a right to communicate with and be visited by a medical practitioner of the detainee's choice. Detainees' health interests have likely been singled out for protection because of their inability to procure access to medical services for themselves, and because of the various potential health hazards posed by incarceration.[97]

The extent of the entitlements conferred by s 35(2)(e) depends on what is meant by 'adequate medical treatment'. De Waal, Currie and Erasmus argue that 'adequacy' of treatment should depend on whether, viewed in conjunction with other circumstances of confinement, the standard of available treatment contributes to 'conditions of detention that are consistent with human dignity'.[98] More concretely, Ngwena suggests that 'adequacy' should be assessed in the context of a particular prisoner's medical condition, the capacity of detention centres' available health care facilities to provide the medical treatment required

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[95]See Chirwa op cit note 7 at 4; Brigitte Clark 'Children's right to support - a public responsibility?' (1996) *Acta Juridica* 82 at 84; Liebenberg (in Chaskalson et al) op cit note 4 at 36; 46; Marius Pieterse 'Reconstructing the private/public dichotomy? The enforcement of children's constitutional social rights and care entitlements' (2003) *TSAR* 1 at 7-8.

[96]This accords with the position at common law and international law. See arts 18 and 27 of the CRC; De Vos op cit note 81 at 256; De Vos op cit note 1 at 87-88; De Waal; Currie & Erasmus op cit note 8 at 463; Pieterse op cit note 95 at 6-9; Scott & Alston op cit note 1 at 230. See further 5.3(d) below.

[97]These include the close physical proximity in which detainees are held and the general conditions in prisons. See De Wet op cit note 44 at 110.

[98]De Waal; Currie & Erasmus op cit note 8 at 614. See also De Wet op cit note 44 at 113; John C Mubangizi 'The constitutional rights of prisoners in South Africa: A critical review' (2002) 35 *De Jure* 42 at 48-49.

by the prisoner, as well as the standard of medical treatment available outside of prisons.[99] According to s 12(1) of the Correctional Services Act 111 of 1998, medical facilities in prisons should be aimed at allowing prisoners to lead healthy lives and should focus on providing primary health care, whereas s 12(2)(a) of the Act explicitly excludes cosmetic medical treatment from its conception of 'adequacy'. Further, under the UN Standard Minimum Rules for the Treatment of Prisoners, prisoners should have access to basic medical, dental and psychiatric health services rendered by qualified officials, prisoners requiring specialised treatment should be transferred to facilities which are capable of meeting their needs, and necessary pre- and post-natal care should be provided.[100]

Accordingly, I would submit that s 35(2)(e) encompasses at least an entitlement to receive primary health care services,[101] non-compliance with which is capable of justification only in terms of s 36 of the Constitution.[102] It may further be argued that s 35(2)(e) entitles prisoners to have their individual health needs considered in all decisions impacting on the duration, locality and conditions of their detention.

3.3 SUMMARY: THE POTENTIAL OF CONSTITUTIONAL HEALTH RIGHTS TO RENDER TANGIBLE BENEFITS

The Bill of Rights in the 1996 Constitution empowers individuals and groups to assert a wide range of fully justiciable socio-economic rights against the State or private entities. It allows courts to interpret these rights generously, purposively and in accordance with their meaning in international law. It

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[99]Ngwena op cit note 49 at 17-18.

[100]Rules 22-23 of the UN 'Standard Minimum Rules for the Treatment of Prisoners' (1955). See also rules 24-26.

[101]De Wet op cit note 44 at 110 argues that, given the particular vulnerability of prisoners, 'adequate' treatment might well amount to more than the 'basic' treatment envisaged by s 28(1)(c).

[102]See De Wet (ibid); Fanyana ka Mdumbe 'Socio-economic rights: *Van Biljon* versus *Soobramoney*' (1998) 13 *SA Public Law* 460 at 469; Liebenberg (in Chaskalson et al) op cit note 4 at 37; Mubangizi op cit note 15 at 349.

promotes accountability by requiring of respondents to justify any limitation on the enjoyment of a right and allows courts to balance individual and societal interests in deciding whether an infringement of a right was justifiable. In the event of an unjustifiable infringement, it allows for the granting of effective relief, which amounts to adequate reparation for the infringement, without losing sight of the demands of justice, equity and appropriateness in the particular circumstances of each case.

Several substantive provisions of the Bill of Rights correspond to elements of the health rights package in international law. Section 12(2) of the Constitution entrenches a variety of health-related freedoms, whereas the equality element of the right to health, in addition to underlying rights of access to care, finds protection under s 9 of the Constitution and under the various legislative enactments that elaborate on its operation. Rights to determinants of health are found throughout the Constitution, with s 24(a) embodying a right to environmental health and various other health-conducive social goods finding protection under ss 26-29 of the Constitution. Finally, s 27(1)(a) provides generically for a right to have meaningful access to primary, secondary and tertiary health care services of adequate quality, whereas more explicit entitlements to emergency medical care, basic health care services for children and adequate health care services for detainees are conferred by ss 27(3), 28(1)(c) and 35(2)(e) of the Constitution respectively.

Whereas the benefits implied by many of these rights appear to be immediately enforceable (subject, of course, to the provisions of s 36 and the exercise of courts' remedial flexibility), rights to most determinants of health as well as the generic right of access to health care services are limited in the extent to which they may immediately be claimed. In relation to these rights, s 27(2) of the Constitution determines that the State is obliged to adopt reasonable measures aimed at their progressive realisation within its available resources. Nevertheless, I have argued in relation to s 27(1)(a) that at least entitlements associated with the obligation to respect the right as well as with the obligation to ensure equal access to the amenities it implies are capable of

immediately being enforced. Furthermore, I have suggested that additional minimum core obligations may be inherent in s 27(1)(a) and that non-compliance with these may amount to an infringement of s 27(1)(a), notwithstanding s 27(2). This would not necessarily entail that all relevant treatments or benefits may immediately and without reservation be demanded by all rights-bearers, but rather that infringements of these entitlements should tangibly be remedied unless such a remedy would be inappropriate, or the infringement of the right may be justified in terms of s 36 of the Constitution.

Overall, the Bill of Rights offers sufficient protection to the right to health and provides an ideal setting for a study of the extent to which individual benefits may flow from reliance on health rights in litigation. The following chapter assesses reported judgments of South African courts in which health rights have come into play, in an attempt to establish whether the textual potential of health rights has been realised in cases where tangible health-related benefits have been claimed before the courts.

CHAPTER 4
HEALTH RIGHTS IN THE COURTS

4.1 GENERAL

Chapter 3 illustrated the potential of health rights in the 1996 Constitution to result in meaningful benefits, by discussing the interpretation of constitutional provisions which firstly enable a benefit-focused approach to socio-economic rights and secondly embody the various interests represented by the right to health in international law. This chapter is concerned with the manner in which South African courts have thus far dealt with health rights in cases before them. It considers the content that courts have awarded to health rights as well as the limitations to which they have subjected them, and comments on the manner in which courts' interpretative, evaluative and remedial approaches to health rights impact upon the potential of these rights to make a meaningful difference to the lives of their benficiaries.

Of course, socio-economic rights jurisprudence in South Africa is still in its infancy and there has only been a handful of reported decisions at High Court level and above that directly involve health rights. Many of these offer only tentative and exploratory observations on the content and enforcement of the rights concerned and many aspects of health rights have thus far received only minimal judicial attention. The empirical basis for conclusions drawn in this chapter is therefore necessarily limited. However, when viewed together with judgments on non-health-related socio-economic rights,[1] it is possible to identify aspects of socio-economic rights jurisprudence generally, and of health-rights jurisprudence specifically, that present cause for concern from a benefit-focused perspective.

Section 4.2 below analyses the various reported judgments that involve

[1] I refer also to findings concerning rights in ss 26(1) and 27(1)(b) and (c), as well as non-health-related rights in s 28(1)(c) of the Constitution. To the extent that entitlements awarded by these provisions are phrased and/or limited in a similar way to health-related rights, courts' approach to these entitlements will likely also inform their approach to health rights.

constitutional health rights or that are otherwise relevant to their enforcement. It concludes that, while a measure of tangible benefits is indeed resulting from health rights litigation, several aspects of our emerging health rights jurisprudence unduly limit the potential of health rights in this respect. Possible explanations for such unduly limiting aspects are considered in section 4.3. I argue that, while constraints imposed by the separation of powers, the polycentricity of health-related matters and the intricacy of the specialist and complex medical issues that they involve may justify a degree of judicial caution in health rights matters, they do not preclude courts from directly and tangibly remedying infringements of health rights where these occur. Accordingly, they do not provide a convincing explanation for courts' hesitance to interpret and enforce health rights in a manner that may render tangible benefits more directly. The chapter concludes by speculatively considering other factors that may explain this hesitance.

4.2 SOUTH AFRICAN HEALTH RIGHTS JURISPRUDENCE FROM A BENEFIT-FOCUSED PERSPECTIVE

The Constitutional Court has twice decided matters directly involving health rights. In *Soobramoney v Minister of Health, KwaZulu Natal*[2] ('*Soobramoney*'), the Court dismissed an appeal by a chronically ill man in need of life-sustaining kidney dialysis to have such treatment provided at state expense. In *Minister of Health v Treatment Action Campaign (No 2)*[3] ('*TAC2*'), the Court confirmed a High Court decision that the government's policy regulating the availability of a drug used to prevent mother-to-child-transmission of HIV did not satisfy constitutional standards and issued an order requiring the drug to be made more widely available. Health rights were further implicated in a procedural matter relating to the *Treatment Action Campaign* challenge,[4] in an administrative-law

[2]1998 (1) SA 745 (CC).
[3]2002 (5) SA 721 (CC).
[4]*Minster of Health v Treatment Action Campaign (No 1)* 2002 (5) SA 703 (CC) ('*TAC 1*').

challenge to the validity of regulations aimed at making medicines more affordable[5] and in a small number of judgments, including the lower court decisions in the above matters, by the High Courts and the Supreme Court of Appeal (SCA).

The context within which these health rights decisions must be understood further includes judgments relating to other, non-health-related, socio-economic rights, especially that of *Government of the Republic of South Africa v Grootboom*[6] ('*Grootboom*'), an access to housing case in which the Constitutional Court first set out its current approach to socio-economic rights adjudication. Apart from *Grootboom*, reference will also be made to dicta in the *First Certification* judgment[7] pertaining to socio-economic rights adjudication in general; to the simultaneous vindication of the rights to equality and to have access to social security in *Khosa v Minister of Social Development; Mahlaule v Minister of Social Development*[8] ('*Khosa/Mahlaule*'); to the vindication of the obligation to respect the right of access to housing in *Jaftha v Schoeman; Van Rooyen v Stotlz*[9] ('*Jaftha*'); as well as to assorted lower court judgments involving particular aspects of non-health-related, socio-economic rights.

Whereas the rights involved in the majority of the judgments classified here as non-health-related all represent determinants of health, the rights are not implicated as such in any of the above judgments. Consequently, judicial enforcement of determinants of health is not separately discussed in this chapter. However, conclusions drawn from the discussion of s 27(1)(a) below also apply to claims relating to non-medicinal, health-conducive social amenities. Given further that the health-related freedoms in s 12(2) and the right to an environment that is not harmful to health or well-being in s 24(a) have not yet been directly implicated in constitutional litigation, their vindication will not

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[5] *Minister of Health v New Clicks South Africa* CCT 59/04, judgment of 30 September 2005 (unreported) ('*New Clicks*').

[6] 2001 (1) SA 46 (CC).

[7] *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa, 1996* 1996 (4) SA 744 (CC).

[8] 2004 (6) SA 505 (CC).

[9] 2005 (2) SA 140 (CC).

be discussed in this chapter.

(a) Decisions concerning the right to have access to health care services

The first socio-economic rights matter to reach the Constitutional Court, *Soobramoney*, involved a challenge by a man in need of life-sustaining renal dialysis to the resource-rationing policy of a State hospital according to which he was excluded from receiving such treatment. Due to its limited resources, the hospital could provide dialysis only to a limited number of patients. It therefore allowed treatment only for those patients whose conditions could be cured by dialysis, or whose general state of health made them eligible for a kidney transplant. This did not include Mr Soobramoney who, because he would die if he did not receive dialysis, alleged that his exclusion from treatment unjustifiably infringed his rights to life and not to be refused emergency medical treatment. The challenge was dismissed by the Durban High Court, which held that Mr Soobramoney's circumstances did not fall within the ambit of the right not to be refused emergency medical treatment and that his right to have access to the relevant health care services was limited by resource scarcity and the competing rights of other patients.[10] On appeal to the Constitutional Court, the rights to life and not to be refused emergency medical treatment were held not to be applicable to the matter.[11] Instead, the Court considered whether the rationing policy fell foul of s 27(1)(a). It held that it did not, mainly because it found the policy to have been rationally conceived and implemented in good faith by hospital authorities, which were better placed to take the decision of who

[10] *Soobramoney v Minister of Health, KwaZulu Natal* 1998 (1) SA 430 (D) ('*Soobramoney* High Court') at 437A-D; 439E-440D.

[11] *Soobramoney* op cit note 2 at paras 17-21. The Court's findings in relation to s 27(3) are discussed in 4.2(c) below. The socio-economic dimensions of the right to life and its significance for a benefit-focused approach to all socio-economic rights is beyond the scope of this dissertation. I have discussed the potential of the right to life in this regard and have criticised the manner in which the right to life challenge in *Soobramoney* was dismissed elsewhere - see Marius Pieterse 'A different shade of red: Socio-economic dimensions of the right to life in South Africa' (1999) 15 *SAJHR* 372-385; also Marius Pieterse 'Possibilities and pitfalls in the domestic enforcement of socio-economic rights: Contemplating the South African experience' (2004) 26 *Human Rights Quarterly* 882 at 899-900.

was to receive treatment within prevailing resource constraints.[12]

Soobramoney was far from an ideal case for establishing the potential reach of s 27(1)(a). The benefit claimed by the appellant was to be provided with very expensive tertiary treatment (which would neither cure nor significantly alleviate his condition, but would merely marginally prolong his life) at State expense, in the face of relatively convincing evidence that providing such treatment fell outside of the State's financial capacity. It was accordingly to be expected that the appeal would fail. Without therefore taking issue with the outcome of the case, certain aspects of the Court's engagement with the right to have access to health care services are nevertheless worrying from a benefit-focused perspective.

The factual circumstances in *Soobramoney* explain why the Court engages more with the limits to s 27(1)(a) than with the content of the entitlements it awards - the judgment seems to accept that the claimed treatment falls within the meaning of the concept 'health care services', but seeks to limit the extent to which the provision of such treatment may immediately be demanded under the provision. Interestingly, the limitation clause is nowhere invoked for this purpose. Instead, the Court attempts to restrict the extent of the appellant's entitlement by firstly awarding a narrow and specific meaning to s 27(1)(a)[13] and secondly by limiting the right through s 27(2).

Much seemed to turn on the fact that the State could not afford to provide the requested treatment to the appellant and others in his position. The Court was clearly of the opinion that the relevant authorities were doing the best they could, within their limited resources, by restricting treatment to those who were most likely to benefit from it. Moreover, it was understandably concerned that second-guessing the rationing decision (impacted as it were, by financial as well

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[12] *Soobramoney* op cit note 2 at paras 25; 29-30 (per Chaskalson P for the majority); 58 (per Sachs J concurring separately).

[13] Ibid paras 11; 17. This aspect of the judgment is criticised by Frank Michelman 'The Constitution, social rights and reason: A tribute to Etienne Mureinik' (1998) 14 *SAJHR* 499 at 503-504; Craig Scott & Philip Alston 'Adjudicating constitutional priorities in a transnational context: A comment on *Soobramoney*'s legacy and *Grootboom*'s promise' (2000) 16 *SAJHR* 206 at 239.

as medical considerations) would do more harm than good and would amount to overstepping its institutional boundaries.[14]

However, two aspects of the Court's approach to the limiting effect of resource constraints present cause for concern. The first is that the Court seems too readily to accept the respondent's assertion of scarcity without in any meaningful manner inquiring into the accuracy of the assertion or reasons for the alleged scarcity. In particular, the Court may be criticised for apparently regarding the inability of the hospital and provincial health department in question to satisfy the appellant's claim (due to lack of human, financial and technological resources) as conclusive proof that satisfying the claim was beyond the resource capacity of the State as a whole.[15] This is patently defeatist in that it potentially allows the State to shirk its constitutional responsibilities in relation to the delivery of particular health care services simply by allocating minimal funds for the purpose. Failing to subject government assertions of resource scarcity to meaningful scrutiny allows for the undifferentiated 'tolling of the resource-bell' by the State in every matter where it falls foul of its socio-economic obligations, thereby stripping socio-economic rights of much remedial potential.[16]

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[14] *Soobramoney* op cit note 2 at para 29. See also Sachs J's concurring remarks at ibid para 58 ('[t]he provisions of the bill of rights should furthermore not be interpreted in a way which results in Courts feeling themselves unduly pressurised by the fear of gambling with the lives of claimants into ordering hospitals to furnish the most expensive and improbable procedures, thereby diverting scarce medical resources and prejudicing the claims of others'). See further 4.3(a) below.

[15] The *Soobramoney* Court's narrow and deferent approach to ascertaining resource availability is criticised by Darrel Moellendorf 'Reasoning about resources: *Soobramoney* and the future of socio-economic rights claims' (1998) 14 *SAJHR* 327 at 330-332; Charles Ngwena 'The historical development of the South African health-care system: From privilege to egalitarianism' (2004) 37 *De Jure* 290 at 309; Jeremy Sarkin 'Health' (1997/8) 8 *SA Human Rights Yearbook* 97 at 101-02; Scott & Alston op cit note 13 at 239; 241; Ferdinand Van Oosten 'Financial resources and the patient's right to health care: Myth and reality' (1999) 32 *De Jure* 1 at 17. See also Christa Van Wyk 'The enforcement of the right of access to health care in the context of HIV/AIDS and its impact on the separation of powers' (2003) 66 *THRHR* 389 at 396; 398.

[16] Sandra Liebenberg 'Socio-economic rights' in Matthew Chaskalson et al (eds) *Constitutional Law of South Africa* (RS5, 1999) ch 41 at 41; Charles Ngwena 'Access to health care as a fundamental right: The scope and limits of section 27 of the Constitution' (2000) 25(1) *Journal for Juridical Science* 1 at 7. See further Pierre De Vos 'Pious wishes or directly enforceable human rights?: Social and economic rights in South Africa's 1996 Constitution' (1997) 13 *SAJHR* 67 at 97; Moellendorf op cit note 15 at 332; Charles Ngwena & Rebecca Cook 'Rights concerning health' in Danie Brand & Christof Heyns (eds) *Socio-economic rights in South*

Second, in justifying the finding that Mr Soobramoney's claim was untenable in the face of competing individual and societal demands for limited resources, the Court took an overly defeatist stance. Consider the following passages from Chaskalson P's majority judgment:

> 'The appellant's case must be seen in the context of the needs which the health services have to meet, for if treatment has to be provided to the appellant it would also have to be provided to all other persons similarly placed.... If all the persons in South Africa who suffer from chronic renal failure were to be provided with dialysis treatment ... the cost of doing so would make substantial inroads into the health budget. And if this principle were to be applied to all patients claiming access to expensive medical treatment or expensive drugs, the health budget would have to be dramatically increased to the prejudice of other needs which the State has to meet'.[17]

> 'There are also those who need access to housing, food and water, employment opportunities, and social security.... The State has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt an holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society'.[18]

Along similar lines, Sachs J stated in a separate concurring judgment that

> '[w]hen rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as imposing limits on those rights (which would then have to be justified in terms of s 36), but as defining the circumstances in which the rights may most fairly and effectively be enjoyed'.[19]

Craig Scott and Philip Alston warn against invoking and endorsing such justifications for restricting the ambit of individual rights to access care, arguing that this could lead to a situation where '[t]he individual is quickly sacrificed to the amorphous general good on this kind of reasoning which, if taken all the way, would preclude virtually any adjudication of a claim to resources as enjoying constitutional priority over other claims'.[20] The idea that a particular

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Africa (2005) 107 at 137; Sarkin op cit note 15 at 103; Jeremy Sarkin 'A review of health and human rights after five years of democracy in South Africa' (2000) 19 *Medicine & Law* 287 at 293.

[17] *Soobramoney* op cit note 2 at para 28.

[18] Ibid para 31.

[19] Ibid para 54. See also para 58. Kevin Iles 'Limiting socio-economic rights: Beyond the internal limitations clauses' (2004) 20 *SAJHR* 448 at 454 criticises this dictum for importing a proportionality inquiry, which typically forms part of a s 36 limitations analysis, into the definition of the ambit of the right. See also Fanyana Ka Mdumbe 'Socio-economic rights: *Van Biljon* versus *Soobramoney*' (1998) 13 *SA Public Law* 460 at 467.

[20] Scott & Alston op cit note 13 at 252-253. See also ibid 241-245 and, in the context of

claim should be unenforceable merely because other similar claims (or dissimilar claims of equal importance and cost) remain unrealised, is simply at odds with the notion of individual rights. One would be hard pressed to imagine a court similarly rendering a claim based on a civil or political right contingent upon whether the State could satisfy all similar claims and could meet all its other constitutional obligations towards society at large.[21]

Indeed, there are indications in *Soobramoney* that the Court does not view s 27(1)(a) as embodying a fully-fledged right at all. In a separate concurring judgment, Madala J stated:

> 'The Constitution is forward-looking and guarantees to every citizen fundamental rights in such a manner that the ordinary person-in-the-street, who is aware of these guarantees, immediately claims them without further ado - and assumes that every right so guaranteed is available to him or her on demand. Some rights in the Constitution are the ideal and something to be strived for. They amount to a promise, in some cases, and an indication of what a democratic society aiming to salvage lost dignity, freedom and equality should embark upon'.[22]

While this remark was not explicitly endorsed by the majority of the Court, it reveals an ideological discomfort with viewing socio-economic rights as embodying immediately enforceable individual claims,[23] which could significantly hinder the potential of socio-economic rights to render tangible benefits for those who rely on them in litigation.

This discomfort influenced the Court's subsequent development of a coherent approach to socio-economic rights adjudication in *Grootboom*, where it was at pains to emphasise that the right to have access to adequate housing

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the subsequent *Grootboom* case, David Bilchitz 'Giving socio-economic rights teeth: The minimum core and its importance' (2002) 119 *SALJ* 484 at 499 ('[c]ollective goals cannot outweigh protections for the most basic interests of individuals').

[21] See also Sandra Liebenberg 'South Africa's evolving jurisprudence on socio-economic rights: An effective tool in challenging poverty?' (2002) 6 *Law, Democracy & Development* 159 at 187 (remarking that the Court's approach to socio-economic rights is distinguishable from its approach to civil and political rights, where larger societal concerns at most enter the inquiry under the limitation clause, and not in the rights-definition stage).

[22] *Soobramoney* op cit note 2 at para 42.

[23] Also pointed out by Nomthandazo Ntlama 'Unlocking the future: Monitoring court orders in respect of socio-economic rights' (2005) 68 *THRHR* 81 at 82fn2. See further 4.3(b) below.

did not entitle people 'to claim shelter or housing immediately on demand'.[24] In dismissing the amici's assertion that s 26(1) of the Constitution embodied an immediately enforceable minimum core obligation, the Court found that determining the content of such an obligation was overly complex and would be impossible without 'having the requisite information on the needs and the opportunities for the enjoyment of this right'.[25] Instead, the Court held that the 'real question' in terms of the Constitution was whether the current State policy in relation to housing delivery was reasonable under s 26(2),[26] hence shifting the focus of its inquiry to the internal limitation on the right.

According to the *Grootboom* Court, an inquiry into the reasonableness of State measures must have regard to the value of human dignity.[27] Reasonableness of socio-economic measures should be assessed on a case-by-case basis and depends on the context of the litigation, the broader social, economic and historical context and the context of the Bill of Rights as a whole. Reasonableness of measures depends not only on their content, but also on their implementation. Measures must be aimed at the effective and expeditious progressive realisation of a particular right, within the State's means. In addition to the financial resources available, the capacity of relevant State institutions to implement measures should also be taken into account. Measures must further be comprehensive, coherent, balanced and flexible, must be adequate to satisfy the obligations posed by the relevant right, should clearly set out the

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[24] *Grootboom* op cit note 6 at para 95.

[25] Ibid para 32. The *Grootboom* approach to minimum core has been criticised for misunderstanding the concept and overstating its complexity, for failing to recognise the universality of basic subsistence needs and for not insisting that the State prioritise satisfying the primal needs of vulnerable sectors of society. See Bilchitz op cit note 20 at 487-489; Pierre De Vos 'Substantive Equality after *Grootboom*: The emergence of social and economic context as a guiding value in equality jurisprudence' (2001) *Acta Juridica* 52 at 58; Liebenberg op cit note 21 at 174; Theunis Roux 'Understanding *Grootboom* - A Response to Cass R Sunstein' (2002) 12(2) *Constitutional Forum* 41 at 48; 51.

[26] *Grootboom* op cit note 6 at para 33.

[27] Ibid para 83 ('[t]he proposition that rights are interrelated and are all equally important is not merely a theoretical postulate. The concept has immense human and practical significance in a society founded on human dignity, equality and freedom. It is fundamental to the evaluation of the reasonableness of State action that account be taken of the inherent dignity of human beings. The Constitution will be worth infinitely less than its paper if the reasonableness of State action concerned with housing is determined without regard to the fundamental constitutional value of human dignity').

responsibilities of different spheres of government and must ensure that appropriate resources are available for their implementation. Measures may further not exclude a significant segment of society, must plan, budget and monitor the fulfillment of immediate needs and the management of crisis situations, and must cater for the urgent needs of the most vulnerable sectors of society. Courts should also be influenced by the extent to which the exercise of the right in question is being impeded in a particular case.[28]

The nationwide housing programme evaluated for reasonableness in *Grootboom* was held to fall short of the standard, particularly because it did not cater for the emergency needs of vulnerable groups.[29] A declaratory order to this effect was issued, with the implied demand that government adjust its policy in order to conform to the dictates of reasonableness.

While the Court's elevation of one of the terms in the s 26(2) internal limitation to the central yardstick for measuring compliance with the State's obligations in *Grootboom* might have seemed curious, it became clear in the subsequent *TAC2* that the Court not only viewed '*Grootboom* reasonableness' as equally applicable to the right to have access to health care services, but that it considered the State's obligation to adopt reasonable measures in the quest for progressive realisation of socio-economic rights to be the primary (if not sole) justiciable obligation generated by s 27(1)(a) of the Constitution.

In *TAC2*, the amici contended for an interpretation of s 27(1)(a) that reflected a minimum core obligation inherent in the right. Since the drug Nevirapine (the provision of which was central to the *TAC2* challenge) appeared on the WHO's list of essential drugs (which, according to UNCESCR General Comment 14, should be provided as part of the minimum core of the right to health), a minimum core approach to s 27(1)(a) would have entailed elevating the provision of Nevirapine above the dictates of s 27(2) of the Constitution and would accordingly have required its availability in the public sector (unless, presumably, its non-availability could be justified under s 36). The Court

[28]Ibid paras 39-44. See also paras 46; 66; 68; 82.
[29]Ibid para 69.

emphatically dismissed this argument, characterising it as implying that ss 27(1) and (2) would always engender separate obligations.[30] According to the Court, a purposive approach to s 27 precluded a finding that s 27(1)(a) imposed any minimum core obligation. It stated:

> 'It is impossible to give everyone access even to a "core" service immediately. All that is possible, and all that can be expected of the state, is that it act reasonably to provide access to the socio-economic rights identified in sections 26 and 27 on a progressive basis'.[31]

The Court went on to hold that courts were not institutionally equipped to 'make the wide-ranging factual and political enquiries necessary for determining what the minimum-core standards ... should be', since this would have 'multiple social and economic consequences for the community'.[32] Finally, the Court indicated that s 27(1)(a) should never fulfill more than a definitional role:

> 'section 27(1) of the Constitution does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in section 27(2). Sections 27(1) and 27(2) must be read together as defining the scope of the positive rights that everyone has and the corresponding obligations on the state to "respect, protect, promote and fulfill" such right. The rights conferred by sections 26(1) and 27(1) are to have "access" to the services that the state is obliged to provide in terms of sections 26(2) and 27(2)'.[33]

Instead of attempting to award discernible and claimable content to s 27(1)(a), the *TAC2* Court followed the *Grootboom* reasonableness inquiry in relation to s 27. The Court reiterated that the extent of the rights-violation in question must influence the reasonableness inquiry, and again emphasised that the reasonableness standard required of measures to be coherent, balanced and flexible, and not to exclude already vulnerable members of society. Regarding the latter requirement, the *TAC2* Court added that inability to afford treatment is considered indicative of such vulnerability. The Court further seemed to add an additional requirement that measures should be transparent

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[30] *TAC2* op cit note 3 at para 29.

[31] Ibid para 35. See also para 34 ('the socio-economic rights of the Constitution should not be construed as entitling everyone that the minimum core be provided to them').

[32] Ibid paras 37-38.

[33] Ibid para 39. See also paras 31-32.

in order to satisfy the dictates of reasonableness.[34]

The Court found that the government policy according to which Nevirapine could not be administered in the public health care sector except at certain designated 'research and training sites' (regardless of whether the capacity to administer it existed elsewhere) failed the requirement of reasonableness primarily due to its rigidity and inflexibility.[35] Other factors influencing the finding of unreasonableness were the negligible cost of administering the drug, that its safety and efficacy was beyond question, that the procedure for administering it was simple and that funds to expand its provision outside of designated sites were available.[36] The Court accordingly ordered the government to take reasonable measures to remove restrictions on administering the drug in instances where this was medically indicated and where the capacity to do so existed, to 'permit and facilitate' the use of the drug in these circumstances, to make it available for this purpose and to take reasonable measures to extend HIV testing and counseling facilities at public hospitals which still lacked the capacity to administer the drug.[37] Despite the far-reaching terms of this order and despite viewing universal access to Nevirapine as a goal that needed to be accomplished as soon as possible, the Court was still at pains to point out that its finding of unreasonableness 'does not mean that everyone can immediately claim access to such treatment'.[38]

In *TAC2*, the Constitutional Court clearly distanced itself from an approach to the right of access to health care services that entails the recognition of enforceable individual claims.[39] Instead, it opted for an essentially

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[34]Ibid paras 68; 70; 123. On the additional requirement of transparency, see also Liebenberg op cit note 21 at 184.

[35]*TAC2* (ibid) at paras 80; 95. The *TAC* High Court held that the State's programme was unreasonable because it was 'open-ended and leaves everything for the future' and thus could not 'be said to be coherent, progressive and purposeful'. *Treatment Action Campaign v Minister of Health* 2002 (4) BCLR 356 (T) ('*TAC* High Court') at 385F-G.

[36]*TAC2* (ibid) at paras 49; 72-73; 120. For a general discussion of the application of the *Grootboom* reasonableness standard in *TAC2*, see Sibonile Khoza 'Reducing mother-to-child transmission of HIV: The Nevirapine case' (2002) 3(2) *ESR Review* 2 at 4-5.

[37]*TAC2* (ibid) at para 135. See also paras 64; 69; 71; 95.

[38]Ibid para 125.

[39]Remarked also by Danie Brand 'The proceduralisation of South African socio-economic rights jurisprudence, or "what are socio-economic rights for?"' in Henk Botha et al (eds) *Rights and Democracy in a Transformative Constitution* (2003) 33 at 46; Pierre De Vos 'So

procedural inquiry into the reasonableness of measures taken in pursuit of the progressive realisation of the right. Its unwillingness to acknowledge an enforceable individual right flowing from s 27(1)(a) appears to betray the constitutional text (which clearly separates the right in s 27(1)(a) from the qualifiers to the positive obligations it imposes in s 27(2)), to contradict the Court's interpretative approach to all other internal limitations in the Constitution[40] and to reinforce the dichotomy between socio-economic and civil and political rights (which the Court has consistently interpreted as conferring enforceable individual entitlements). Opting for reasonableness as an alternative to a rights-based approach also lacks textual support, since it seems clear from the wording of s 27(2) that the reasonableness standard was intended to prescribe the content of measures adopted in pursuit of progressively realising the right, rather than to substitute an inquiry into the meaning of the right itself or into the implications of the progressive realisation standard or the resource specification.[41] In light of its own objections to reading s 27(1)(a) independently from s 27(2), it is ironic that the Court has inversely severed a single requirement in s 27(2) from the remainder of s 27.

Indeed, the Court's approach has allowed it altogether to avoid engaging with the ambit and scope of s 27(1)(a). While *TAC2* seems to accept that provision of Nevirapine legitimately falls within the ambit of s 27(1)(a), the judgment nowhere explicitly engages with the many interpretative issues raised by the phrase 'access to health care services'. Hence there is no indication as to when there is considered to be access to health care services, the kind of

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much to do, so little done: The right of access to anti-retroviral drugs post-*Grootboom*' (2003) 7 *Law, Democracy & Development* 83 at 89; Liebenberg op cit note 21 at 187.

[40]See for instance *S v Lawrence; S v Negal; S v Solberg* 1997 (4) SA 1176 (CC) at para 37 (Court assumes that s 26(1) of the interim Constitution can be infringed separately from s 26(2), implying that such violation would require justification under s 33 of the interim Constitution); *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC) at para 27 (Court assumes violation of s 31 of the 1996 Constitution without any consideration of s 31(2), and continues to conduct a limitations analysis under s 36); *Islamic Unity Convention v Independent Broadcasting Authority* 2002 (4) SA 294 (CC) at paras 32-34 (Court holds explicitly that limitations on expression which fall outside of the restriction on freedom of expression in s 16(2) of the 1996 Constitution need to be justified under s 36, accordingly that s 16(1) is capable of independent violation).

[41]Bilchitz op cit note 20 at 496.

services to which access may be claimed, the levels at which such services must be provided or the quality standards to which such services should adhere. Similarly, *TAC2* nowhere clearly articulates the obligations that the State incurs in relation to these and other aspects of the right.[42]

Grootboom reasonableness further precludes meaningful engagement with the other standards contained in s 27(2), with both the progressive realisation standard and the resource specification functioning only as non-specific indicators of reasonableness.[43] For instance, while it is clear from both *Grootboom* and *TAC2* that the affordability of a particular social good is central to whether or not the non-provision of that good will be regarded as reasonable,[44] neither judgment gives any indication of the degree of scrutiny to which assertions of resource scarcity should be subjected, or of the manner in which resource-availability should be assessed.[45]

Declining to ascertain the ambit and scope of the entitlements conferred by rights also precludes meaningful engagement with their limits. In particular, confining the inquiry into compliance with the obligations imposed by s 27(1)(a) to the reasonableness of measures in terms of s 27(2) seems to preclude (or at least significantly to complicate) engagement with the limiting effect of s 36. This is because a finding of unreasonableness under s 27(2) appears to exclude the possibility of holding that measures which limit a particular entitlement conferred by s 27(1)(a) are nevertheless reasonable and justifiable in terms of

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[42]Lamented also by David Bilchitz 'Placing basic needs at the centre of socio-economic rights jurisprudence' (2003) 4(1) *ESR Review* 2 at 3; David Bilchitz 'Towards a reasonable approach to the minimum core: Laying the foundations for future socio-economic rights jurisprudence' (2003) 19 *SAJHR* 1 at 6; 8; 10; Brand op cit note 39 at 45-46; Iles op cit note 19 at 454.

[43]*Grootboom* op cit note 6 at paras 46; 94.

[44]The affordability of Nevirapine is given significant weight in the *TAC* reasonableness inquiry. See *TAC2* op cit note 3 at paras 48-49; 71; 89; 120; 125; *TAC* High Court op cit note 35 at 386C-G. See further remarks of Liebenberg op cit note 21 at 173; Van Wyk op cit note 15 at 401; Murray Wesson '*Grootboom* and beyond: Reassessing the socio-economic jurisprudence of the South African Constitutional Court' (2004) 20 *SAJHR* 284 at 296.

[45]See Fons Coomans 'Reviewing implementation of social and economic rights: An assessment of the 'reasonableness' test as developed by the South African Constitutional Court' (2005) 65 *Heidelberg J of International Law* 167 at 190-191; Sandra Liebenberg 'The right to social assistance: The implications of *Grootboom* for policy reform in South Africa' (2001) 17 *SAJHR* 232 at 255; Liebenberg op cit note 21 at 179.

s 36(1).[46] This is unfortunate from a benefit-focused perspective, since courts will understandably be loath to award meaningful content to s 27(1)(a) if doing so will always create an entitlement incapable of limitation. Excluding the application of s 36 from socio-economic rights matters further means that relevant policies may never be subjected to the additional scrutiny envisaged by the standards of justifiablility and proportionality contained in s 36(1) and will accordingly always pass constitutional muster if they satisfy the (arguably more lenient) standard of reasonableness.[47]

Non-application of s 36 to socio-economic rights matters also appears to preclude courts from following the 'two-stage' approach of adjudication when ascertaining whether there has been an infringement of s 27(1)(a). Indeed, *Grootboom* reasonableness focuses neither on the interpretation of the content of the right in question nor on the limits to which it may be subjected (as would be the case under the 'two-stage approach'). Instead, it is concerned only with the internal limitation to s 27(1)(a), which would ordinarily be considered as part of the first stage of adjudication. As Sandra Liebenberg indicates, this has the unfortunate consequence of placing an unfairly onerous burden of proof on applicants, who have to show that government measures aimed at the progressive realisation of s 27(1)(a) are unreasonable in terms of s 27(2). This would require them to review and evaluate a wide range of complex budgetary

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[46]Johan De Waal; Iain Currie & Gerhard Erasmus *The Bill of Rights Handbook* (4th ed 2001) at 451; Iles op cit note 19 at 451-452; Marius Pieterse 'Towards a useful role for section 36 of the Constitution in social rights cases? *Residents of Bon Vista Mansions v Southern Metropolitan Local Council*' (2003) 120 *SALJ* 41 at 43. The anomalies caused by the duplication of the reasonableness standard in ss 27(2) and 36 were acknowledged by the Constitutional Court in *Khoza/Mahlaule* op cit note 8 at paras 83 (per Mokgoro J for the majority); 105 (per Ngcobo J partially dissenting).

[47]Iles op cit note 19 at 464; Sandra Liebenberg 'Violations of socio-economic rights: The role of the South African Human Rights Commission' in Penelope Andrews & Stephen Ellmann (eds) *The Post Apartheid Constitutions: Perspectives on South Africa's Basic Law* (2001) 405 at 424; Pieterse op cit note 46 at 47. See however M Geldenhuys 'The rights to health care and housing: Some aspects of constitutional interpretation' (2005) 17 *SA Mercantile LJ* 182 at 185-187 (arguing that the Court's approach to reasonableness contains elements of a limitations inquiry in terms of s 36). A detailed comparison of the standards of scrutiny envisaged by ss 27(2) and 36 is beyond the scope of this dissertation. It may however be accepted that the s 36 standard is more stringent. See Iles (ibid) at 456-457; Theunis Roux 'Legitimating Transformation: Political Resource Allocation in the South African Constitutional Court' (2003) 10 *Democratization* 92 at 97.

and policy processes, which would in turn require them to have access to complex and specialist information which is typically only available to the State. Many claimants would be simply incapable of coping with the various logistical demands associated with satisfying this onus which, under the two-stage approach, would instead have rested with the State.[48]

Furthermore, the Court's exclusive focus on s 27(2) serves to obscure the horizontal elements of s 27(1)(a), since it complicates the process of distinguishing obligations capable of horizontal application from the (seemingly exclusively vertical) obligations contained in s 27(2). While the obligations detailed in s 27(2) are probably too onerous to bind private entities, a denial that s 27(1)(a) also entails obligations beyond those listed in s 27(2) means that many of the interests served by the right to have access to health care services are left without adequate protection in many of the settings where they are most often threatened.[49]

Overall, when applied without reference to the content of the right it is meant to qualify, the reasonableness standard becomes ad hoc, amorphous and incapable of addressing the substantive concerns that arise when social policy measures are challenged.[50] Moreover, divorcing the focus of the reasonableness inquiry from the right to which it relates in this manner, strips the

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[48]The nature of this burden of proof and its unfair ramifications for applicants in socio-economic rights matters is discussed by Liebenberg op cit note 21 at 188; Sandra Liebenberg 'The interpretation of socio-economic rights' in Stuart Woolman (ed) *Constitutional Law of South Africa* (2ed; 2003) ch 33 at 30; Sandra Liebenberg 'Basic rights claims: How responsive is reasonableness review?' (2004) 5(5) *ESR Review* 7 at 10; Sandra Liebenberg 'The value of human dignity in interpreting socio-economic rights' (2005) 21 *SAJHR* 1 at 22-23. See also Iles op cit note 19 at 464.

[49]See Chrystal Chetty 'The right to health care services: Interpreting section 27 of the Constitution' (2002) 17 *SA Public Law* 453 at 455; Danwood Mzikenge Chirwa 'Non-state actors' responsibility for socio-economic rights: The nature of their obligations under the South African Constitution' (2002) 3(3) *ESR Review* 2 at 5; and also remarks of Stephen Ellmann 'A constitutional confluence: American "State-action" law and the application of South Africa's socio-economic rights guarantees to private actors' in Andrews & Ellmann op cit note 47, 444 at 461; Liebenberg op cit note 16 at 45; Michelman op cit note 13 at 504; John C Mubangizi 'Public health, the South Arican Bill of Rights and the socio-economic polemic' (2002) *TSAR* 343 at 345; Marius Pieterse 'Beyond the welfare state: Globalization of neo-liberal culture and the constitutional protection of social and economic rights in South Africa' (2003) 14 *Stellenbosch LR* 3 at 26.

[50]Bilchitz (*SAJHR*) op cit note 42 at 8-10. See also Bilchitz op cit note 20 at 496-499; Bilchitz (*ESR*) op cit note 42 at 3; Marius Pieterse 'Coming to terms with judicial enforcement of socio-economic rights' (2004) 20 *SAJHR* 383 at 407.

right of meaningful content. As Iain Currie observes:

> 'The trouble is that interpreting the rights in the way the Constitutional Court has done leaves them empty. They are not a right to anything of substance, only to reasonableness in the formulation and carrying out of whatever measures the state has decided to adopt. Reasonableness is no more than a relational standard - ends measured against means. It is not an obligation to provide *something*. Read in this way, the socio-economic rights are not a right to, say, a roof over your head or anti-retroviral drugs, but only to have evaluated the reasonableness of a decision to provide or not to provide these things'.[51]

In affirming only the existence of a right to have measures aimed at addressing health-related concerns in place and to have such measures evaluated for their adherence to principles of good governance, the extent of the entitlements conferred by *Grootboom* reasonableness appear identical to those implied by the right to reasonable and procedurally fair administrative action in s 33 of the Constitution.[52] Apart from this, *Grootboom* reasonableness seems at most to award a relatively weak claim for inclusion in the ambit of policy aimed at satisfying health needs generally, which could in any event be claimed under s 9(1) of the Constitution,[53] or indeed under common law principles of administrative law (which, even in the pre-Constitutional era, could be used to

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[51]Iain Currie 'Bill of Rights jurisprudence' (2002) *Annual Survey of SA Law* 36 at 72. For similar characterisations of the Court's approach see, for example, Bilchitz (*ESR*) op cit note 42 at 2; Bilchitz (*SAJHR*) op cit note 42 at 10; Brand op cit note 39 at 36-37; 39; 49; Chetty op cit note 49 at 461; Coomans op cit note 45 at 188; Pierre De Vos '*Grootboom*, the right of access to housing and substantive equality as contextual fairness' (2001) 17 *SAJHR* 258 at 271; Heinz Klug 'Access to health care: Judging implementation in the context of AIDS: *Treatment Action Campaign v Minister of Health*' (2002) 18 *SAJHR* 114 at 115; Heinz Klug 'Five years on: How relevant is the Constitution to the new South Africa' (2002) 26 *Vermont LR* 803 at 807-808; Liebenberg op cit note 21 at 176; Dwight G Newman 'Institutional monitoring of social and economic rights: A South African case study and a new research agenda' (2003) 19 *SAJHR* 189 at 196; Pieterse op cit note 11 at 898; Roux op cit note 25 at 46; Andre van der Walt 'A South African reading of Frank Michelman's theory of social justice' in Botha et al op cit note 39, 163 at 200. Indeed, in *Grootboom* op cit note 6 at para 83, the Court stated: 'Section 26, read in the context of the Bill of Rights as a whole, must mean that the respondents have the right to reasonable action by the State in all circumstances and with particular regard to human dignity'.

[52]Currie op cit note 51 at 72. It is for this reason that *Grootboom* reasonableness is sometimes described as approximating an administrative law inquiry (see, for example, Bilchitz op cit note 20 at 495; Cass R Sunstein 'Social and economic rights? Lessons from South Africa' (2001) 12 *Constitutional Forum* 123). The claim is not (as Wesson op cit note 44 at 289-293 assumes) that *Grootboom* reasonableness is identical to any particular standard in administrative law, but rather that the benefits flowing from application of the standard appear to be similarly confined.

[53]See Brand op cit note 39 at 49-50; De Vos op cit note 39 at 90; Liebenberg op cit note 21 at 176; Roux op cit note 25 at 46; Wesson op cit note 44 at 293; 295; 297. This appears especially from *Khosa/Mahlaule* op cit note 8.

obtain access to treatment from which a patient was arbitrarily or irrationally excluded, or where a legitimate expectation was created that she would receive such treatment).[54] This makes apparent nonsense of s 27's separate inclusion as a justiciable right in the Bill of Rights.

In focusing on the coherence, rationality, inclusiveness and flexibility of legislative or policy measures, instead of on the alleviation of the concrete consequences of socio-economic deprivation, *Grootboom* reasonableness has rendered the material needs of socio-economic rights' subjects extraneous to the inquiry into constitutional compliance with socio-economic obligations.[55] This inquiry neither concerns itself with evaluating the urgency of applicants' needs (unlike, for instance, a minimum core approach to socio-economic rights adjudication), nor necessarily demands their satisfaction.

The beneficiaries of socio-economic rights stand to gain virtually no tangible benefit from the outcome of an inquiry into the adherence of law or policy to essentially procedural standards. Part of the reason for this is that the only remedy practically allowed for by a finding that law or policy has failed to comply with *Grootboom* reasonableness, appears to be an order declaring the extent of such non-compliance and calling for the law or policy to be modified in order to adhere to the standard. Whereas the adherence of health care policy to the dictates of *Grootboom* reasonableness will no doubt have positive consequences for the progressive realisation of s 27(1)(a) generally and whereas *Grootboom* reasonableness accordingly fulfills a valuable 'directive principle function',[56] such an order will more often than not be of little use to people in urgent need of access to particular health care goods, facilities or services, whose needs will remain unsatisfied.[57] This is further exacerbated by

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[54]This is illustrated by *Applicant v Administrator Transvaal* 1993 (4) SA 733 (W), where an HIV-positive patient successfully challenged an administrative decision by a State hospital not to provide him with a particular drug.

[55]See Bilchitz op cit note 20 at 499; Bilchitz (*ESR*) op cit note 42 at 3-4; Brand op cit note 39 at 36-37; 49; 55; Chetty op cit note 49 at 455; Pieterse op cit note 50 at 407; Van der Walt op cit note 51 at 200.

[56]Acknowledged by Bilchitz (*SAJHR*) op cit note 42 at 1; Coomans op cit note 45 at 168; 181; 186; Liebenberg op cit note 45 at 250; Liebenberg op cit note 21 at 178; 190.

[57]See Coomans op cit note 45 at 188; 195; Liebenberg op cit note 21 at 176; Liebenberg (2003) op cit note 48 at 30; Pieterse op cit note 11 at 896.

the Constitutional Court's apparent reluctance to enforce compliance with the orders it has issued in *Grootboom* and *TAC2* (through, for instance, combining its declaratory orders with structural interdicts), the result of which has been that 'litigants have won cases and government has done little to produce the tangible benefits that these litigants were entitled to expect from their success'.[58]

Accordingly, it would seem that, despite its ostensible concern for the protection and safeguarding of human dignity, the manner in which *Grootboom* reasonableness depicts the entitlements conferred by the socio-economic rights in the 1996 Constitution serves to strip the rights of much of their remedial potential. Whereas *Grootboom* reasonableness is potentially useful as an indicator of State compliance with the obligation to adopt reasonable measures in terms of s 27(2),[59] it becomes problematic when viewed as representative of the totality of entitlements implied by the socio-economic rights in the 1996 Constitution. This is simply because a procedural standard such as reasonableness, by its very nature, cannot and should not fulfill a substantive role by masquerading as a human right. As long as the Constitutional Court insists on depicting the obligation of reasonableness in s 27(2) as exhaustive of the entitlements implied by s 27(1)(a), the right to have access to health care services will fail effectively to confront denial of the needs it represents.

It may therefore be tempting to conclude that s 27(1)(a) has become merely another example of rights discourse's inability to bring about meaningful social change and that, as the skeptics predicted, the inclusion of justiciable socio-economic rights in the 1996 Constitution clearly demanded more of South African courts than they were capable of delivering. But such a conclusion

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[58]Dennis Davis 'Socio-economic rights in South Africa: The record of the Constitutional Court after ten years' (2004) 5(5) *ESR Review* 3 at 6. See also Mia Swart 'Left out in the cold? Crafting constitutional remedies for the poorest of the poor' (2005) 21 *SAJHR* 215 at 218. *Grootboom*, for instance, did not result in an alleviation of the respondents' housing need, despite their successful challenge.

[59]De Vos op cit note 51 at 266; 270-272; Liebenberg (2005) op cit note 48 at 22; Liebenberg (2004) op cit note 48 at 9; Sandra Liebenberg & Michelle O'Sullivan 'South Africa's new equality legislation: A tool for advancing women's socio-economic equality?' (2001) *Acta Juridica* 70 at 76. For instance, Sachs J found in *New Clicks* op cit note at 5 paras 650-656 that regulations aimed at making medicines more affordable, despite being aimed at progressively realising the s 27(1)(a) right, were not reasonable because they failed to take into account the special needs served by and obstacles faced by rural pharmacies.

would not only be premature (being based, after all, on only three judgments), it would also ignore the fact that the effect of applying *Grootboom* reasonableness in *TAC2* has been that many women who were previously denied access to Nevirapine can now access the drug. By improving access to the drug, *TAC2* did result in a measure of tangible benefit for rights-bearers, notwithstanding the Court's reluctance to depict such benefits as flowing from an enforceable right.[60] The problem is that the procedural nature of the reasonableness standard obscures the jurisprudential basis for this welcome result, which is depicted by the *TAC2* Court as incidentally flowing from application of the standard rather than from a discernible notion of individual entitlement. Chapter 5 below will further probe the *TAC2* decision and order in an attempt to uncover this basis.

Moreover, there are suggestions in *Grootboom* and *TAC2*, supplemented by indications from Constitutional Court judgments subsequent to *TAC2*, that there may well be enforceable obligations lurking in socio-economic rights, notwithstanding the limits of *Grootboom* reasonableness. When these indications are considered together with a number of High Court judgments where the ambit and scope of s 27(1)(a) were not made exclusively contingent on the confines of *Grootboom* reasonableness, it becomes possible to identify elements of s 27(1)(a) that may yet, even on the Court's current restrictive approach to the adjudication of socio-economic rights, render some of the tangible benefits they promise.

For instance, the *Grootboom* Court's determination that, in order to satisfy the dictates of reasonableness, policy measures must recognise 'the obligation to meet immediate needs' and should 'ensure that a significant number of desperate people in need are afforded relief, though not all of them need receive it immediately',[61] presents the standard's strongest acknowledgment of need and stops just short of actually conferring an enforceable right to (albeit undefined)

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[60]Liebenberg op cit note 21 at 180; Liebenberg (2005) op cit note 48 at 29; Pieterse op cit note 11 at 895; Wesson op cit note 44 at 296.

[61]*Grootboom* op cit note 6 at para 68.

relief in emergency situations.[62]

Furthermore, while it is true that to insist that policy does not ignore the needs of vulnerable groups does not in itself confer any tangible benefits on them,[63] the benefit of inclusion in the ambit of social policies that *Grootboom* reasonableness seemingly confers on vulnerable sectors of society, appears to correspond to that implied by the presence of the word 'everyone' in s 27(1)(a) and to the prohibition of irrational differentiation under s 9(1) and of unfair discrimination under s 9(3).[64] These links were seemingly affirmed by *TAC2* which, in addition to indicating that the *Grootboom* benefit of 'policy-inclusion' extended to financially vulnerable groups (and accordingly that health policy may not ignore the needs of those who cannot afford to pay for treatment), held that restricting the provision of Nevirapine to designated sites was unreasonable because it excluded people who could reasonably have been included in the ambit of the policy.[65] The outcome of *TAC2* further suggests that there are circumstances in which inclusion within the ambit of a policy will also entail sharing in the tangible benefits conferred by the policy.

More explicitly, the majority of the Constitutional Court in the subsequent *Khosa/Mahlaule* case found that the arbitrary and unfairly discriminatory exclusion of foreigners from social security benefits conferred by legislation fell foul of *Grootboom* reasonableness. The Court accordingly ordered the reading of words into the legislation that would explicitly extend the benefits also to the applicants.[66] While acknowledging that equality of access to social goods is implied by the word 'everyone' in s 27(1), the majority (per Mokgoro J) nevertheless refused to adopt a severed reading of ss 27(1) and (2), instead conducting a reasonableness inquiry under s 27(2).[67] Ngcobo J's minority

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[62]See De Vos op cit note 51 at 266; 270-272; Liebenberg op cit note 21 at 172; 175; Van der Walt op cit note 51 at 202-203.

[63]Roux op cit note 25 at 47; 49. See also Bilchitz op cit note 20 at 498; De Vos op cit note 25 at 58.

[64]De Vos op cit note 51 at 267 further suggests that this aspect of *Grootboom* reasonableness is permeated with the value of substantive equality, and approximates an inquiry into the impact of unfair discrimination in equality cases.

[65]*TAC2* op cit note 3 at paras 70; 125.

[66]*Khoza/Mahlaule* op cit note 8 at paras 53; 82; 85; 89 (per Mokgoro J).

[67]Ibid paras 42-43; 47; 49. See critical remarks of Iles op cit note 19 at 452.

judgment, however, adopted a different approach, locating the infringement in the 'everyone' standard in s 27(1) and proceeding to hold that the exclusion of non-citizens from certain (but not all) of the benefits in question was justifiable in terms of s 36.[68] Whereas one may disagree with this latter finding, the minority's willingness to transcend the confines of *Grootboom* reasonableness, by acknowledging that s 27(1)(a) embodies interests capable of infringement notwithstanding the provisions of s 27(2), is welcomed.

Beyond the equality-threshold of s 27(1)(a), a number of judgments have hinted that the 'access' standard contained in the subsection may be read as conferring several interrelated entitlements on beneficiaries. In *Grootboom*, the Court recognised that the 'access' standard in s 26(1) of the Constitution required that housing to which people have access must satisfy certain qualitative requirements, though it did not pursue this further.[69] An acknowledgment that access to health care services must similarly be meaningful was, however, absent from *TAC2*. Somewhat more encouragingly, the SCA recently remarked in *Pharmaceutical Society of South Africa v Tshabalala-Msimang* that 'access' to health care services required services to be both physically accessible and affordable, and acknowledged that prohibitive pricing of medicines may amount to a denial of access. It also indicated that it viewed the phrase 'health care services' as at least including medicines (hence representing the first explicit judicial attempt to award content to the phrase).[70] In the subsequent appeal judgment in this matter by the Constitutional Court, these dicta were affirmed in a separate judgment by Moseneke J.[71]

The question whether the 'access' standard requires of health care services to be of sufficient quality was answered affirmatively by the Pretoria High Court in *Strydom v Afrox Healthcare*, where a contractual clause insulating a health care facility from delictual liability arising from the negligent conduct of its personnel was declared contra bonos mores and unenforceable. The Court

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[68] *Khoza/Mahlaule* (ibid) at paras 111-112; 134-136 (per Ngcobo J).

[69] *Grootboom* op cit note 6 at paras 35-36.

[70] *Pharmaceutical Society of South Africa v Tshabalala-Msimang; New Clicks South Africa v Minister of Health* 2005 (3) SA 238 (SCA) at paras 42; 53; 77.

[71] *New Clicks* op cit note 5 at para 706.

seemingly viewed s 27(1)(a) as indirectly horizontally applicable to private hospitals and held that the right of access to health care services awarded patients a legitimate expectation that the services to which they have access would be rendered with skill and care by professional and trained health care personnel.[72] This amounts to the most definite affirmation of the horizontal dimensions and implicit quality standards inherent in s 27(1)(a) thus far and is welcomed accordingly.[73] Whereas the SCA overturned this judgment on appeal (since it felt that the exclusion clause did not deny access to treatment and did not explicitly allow for negligent or substandard care), it assumed in favour of the applicant that the right could be horizontally applied and left open the question of whether s 27(1)(a) presupposed a minimum level of care.[74]

Ever since the Constitutional Court stated in its *First Certification* judgment that socio-economic rights could at least be protected against improper invasion,[75] there have been arguments that the obligation to respect s 27(1)(a) could be immediately enforced. That non-compliance with the obligation could uncontroversially be remedied was illustrated in relation to the right to have access to water in *Residents of Bon Vista Mansions v Southern Metropolitan Council*, where the WLD granted a temporary interdict ordering the respondent to restore the water supply to the applicants' apartment complex, holding that discontinuing the water amounted in the circumstances to non-compliance with the obligation to respect the right of access to water.[76] While

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[72] *Strydom v Afrox Healthcare* [2001] 4 All SA 618 (T) at 626b-h; 627f-g. Section 27(1)(a) was also held to be implicated in matters of medical negligence in *Korf v Health Professions Council of South Africa* 2000 (1) SA 1171 (T) at 1179B-D.

[73] See also Currie op cit note 51 at 74. The only other indication that s 27(1)(a) may sometimes apply horizontally is to be found in an obiter remark by Madala J in *Soobramoney* op cit note 2 at para 48 on the 'important role' played by the private sector in rendering complex medical treatment beyond the resource capacity of the State, where he appeared to indicate that he would have no difficulty holding the private sector accountable under s 27(1)(a) in matters where it is duly before the Court. The majority judgment however appeared to distance itself from these remarks. Ibid para 35.

[74] *Afrox Healthcare v Strydom* 2002 (6) SA 21 (SCA) at paras 13; 15; 19-21. This finding will be criticised in 5.3(b)(ii) below.

[75] *First Certification* judgment op cit note 7 at para 78.

[76] *Residents of Bon Vista Mansions v Southern Metropolitan Local Council* 2002 (6) BCLR 625 (W) at paras 11-20; 27. The Court interpreted s 7(2) of the Constitution with reference to international law, holding that the obligation to respect s 27(1)(b) was not subject to s 27(2) and that an infringement thereof required justification. For discussion, see generally Pieterse op cit

the existence of such a negative dimension of socio-economic rights was affirmed in both *Grootboom* and *TAC2*, and while there are at least some indications in the *TAC2* order that the Court regarded the challenged policy as contravening this obligation,[77] it appeared from the Court's resort to a reasonableness analysis in both cases and especially from its categorical refusal to recognise an enforceable entitlement flowing from s 27(1)(a) in *TAC2*, that such affirmation would remain at the level of rhetoric only. Entitlements associated with the obligation to respect s 27(1)(a) accordingly appeared beyond the reach of rights-bearers unless their vindication could somehow be made to resonate with *Grootboom* reasonableness.

Subsequently however, in a welcome about-turn from its seemingly uncompromising position in *TAC2*, the Constitutional Court found in *Jaftha* that infringements of negative obligations generated by the right of access to housing may be remedied without reference to *Grootboom* reasonableness. The Court (per Mokgoro J) dismissed the submission by the respondents that, in line with *TAC2*, self-standing obligations could never be generated by s 26(1). It held that the relevant *TAC2* dicta pertained only to positive obligations generated by socio-economic rights and that non-compliance with their implied negative obligations had to be justified under s 36 of the Constitution.[78] Given the close textual similarities between ss 26 and 27 of the Constitution, it may be expected that a similar stance may in appropriate cases be adopted in relation to s 27(1)(a). It is therefore possible that entitlements associated with the obligation to respect the right of access to health care services may be demanded where non-compliance with the obligation cannot be justified under s 36.

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note 46.

[77] See *Grootboom* op cit note 6 at paras 34; 88; *TAC2* op cit note 3 at para 46; 135.3(a) ('Government is ordered without delay to remove the restrictions that prevent Nevirapine from being made available'). See also *TAC* High Court op cit note 35 at 384E-F (explicitly stating that the refusal to make Nevirapine available outside of designated sites breached the obligation to respect s 27(1)(a)), as well as remarks of Bilchitz (*SAJHR*) op cit note 42 at 8; Iles op cit note 19 at 462; Liebenberg op cit note 21 at 170; 170-178; 183; Liebenberg (2003) op cit note 48 at 18.

[78] *Jaftha* op cit note 9 at paras 31-32; 34. This aspect of the judgment is welcomed by Liebenberg (2004) op cit note 48 at 7-8.

Finally, the *Grootboom* Court endorsed UNCESCR's understanding of 'progressive realisation'.[79] Whereas this may appear superfluous in light of the fact that the standard is sidelined by *Grootboom* reasonableness, it may serve as a basis for finding that deliberately retrogressive measures fall foul of s 27(1) notwithstanding s 27(2).[80] This may render benefits similar to those implied by the obligation to respect s 27(1)(a). Given that the minimum core concept also originated from this understanding of progressive realisation and is arguably integral to the functioning of the standard, the endorsement may also serve as basis for future arguments attempting to resurrect judicial sensitivity to the minimum core dimensions of s 27(1)(a).

Overall, whereas the Constitutional Court's approach to the interpretation of socio-economic rights may rightly be criticised as overly restrictive, there remain indications that the possibility of it adopting a more benefit-conducive approach to s 27(1)(a) over time is not out of the question. The Court's post-*TAC2* judgments, together with the High Court judgments discussed here, further show that *Grootboom* reasonableness does not entirely stifle s 27(1)(a)'s benefit-rendering potential. In any event, the failure of *Grootboom* reasonableness to engage meaningfully with the content of entitlements implied by s 27(1)(a) means that the subsection in principle remains open for a generous interpretation approximating that envisaged in chapter 3 above. The contextual nature of *Grootboom* reasonableness further means that it may in appropriate circumstances be applied in such a way that tangible benefits result more explicitly from it, or that the approach may be changed or supplemented to this effect.

(b) Decisions concerning the right to equality

While South African courts are yet to consider the relationship between health rights and s 9 of the Constitution, the *Khoza/Mahlaule* judgment indicates

[79] *Grootboom* op cit note 6 at para 45.
[80] See remarks of Coomans op cit note 45 at 194; Liebenberg op cit note 21 at 179.

beyond question that the right to equality may be used alongside s 27 to secure benefits from which an applicant was excluded due to unfair discrimination. In addition to falling foul of *Grootboom* reasonableness, Mokgoro J held that the exclusion of all non-citizens from social security benefits amounted to an infringement of s 9(3), and could not be justified under s 36. The benefits accordingly had to be extended to those unfairly excluded, notwithstanding the significant financial implications this held for the respondent.[81]

A finding that health-related benefits were unjustifiably withheld due to unfair discrimination could therefore be reached without reference to s 27(2) or to *Grootboom* reasonableness. An infringement of s 9(3) in these circumstances would also not depend on the resource limitation in s 27(2), meaning that resource scarcity could only justify non-extension of a benefit which was withheld in contravention of s 9(3) where this is reasonable and justifiable in terms of s 36.

That s 9 of the Constitution may operate in this way to secure health-related benefits is also illustrated by the decision in *Langemaat v Minister of Safety and Security*, where the TPD held that the exclusion of same-sex partners from the definition of 'dependant' in a medical aid scheme was inconsistent with the prohibition of discrimination on the ground of sexual orientation in s 9(3). The Court held that this exclusion discriminated unfairly not only against the person who was refused the status of 'dependant', but also against the member of the medical aid scheme who, as a result of the exclusion, 'would have to find the financial means elsewhere to pay for the medical care of excluded dependants'.[82] Section 27(1)(a) of the Constitution is nowhere referred to in the judgment. The Medical Aid Scheme sought to justify the exclusion under s 36, arguing that it would face a flood of similar claims from gay and lesbian members to have their partners registered as dependants on the scheme. This argument was also dismissed.[83] The Court ordered that the scheme had to

[81] *Khoza/Mahlaule* op cit note 8 at paras 62; 74-75; 77; 80. Irrational exclusion from social security benefits was also held to fall foul of s 9(1). Ibid para 53.

[82] *Langemaat v Minister of Safety and Security* 1998 (3) SA 312 (T) at 316A-C.

[83] Ibid 317D-F.

consider the application for registering the applicant's same-sex partner as her dependant afresh, 'without the complication of a definition of what a dependant is'.[84]

(c) Decisions concerning the right not to be refused emergency medical treatment

Soobramoney remains the only matter in which a South African Court has considered the ambit and scope of the s 27(3) right not to be refused emergency medical treatment. In holding that the appellant's need for long-term, life-prolonging kidney dialysis did not constitute a medical emergency and that the right was accordingly not applicable to the case, the Constitutional Court described s 27(3) as being aimed at the non-refusal of treatment where someone 'suffers a sudden catastrophe which calls for immediate medical attention'.[85] While the Court's seeming exclusion of life-threatening conditions not occasioned by a sudden disastrous occurrence has been subjected to some criticism,[86] this definition is arguably wide enough to encompass a relatively broad range of urgent medical conditions and injuries. It also adequately carves out a role for s 27(3) that is distinct from that of s 27(1)(a) and that relates specifically to the compelling needs it aims to satisfy.

Far more disconcerting is the *Soobramoney* Court's reading of resource- and practical limitations into the scope of s 27(3), from which they are textually absent. The Court seemed to hint that s 27(3) should be understood in light of the limitations espoused in s 27(2),[87] though in this regard it may be noteworthy

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[84]Ibid 317I.

[85]*Soobramoney* op cit note 2 at para 20 (per Chaskalson P). See also paras 13; 18; 21 (per Chaskalson P); 38 (per Madala J - 's 27(3) envisages a dramatic, sudden situation or event which is of a passing nature in terms of time'); 51 (per Sachs J - '[t]he special attention given by s 27(3) to non-refusal of emergency medical treatment relates to the particular sense of shock to our notions of human solidarity occasioned by the turning away from hospital of people battered and bleeding or of those who fall victim to sudden and unexpected collapse') as well as *Soobramoney* High Court op cit note 10 at 440B-C (emergency treatment aimed at alleviating 'sudden illness or ... unexpected trauma').

[86]See Van Oosten op cit note 15 at 12-13 and, more generally, Brand op cit note 39 at 47.

[87]See *Soobramoney* op cit note 2 at para 11.

that s 27(3) was subsequently absent from the *TAC2* judgment's list of rights entailing only an obligation to adopt reasonable measures aimed at progressive realisation.[88] However, the *Soobramoney* majority regarded the negative phrasing of s 27(3) as significant. Chaskalson P stated:

> 'The purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a [medical emergency] ... should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment'.[89]

The Court accordingly denied the existence of any positive obligation on the State to ensure the availability, accessibility and adequacy of emergency services. Scott and Alston are severely critical of this, pointing out that the Court has rendered s 27(3) 'virtually redundant' by denying the existence of an obligation to ensure that emergency services are sufficient to meet the needs of those in need of care, thereby failing to insist that the rendering of emergency services be prioritised and accordingly restricting the meaning of s 27(3) as barely (if at all) extending beyond the scope of s 27(1)(a).[90] The practical consequence of this appears to be, as Liebenberg points out, that the right neither requires that emergency medical services be established where they did not exist previously, nor provides any insurance against the culling of existing emergency services or the reduction of the budget for the provision of such services.[91]

The Court's restrictive reading of s 27(3) also serves to deny (or at least significantly to limit) the existence of an enforceable individual entitlement that emergency treatment be rendered when required, outside of the narrow circumstances described by Chaskalson P.[92] Indeed, much like *Grootboom*

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[88] *TAC2* op cit note 3 at para 30. This list contained only s 26(1) as well as ss 27(1)(a), (b) and (c). A more explicit determination to this effect is to be found in *TAC* High Court op cit note 35 at 380E-F.

[89] *Soobramoney* op cit note 2 at para 20. For a similarly limited view of the ambit of the right, see *Soobramoney* High Court op cit note 10 at 439H-440B.

[90] Scott & Alston op cit note 13 at 245; 247-248. See also Brand op cit note 39 at 47; Ngwena op cit note 15 at 309; Ngwena & Cook op cit note 16 at 136-137; Pieterse op cit note 11 at 901.

[91] Liebenberg op cit note 16 at 42fn1; Liebenberg op cit note 21 at 165.

[92] Liebenberg op cit note 21 at 165; 167; Geraldine Van Bueren 'Health' in MH Cheadle

reasonableness that was to come after it, *Soobramoney* appears to view s 27(3) only as a 'right not to be arbitrarily excluded from that which already exists'.[93] In this respect, the judgment may be criticised for proceduralising the right to emergency care and for sidelining the critical need underlying its explicit inclusion in the Constitution.[94]

(d) Decisions concerning the right of children to basic health care services

The interaction between children's right to shelter in s 28(1)(c) and the right of access to adequate housing in s 26 of the Constitution, as well as that between s 28(1)(c) and the right to parental care in s 28(1)(b), was discussed in *Grootboom*. Due to the overlap between the provision concerned there and children's right to basic health care services under the same subsection, this discussion is also relevant to a benefit-focused analysis of the latter right.

Whereas the *Grootboom* High Court held that s 28(1)(c) imposed an immediately enforceable obligation on the State to provide shelter for children where their parents were unable to do so,[95] the Constitutional Court rejected this interpretation of s 28(1)(c) and instead decided the matter solely on the basis of s 26. The Court held that the 'carefully prescribed constitutional scheme for progressive realisation of social rights would make little sense if it could be trumped in every case by the rights of children to get shelter from the State', and accordingly that '[t]he obligation created by s 28(1)(c) can properly be ascertained only in the context of the rights and, in particular, the obligations created by ss 25(5); 26 and 27 of the Constitution'.[96] The Court thus seemed to indicate that the qualifications on the duties of the State under ss 26(2) and

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et al (eds) *South African Constitutional Law: The Bill of Rights* (2002) 491 at 505.

[93]MA Christianson 'Health care' in EML Strydom (ed) *Social Security Law* (2001) 122 at 134; De Waal; Currie & Erasmus op cit note 46 at 450; Scott & Alston op cit note 13 at 236. See also Brand op cit note 39 at 47.

[94]See for instance Brand (ibid) at 47; Van Bueren op cit note 92 at 505.

[95]*Grootboom v Oostenberg Municipality* 2000 (3) BCLR 277 (CC) ('*Grootboom* High Court') at 290G-H; 291B-D. See Julia Sloth-Nielsen 'Children' in Cheadle et al op cit note 92, 507 at 516.

[96]*Grootboom* op cit note 6 at paras 71 and 74 respectively.

27(2) should also be read into s 28(1)(c).[97] Anxious that s 28(1)(c) could be misused by indigent parents to procure shelter for themselves, the Court further read down the ambit of s 28(1)(c) to coincide with its interpretation of s 28(1)(b), holding that the State only incurred a primary obligation for the realisation of s 28(1)(c) rights where children had been abandoned by their parents or had otherwise been removed from the family environment. As far as children in the care of their parents were concerned, the State's duties were held to be limited to creating a legal, administrative and infrastructural environment that would enable children to enforce their rights against their parents.[98]

I have criticised the judgment elsewhere for rendering the separate inclusion of s 28(1)(c) in the Bill of Rights purposeless and for delineating the interaction between parental and State responsibility for child welfare far more restrictively than is envisaged by common law or the CRC.[99] The conflation of ss 28(1)(c) and 26(2) would seem completely unsupported by the constitutional text and denies the explicit constitutional prioritsation of children's basic social needs over the other competing needs that the State has to address.[100]

On the positive side, *Grootboom* does appear to create a directly enforceable entitlement on the part of orphans or abandoned children for the satisfaction of their basic needs, though it does not indicate the extent of such an entitlement.[101] Indeed, in the recent *Centre for Child Law v Minister of Home Affairs*, the TPD indicated that it understood *Grootboom* as suggesting that 'the State is under a direct duty to ensure basic socio-economic provision for

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[97]See also ibid paras 71; 74; 77-78; 95. For criticism, see Pieterse op cit note 11 at 901; Paula Proudlock 'Children's socio-economic rights: Do they have a right to special protection?' (2002) 3(2) *ESR Review* 6 at 8.

[98]*Grootboom* (ibid) at paras 71; 75-78. Note the unfazed manner in which the Court accepts that s 28(1)(c) does apply horizontally, even to the virtual exclusion of vertical application. See Marius Pieterse 'Reconstructing the private/public dichotomy? The enforcement of children's constitutional social rights and care entitlements' (2003) *TSAR* 1 at 10.

[99]Pieterse (ibid) at 10-11. See also Caroline MA Nicholson 'The right to health care, the best interests of the child and AIDS in South Africa and Malawi' (2002) 35 *CILSA* 351 at 365; Pieterse op cit note 11 at 902; Sloth-Nielsen op cit note 95 at 514-515; 517.

[100]See Roux op cit note 25 at 46.

[101]Brand op cit note 39 at 48; Liebenberg op cit note 21 at 189; Liebenberg (2003) op cit note 48 at 51; Julia Sloth-Nielsen 'Too little? Too late? The implications of the *Grootboom* case for state responses to child-headed households' (2003) 7 *Law, Democracy & Development* 113 at 121; Sloth-Nielsen op cit note 95 at 515.

children who lack family care'.[102] What is disconcerting however, is the manner in which *Grootboom* leaves a far larger category of poor children, who happen to be in the care of their parents, without any tangible relief. A similarly restrictive reading of the right to basic health services would have potentially devastating consequences for the health interests of such children, who are arguably the very objects of s 28(1)(c)'s protection.[103]

While the Constitutional Court's concerns with the possible abuse of children's right to shelter by indigent parents are perhaps understandable, these are unlikely to arise in relation to the right to basic health care services, since parents do not stand to derive comparable benefits from the provision of primary health care services to their children. Accordingly, in the health care context at least, the rationale for the Court's stringent restriction of State responsibility towards children in *Grootboom* falls away, which means that *Grootboom*, at least insofar as it describes the interaction between ss 28(1)(b) and (c), should not be followed in relation to the right of children to basic health care services. From the Court's subsequent judgment in *TAC2* it may be inferred that it has at least implicitly recognised this argument. Counsel for the Government relied on *Grootboom* in arguing that s 28(1)(c) obliges parents, and not the State, to provide their children with basic health care services. The Court seemingly dismissed this contention, emphasising that the State retains some residual responsibility to children in the care of their parents and describing the interests of children in the prevention of mother-to-child-transmission of HIV as 'most urgent' and 'most in peril'.[104] It further seemed to expand the *Grootboom* definition of children lacking parental care, thereby extending the State's responsibilities also towards children of indigent parents. It stated:

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[102]2005 (6) SA 50 (T) at para 17. The case concerned assistance for unaccompanied foreign children.

[103]See Liebenberg op cit note 21 at 173; Liebenberg (2003) op cit note 48 at 50; Pieterse op cit note 98 at 11; Proudlock op cit note 97 at 7-8; SALC Project 110, Discussion Paper 103 *Review of the Child Care Act* (2001) at 461-462. J Sloth-Nielsen 'The child's right to social services, the right to social security, and primary prevention of child abuse: Some conclusions in the aftermath of *Grootboom*' (2001) 17 *SAJHR* 210 at 229-230 adds that *Grootboom* might encourage destitute families to abandon their children in order for an enforceable claim against the State to come into being . See also Sloth-Nielsen op cit note 101 at 119-120.

[104]*TAC2* op cit note 3 at paras 77-78.

> 'The state is obliged to ensure that children are accorded the protection contemplated by section 28 that arises when the implementation of the right to parental or family care is lacking. Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means. They and their children are in the main dependent upon the state to make health care services available to them'.[105]

While thus going back somewhat on its uncompromising position in *Grootboom* regarding the interrelation between ss 28(1)(b) and (c),[106] the Court nevertheless did not explicitly find a violation of s 28. Rather, *TAC2* seemed to turn exclusively on s 27(2). It would thus seem that the Court remains unwilling to read s 28(1)(c) separately from the limitations stipulated in s 27(2), which remains open to criticism for reasons similar to those advanced in relation to the *Grootboom* finding.

(e) Decisions concerning the right of detainees to adequate medical treatment

The Constitutional Court has not yet decided a matter involving the health rights of detainees under s 35(2)(e) of the Constitution. There are however High Court judgments in which the right has been implicated, which amply illustrate the potential of the right to result in tangible benefits for its subjects.

In the first of these, *Van Biljon v Minister of Correctional Services*, the Cape High Court ordered that two HIV-positive prisoners had to be provided with such anti-retroviral treatment as had been medically prescribed to them, at State expense. The order flowed primarily from a finding that such treatment amounted to 'adequate treatment' in the circumstances, notwithstanding its cost and complexity. The Court pointed out that 'adequate' treatment under s 35(2)(e) did not necessarily encompass 'optimal medical treatment' or 'best

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[105] Ibid para 79. It is difficult to see how the Court distinguishes between the children in casu and those in *Grootboom*, whose parents were also indigent and dependent on the State for the realisation of their right of access to housing.

[106] See De Vos op cit note 39 at 97; Geldenhuys op cit note 47 at 189-190; Liebenberg op cit note 21 at 185; Liebenberg (2003) op cit note 48 at 51; Pieterse op cit note 98 at 11fn61; Proudlock op cit note 97 at 7; Sloth-Nielsen op cit note 101 at 120-121.

available medical treatment',[107] and proceeded to evaluate the adequacy of the requested treatment with reference to its medical efficacy and cost-effectiveness. It held that 'adequacy' of treatment in prisons would not necessarily be influenced by the standard of medical care to which non-incarcerated citizens generally have access. In fact, given prisoners' particular vulnerability and the constitutional prioritization of their health interests, it was held that s 35(2)(e) may well require a higher standard of care than what is generally available to non-incarcerated citizens in the public health sector.[108]

However, while finding that resource constraints could under s 35(2)(e) not justify the provision of inadequate medical treatment, the Court nevertheless held that such constraints had to be taken into account in determining 'adequacy'. It stated:

> 'What is "adequate medical treatment" cannot be determined *in vacuo*. In determining what is "adequate", regard must be had to, *inter alia*, what the State can afford. If the prison authorities should, therefore, make out a case that as a result of budgetary constraints they cannot afford a particular form of medical treatment or that the provision of such medical treatment would place an unwarranted burden on the State, the Court may very well decide that the less effective medical treatment which is affordable to the State must in the circumstances be accepted as "sufficient" or "adequate medical treatment"'.[109]

Since the Court regarded the requested treatment as both beneficial and cost-effective, and since the respondents could not show that it was unaffordable, the treatment was regarded as adequate. The failure of the respondents to provide it to the first and second applicants therefore amounted to an infringement of s 35(2)(e). The respondents were accordingly ordered to provide the first and second applicants with the prescribed treatment.[110] The similar application by the third and fourth applicants was however dismissed, because anti-retroviral treatment had not been prescribed to them and because the Court was not

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[107] *Van Biljon v Minister of Correctional Services* 1997 (4) SA 441 (C) (also reported as *B v Minister of Correctional Services* 1997 (6) BCLR 789 (C)) at paras 49; 52.

[108] Ibid paras 52-55. At para 53, the Court stated that 'the standard of medical treatment for prisoners in general cannot be determined by the lowest common denominator of the poorest prisoner on the basis that he or she could afford no better treatment outside'.

[109] Ibid para 49.

[110] Ibid paras 56; 60; 65.

prepared to make an order guiding a decision to prescribe medicine.[111]

The *Van Biljon* judgment has not been without criticism. In particular, there is some discord over the Court's decision to import resource limitations into the ambit of s 35(2)(e), from which they are textually absent. It has convincingly been argued that cost-based restrictions on unlimited, 'priority rights' such as s 35(2)(e), rather than impacting on the ambit of the entitlement, should be viewed as limitations on its enforcement, which would be allowed only if justifiable in terms of s 36.[112] Overall however, the judgment indicates that courts are capable of interpreting constitutional health rights (and especially those that are not subjected to limitations imposed by s 27(2)) as conferring enforceable entitlements on individuals. Following from such an interpretation, *Van Biljon* further illustrates that court orders may grant tangible health-related benefits to individuals who have succeeded in showing that their rights have been infringed.

Other than in *Van Biljon*, s 35(2)(e) has not been used to attain access to particular forms of medical treatment. It has however come into play in a different context - the release of prisoners on parole on medical grounds. In *Stanfield v Minister of Correctional Services*, it was held that to insist on the continued incarceration of a terminally ill prisoner, despite the fact that the medical facilities at the prison were not adequate to provide the care necessitated by his condition, affronted his rights to dignity and to dignified conditions of detention (including the provision of adequate medical care). The refusal to grant parole was accordingly overturned.[113] Whereas a specific analysis of s 35(2)(e) was not conducted, it is clear that the Court conceived of the subsection as essentially requiring an inquiry into whether detention conditions are consistent with human dignity, the outcome of which inquiry depended, among other factors, on whether the correctional facility was capable

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[111]Ibid paras 33-37; 61; 65. For criticism of this aspect of the order, see Ngwena & Cook op cit note 16 at 134.

[112]See Liebenberg op cit note 16 at 37; Ka Mdumbe op cit note 19 at 462-463.

[113]*Stanfield v Minister of Correctional Services* 2004 (4) SA 43 (C) at paras 125; 129; 132.

of rendering such medical care as was required by the detainee's condition.[114]

Section 35(2)(e) similarly, although less explicitly, influenced the overturning of a refusal to grant medical parole to a prisoner in need of palliative care (the rendering of which was outside of the capacity of the correctional institution) in *Du Plooy v Minister of Correctional Services*.[115] Read together, *Stanfield* and *Du Plooy* present a potentially interesting remedial alternative in cases where a detainee requires medical treatment beyond the financial capacity of the State. Reading these decisions together with *Van Biljon*, it seems that s 35(2)(e) may operate either to secure prisoners access to such health care services as has been medically indicated for their conditions, or to secure their early and conditional release so that they are placed in a position to access such services for their own account. In appropriate circumstances, detainees' rights in this regard may of course be limited in accordance with s 36 of the Constitution.

(f) Evaluation

The above survey of reported judgments by South African courts involving socio-economic rights generally and/or health rights specifically has shown that, while much uncertainty still surrounds the ambit, scope and limits of constitutional health rights, they may in appropriate circumstances be used successfully to prevent their imminent infringement, to attain adequate compensation for their infringement, or to attain access to particular health-related goods and/or services.

It for instance appears from the Constitutional Court's judgments in socio-economic rights matters that citizens may demand to be included in the ambit of policy which confers health-related benefits (from which inclusion such benefits will sometimes flow incidentally), may demand to receive health-related benefits where these are being denied as a result of unfair discrimination and

[114]Ibid paras 89-91; 119-122; 125.
[115][2004] 3 All SA 613 (T). See paras 23; 26-27.

may enforce entitlements associated with the obligation to respect their health rights. The Court's engagement with specific health-related rights in the Constitution further seems to confirm the existence of an entitlement to obtain available emergency medical treatment from institutions which are able to provide it as well an undefined entitlement of orphans and abandoned children to receive certain health care services at State expense. Decisions by courts other than the Constitutional Court further hint at the existence of entitlements to accessible and affordable medicine and to medical care of a reasonable quality, have vindicated the guarantee against unfair discrimination in access to health-related benefits, and have indicated that detainees may in appropriate circumstances demand to be provided with particular health care services or to be placed in a position where they may obtain access to such services for themselves.

However, the jurisprudence surveyed, especially that of the Constitutional Court, may be criticised for unduly limiting the extent to which tangible benefits may flow from health rights litigation.[116] Not only has the Constitutional Court categorically denied that health rights embody enforceable, 'positive' individual claims against the State, but its appropriation of *Grootboom* reasonableness in socio-economic rights cases has served to proceduralise the inquiry into compliance with the right to have access to health care services to such an extent that there has been precious little engagement with the content of health rights or with the needs that they aim to satisfy. As a result, it would appear that the remedy for successfully enforcing s 27(1)(a) in the Constitutional Court will almost always be at an abstract policy-modification level, from which tangible benefits would at most result incidentally. Furthermore, the Court has displayed a tendency to read down the ambit and scope of health rights guaranteed by constitutional provisions other than s 27(1)(a) to correspond to its restrictive understanding of the latter right. Such 'negative textual inferentialism'[117] not

[116]See also remarks of Liebenberg op cit note 21 at 190.

[117]The term 'negative textual inferentialism' refers to an overly formalistic interpretative practice in relation to socio-economic rights, according to which interdependent or related rights are read together in a way that results in the creation of a crossover 'ceiling effect', through using the restrictive terms of one provision in order to justify the concomitant reading down of another,

only contradicts the textual positioning and phrasing of these rights, but also denies the explicit prioritisation of the satisfaction of certain material needs over others in the constitutional text.[118] It further significantly diminishes their potential to result in tangible benefits for those that successfully enforce them by closing off a direct remedial avenue that would otherwise uncontroversially have been open for courts.

4.3 POSSIBLE EXPLANATIONS FOR THE LIMITS OF SOUTH AFRICAN HEALTH RIGHTS JURISPRUDENCE

This section explores the possible reasons behind those aspects of the Constitutional Court's socio-economic rights jurisprudence that I regard as overly restrictive of health rights' benefit-rendering potential. I firstly consider the institutional constraints that impact on the manner in which the judiciary decides socio-economic rights matters. I argue that the constraints occasioned by the doctrine of separation of powers, the polycentricity of socio-economic rights matters and the limited expertise of the judiciary in matters involving the specialised field of medicine do not preclude courts from interpreting and enforcing health rights in a manner that renders tangible benefits. Instead, I suggest that the Court's animosity towards adopting an approach towards the adjudication of socio-economic rights likely relates to outdated and erroneous perceptions of the nature of socio-economic rights and of the nature of the judicial role in their enforcement. These perceptions, I believe, are fuelled by the formalist and liberal-individualist undertones of South African legal culture and by discomfort associated with the relative novelty of judicially enforcing socio-economic rights. Accordingly, I contend that the obstacles in the way of a more benefit-friendly approach to health rights are imagined rather than real

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less restrictive, provision. See Craig Scott 'Reaching beyond (without abandoning) the category of "economic, social and cultural rights"' (1999) 21 *Human Rights Quarterly* 633 at 638-640.

[118] Scott & Alston op cit note 13 at 252 state: 'The very point of constitutional rights as priority setters for government would seem to have been missed. Positive rights and the notion of core guarantees *do* have a significant prioritising function. Trying to interpret the constitution to remove or neutralise this function thus misses the constitutional point'. See also ibid 244-245.

and urge courts to modify or supplement their current approach to socio-economic rights adjudication in a manner that will allow for these rights more concretely to serve their constitutional purpose.

(a) Institutional constraints

Courts are typically regarded as less than ideal fora for enforcing socio-economic rights. This is not only due to the counter-majoritarian[119] and separation of powers[120] concerns typically raised where courts exercise powers of judicial review, but also because courts are often regarded as lacking the expertise to decide on the intricacies involved in socio-economic rights matters.[121] It is therefore to be expected that at least part of the Constitutional Court's unwillingness to depict socio-economic rights as entailing enforceable individual entitlements relates to the confines imposed by its institutional role and character.

This is apparently affirmed by the Court's socio-economic rights judgments, in which it has on more than one occasion expressly justified its

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[119]Because it inevitably involves unelected judges striking down legislation or policy conceived by the 'democratic' branches, the institution of judicial review necessarily implies the sacrifice of a measure of direct or representative democracy. See generally Nicholas Haysom 'Constitutionalism, majoritarian democracy and socio-economic rights' (1992) 8 *SAJHR* 451 at 455-458; Patrick Lenta 'Democracy, rights disagreements and judicial review' (2004) 20 *SAJHR* 1 at 3-4; Jeremy Waldron 'A right-based critique of constitutional rights' (1993) 13 *Oxford J of Legal Studies* 18-51. I have discussed these tensions in more detail in Pieterse op cit note 50 at 390-392.

[120]It is often argued that socio-economic rights are particularly ill-suited for judicial review because they appear to require judicial involvement in decisions with policy and budgetary implications, which dramatically departs from depictions of the judicial role under 'traditional' conceptions of the separation of powers. See Chetty op cit note 49 at 458; DM Davis 'The case against the inclusion of socio-economic demands in a Bill of Rights except as directive principles' (1992) 8 *SAJHR* 475 at 489; De Waal; Currie & Erasmus op cit note 46 at 433; Erika De Wet *The Constitutional Enforceability of Economic and Social Rights: The Meaning of the German Constitutional Model for South Africa* (1996) at 108-109; Liebenberg op cit note 16 at 6-7; Frank I Michelman 'The Constitution, social rights and liberal political justification' (2003) 1 *International J of Constitutional Law* 13 at 15; Craig Scott & Patrick Macklem 'Constitutional ropes of sand or justiciable guarantees? Social rights in a new South African constitution' (1992) 141 *Univ Pennsylvania LR* 1 at 41-42; 147-148; Van Wyk op cit note 15 at 394-395.

[121]See Stephen Holmes & Cass R Sunstein *The Cost of Rights* (2000) at 94-95; Liebenberg op cit note 16 at 10; Sheetal B Shah 'Illuminating the possible in the developing world: Guaranteeing the human right to health in India' (1999) 32 *Vanderbilt J of Transnational Law* 435 at 448-449 as well as discussion in Pieterse op cit note 50 at 394.

restrictive stance to the interpretation of socio-economic rights by referring to the institutional constraints under which it operates. In *Soobramoney* for instance, Chaskalson P defended the Court's deference to the terms of the challenged rationing policy by stating:

> 'The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibilities it is to deal with such matters'.[122]

Then, in *TAC2*, the Court justified its resort to *Grootboom* reasonableness instead of adopting a 'minimum core approach' to s 27(1)(a) on institutional grounds. It stated:

> 'Courts are ill-suited to adjudicate upon issues where Court orders could have multiple social and economic consequences for the community. The Constitution contemplates rather a restrained and focused role for the Courts, namely, to require the State to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions achieve appropriate constitutional balance'.[123]

It would appear from these passages that, in relation to health rights, the Court considers itself to be restrained firstly by an imperative that it respect the boundaries of the separation of powers (by not unnecessarily second-guessing the decisions of functionaries and/or dictating budgetary and associated policy processes) and secondly by the inherent polycentricity of socio-economic rights matters.[124] Its order in *TAC2* further indicates that it regards itself as not

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[122] *Soobramoney* op cit note 2 at para 29.

[123] *TAC2* op cit note 3 at para 38.

[124] The term polycentricity refers to decisions that affect an unknown but potentially vast number of interested parties and that have many complex and unpredictable repercussions, which inevitably vary for every subtle difference in the decision. Lon L Fuller 'The forms and limits of adjudication' (1978) 92 *Harvard LR* 353 at 395. See also ibid at 403; Davis op cit note 120 at 478; Liebenberg op cit note 16 at 10; Kate O'Regan 'Introducing socio-economic rights' (1999) 1(4) *ESR Rev* 2 at 3. Courts are considered ill-suited to make polycentric decisions, because all affected parties cannot logistically be made part of the proceedings, all possible consequences of the decision cannot be foreseen and there are limits to the quantity and kinds of information to which a court has access in a particular case. For more detailed discussion,

possessing adequate medical knowledge to second-guess decisions involving the expertise of health care professionals, a concern which arguably also informed its deference in *Soobramoney*.[125] These concerns necessarily impact on the manner in which courts conduct themselves in health rights matters. But do they completely explain the Constitutional Court's aversion to recognising enforceable, individual socio-economic rights claims?

As far as separation of powers is concerned, the text of the 1996 Constitution patently mandates a rather drastic departure from the classical conceptualisation of the doctrine by including justiciable socio-economic rights and by requiring of courts to ensure compliance with these rights through judicial review. The Constitution not only allows judges to get involved in matters of social and economic significance, it *requires* them to do so - South African courts simply 'cannot afford the luxury of the separation of powers doctrine'.[126] In any event, not even the classical conception of the doctrine intended for its boundaries to be rigidly determined and enforced - the doctrine must always be responsive to the particular needs of each society it serves.[127] Rather than endeavouring to keep the functions of government branches separate at all costs, the separation of powers' concern with preventing an over-concentration of power often requires the exact opposite - that power should be diffused and

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see NW Barber 'Prelude to the separation of powers' (2001) 60 *Cambridge LJ* 59 at 74-78; Holmes & Sunstein op cit note 121 at 29-30; 95; Etienne Mureinik 'Beyond a charter of luxuries: Economic rights in the Constitution' (1992) 8 *SAJHR* 464 at 466-468; Pieterse op cit note 50 at 393.

[125]Indeed, commentators have sought to distinguish the rationality review adopted in *Soobramoney* from the less deferent *Grootboom* reasonableness followed in *TAC2* on the basis that the policy scrutinised in *Soobramoney* was conceived by health care professionals. See Kam Chetty 'The public finance implications of recent socio-economic rights judgments' (2002) 6 *Law, Democracy & Development* 231 at 249; Klug (*SAJHR*) op cit note 51 at 118; JC Mubangizi 'The constitutional right of access to health care services in South Africa: From renal dialysis to Nevirapine' (2003) 24 *Obiter* 203 at 211-212; Albie Sachs 'Reflections on emerging themes' (1999) 1(4) *ESR Rev* 14; 23; Scott & Alston op cit note 13 at 243.

[126]Roux op cit note 47 at 107. See also Jonathan M Berger 'Taking responsibilities seriously: The role of the state in preventing transmission of HIV from mother to child' (2001) 5 *Law, Democracy & Development* 163 at 169-170; Liebenberg op cit note 16 at 7-8; Charles Ngwena 'Access to health care and the courts: A note on *Minister of Health v Treatment Action Campaign*' (2002) 17 *SA Public Law* 463 at 469; Pieterse op cit note 50 at 404; Scott & Macklem op cit note 120 at 41-42; 147-148; Yousuf Vavwda 'Is eleven better than one? Democracy and the Constitutional Court *TAC* case' (March 2003) *De Rebus* 59-60.

[127]See Barber op cit note 124 at 68-72.

kept in check through an intricate network of constitutionally mandated interferences, of which the power of judicial review is but one example.[128]

In post-1996 South Africa, courts are constitutionally empowered to award content to socio-economic rights, to ascertain whether the obligations that they generate have been complied with and to appropriately remedy the effects of non-compliance therewith, all the time having due regard to the constitutional role of the other branches of government in light of the interests of justice and good governance. It is up to courts themselves to decide on the appropriate balance to be struck, in the circumstances of every socio-economic rights case, between the need for judicial vigilance in the protection of citizens' rights on the one hand and the need to respect the constitutional role and powers of the 'democratic branches' on the other.[129]

That courts have significant scope for manoeuvre in this regard, was affirmed by the Constitutional Court in *TAC2*, where it dismissed an argument by the government that courts are constrained by the separation of powers doctrine from issuing anything but declaratory orders in socio-economic rights matters.[130] The Court found that, while courts should respect the domains of the legislature and the executive, this did not preclude them from making orders which impact on policy. In fact, to the extent that an intrusion of legislative or executive terrain flowed from a court fulfilling its functions of ascertaining whether the State has fulfilled its constitutional obligations and of remedying non-compliance with such obligations, the Court regarded it as 'an intrusion

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[128]James Madison 'The Federalist no 47' in Alexander Hamilton, James Madison & John Jay *The Federalist, or, The New Constitution* (1992) at 247-248. See also Iain Currie & Johan De Waal *The New Constitutional and Administrative Law: Volume 1 - Constitutional Law* (2001) at 92-95.

[129]See Klug (*Vermont LR*) op cit note 51 at 818-819; Pieterse op cit note 50 at 405; Kameshni Pillay 'Implementation of *Grootboom*: Implications for the enforcement of socio-economic rights' (2002) 6 *Law, Democracy & Development* 255 at 259; 276; Scott & Alston op cit note 13 at 216; Geraldine Van Bueren 'Alleviating poverty through the Constitutional Court' (1999) 15 *SAJHR* 52 at 69; Van Wyk op cit note 15 at 407.

[130]The State's argument is set out at *TAC2* op cit note 3 at paras 96-97 and is echoed by Kevin Hopkins 'Shattering the divide - when judges go too far' (March 2002) *De Rebus* 22-26. Jonathan Klaaren 'A remedial interpretation of the *Treatment Action Campaign* decision' (2003) 19 *SAJHR* 455 at 461 describes the argument as 'an attempt to re-litigate the principle of the non-justiciability of socio-economic rights ... in the remedy stage of the case rather than in rights interpretation'.

mandated by the Constitution itself'.[131] It stated that

> 'South African Courts have a wide range of powers at their disposal to ensure that the Constitution is upheld. How they should exercise those powers depends on the circumstances of each particular case. Here due regard must be paid to the roles of the Legislature and the Executive in a democracy. What must be made clear, however, is that when it is appropriate to do so, Courts may - and, if need be, must - use their wide powers to make orders that affect policy as well as legislation'.[132]

These remarks powerfully confirm that the justiciability of socio-economic rights in the 1996 Constitution is beyond question. As the Constitutional Court has stated on several prior occasions, the question is not *whether* courts may give effect to socio-economic rights, but rather *how* they should do so in the circumstances of each individual case.[133]

However, this unequivocal affirmation of its powers in socio-economic rights matters seems at odds with the rather tentative way in which the Court has exercised these powers to date. In particular, it seems curious that the Court has made little effort to define the content of the socio-economic rights it has been called upon to vindicate. Both from a separation of powers and institutional competence perspective, interpretation is the least controversial of the judicial functions in socio-economic rights matters, since it bears the closest resemblance to the 'ordinary' adjudicative functions of courts, which are generally considered better equipped at the task of interpretation than other branches of government. In exercising this task, courts are accordingly regarded as owing minimal deference to the legislative or executive branches.[134] The Constitutional Court's reluctance to award enforceable content to s 27(1)(a) through interpretation cannot therefore be explained by referring to the separation of powers.

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[131] *TAC2* op cit note 3 at para 99. See also paras 98; 100-114.

[132] Ibid para 113.

[133] See ibid para 25, also *First Certification* judgment op cit note 7 at para 77; *Grootboom* op cit note 6 at paras 20; 94; *TAC1* op cit note 4 at para 20.

[134] See Bilchitz op cit note 20 at 487-488; 496; Bilchitz (*SAJHR*) op cit note 42 at 8; 10; Karl E Klare 'Legal culture and transformative constitutionalism' (1998) 14 *SAJHR* 146 at 171; 188; Scott & Alston op cit note 13 at 219; 253-254; Craig Scott 'Social rights: Towards a principled, pragmatic judicial role' (1999) 1(4) *ESR Review* 4. I have argued this more fully in Pieterse op cit note 50 at 406.

Similarly, while separation of powers concerns should logically impact on the manner in which courts choose to remedy violations of human rights,[135] the extent of South African courts' remedial flexibility in terms of s 38 of the Constitution means that they are able, without much difficulty, to devise remedies that balance the need for effective relief with the equally pressing need to afford the other branches of the State a margin of discretion in deciding on how to give effect to court orders.[136] Despite this, the Constitutional Court has thus far exercised its remedial powers in socio-economic rights matters with extreme caution. In particular, commentators have expressed puzzlement at the Court's failure to combine its orders in *Grootboom* and *TAC2* (restricted as they were to a level of policy-modification) with structural interdicts through which compliance with their terms could be monitored. This is curious, especially since the Court explicitly held in *TAC2* that awarding structural relief for socio-economic rights violations would be permissible under the separation of powers where it is appropriate in terms of s 38.[137] The Court has also, on more than one occasion, vindicated infringements of civil and political rights through awarding such structural relief.[138]

It would therefore appear that, whereas separation of powers concerns no doubt informed the Constitutional Court's formulation of *Grootboom* reasonableness as yardstick for measuring compliance with s 27(2) of the 1996 Constitution, the model of separation of powers underlying the 1996 Constitution does not prohibit courts from awarding enforceable content to socio-economic

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[135]See Thomas J Bollyky 'R if C > B + P: A paradigm for judicial remedies of socio-economic rights violations' (2002) 18 *SAJHR* 161 at 162-164; 180-181; Holmes & Sunstein op cit note 121 at 95-96.

[136]See Bollyky op cit note 135 at 177; Currie & De Waal op cit note 128 at 115-116; Liebenberg (2003) op cit note 48 at 40; Pillay op cit note 129 at 259; Swart op cit note 58 at 217; 240 as well as chapter 3 notes 16; 21 and accompanying text.

[137]*TAC2* op cit note 3 at para 129. For associated criticism of the *Grootboom* and *TAC2* orders, see for instance Bilchitz op cit note 20 at 500-501; Bilchitz (*SAJHR*) op cit note 42 at 23-24; Davis op cit note 58 at 5-7; Mark Heywood 'Preventing mother-to-child HIV transmission in South Africa: Background, strategies and outcomes of the Treatment Action Campaign case against the Minister of Health' (2003) 19 *SAJHR* 278 at 311-312; Ntlama op cit note 23 at 81-82; Pillay op cit note 129 at 256; 275-276; Kent Roach & Geoff Budlender 'Mandatory relief and supervisory jurisdiction: When is it appropriate, just and equitable?' (2005) 122 *SALJ* 325 at 333-334; Roux op cit note 25 at 51; Swart op cit note 58 at 215-216; 224.

[138]See, for example, the order in *August v Electoral Commission* 1999 (3) SA 1 (CC) as well as remarks of Ntlama op cit note 23 at 85; 87-88.

rights beyond *Grootboom* reasonableness. Nor, by the Constitutional Court's own admission, does it prevent them from providing effective relief for infringements of socio-economic rights. The overly restrictive elements of the Court's interpretative and remedial approach to health rights can therefore not be justified by arguing that more direct and affirmative options for giving effect to socio-economic rights were not institutionally available to the Court.

Similarly, the reluctance to interpret health rights in a more benefit-friendly manner is inadequately explained by the polycentricity of socio-economic rights matters. While the polycentricity of a matter certainly mandates that courts be aware of the consequences of their judgments, it cannot preclude their involvement in socio-economic rights matters altogether.[139] In any event, socio-economic rights matters are no more polycentric than cases involving civil and political rights. In relation to the latter rights, the Constitutional Court has indicated that it would not let the potential polycentric consequences of its judgments prevent it from performing its constitutional duties in vindicating human rights. As it stated in *August v Electoral Commission*:

> 'We cannot deny strong actual claims timeously asserted by determinate people because of the possible existence of hypothetical claims that might conceivably have been brought by indeterminate groups'.[140]

As in civil rights matters, courts must manage the potential polycentric consequences of their socio-economic rights judgments by carefully tailoring the remedies they confer, rather than by adopting an overly restrictive interpretation of rights. The Constitutional Court's generous and purposive approach to interpreting civil and political rights, together with the flexibility it often displays in remedying civil rights violations, show that it is certainly capable of this.

Indeed, at the level of remedy, viewing social rights as conferring

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[139] Thomas J Bollyky 'Balancing private rights and public obligations: Constitutionally mandated compulsory licensing of HIV/AIDS related treatments in South Africa' (2002) 18 *SAJHR* 530 at 544-545; Liebenberg op cit note 16 at 41-11; Scott & Alston op cit note 13 at 216; 242.

[140] *August* op cit note 138 at para 30. See also Bollyky op cit note 139 at 541; Sandra Liebenberg 'Social and economic rights: A critical challenge' in Sandra Liebenberg (ed) *The Constitution of South Africa from a Gender Perspective* (1995) 79 at 85; Ngwena op cit note 16 at 18; O'Regan op cit note 124 at 3; Pieterse op cit note 50 at 395; Van Bueren op cit note 129 at 61.

individual entitlements and accordingly as entitling applicants to individual relief in appropriate circumstances would pose less polycentricity-related problems than the Constitutional Court's current holistic approach. Section 38 of the Constitution allows courts to strike a balance between the principle that individual litigants should generally obtain the relief they seek and the principle that relief should generally also benefit similarly situated persons, in the circumstances of every case. Where an order would clearly have unwanted polycentric consequences, the dictates of appropriateness require that this balance be struck to favour the awarding of individual, rather than general, relief. The *Van Biljon* Court, for instance, indicated that it was aware of the potential polycentric consequences of its order (that the prisoners in casu were entitled to receive the anti-retroviral drugs they had been prescribed) and consciously avoided these by limiting the entitlement conferred only to the successful individual applicants.[141] Similarly, in *Langemaat*, the Court dismissed arguments that its order (that a Medical Aid scheme had to reconsider an application by a woman to have her same-sex partner registered as her dependant on the Scheme) would open floodgates of litigation and similarly limited its order to the successful applicant only.[142]

As to the complexities posed by the medical issues often implicated in health rights matters, it appears from the judgments discussed above that courts are unwilling to interfere with the clinical decisions of health care professionals. In *Van Biljon*, the order that the applicants be provided with medicines was limited to those medicines that have been medically prescribed to them.[143] Similarly, both the High Court and the Constitutional Court orders in the *TAC* case were expressly limited to situations where administering Nevirapine was

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[141]See *Van Biljon* op cit note 107 at paras 32; 65 and the critical remarks on the restricted ambit of the order by Ngwena op cit note 15 at 307-308.

[142]*Langemaat* op cit note 82 at 317D-F. Other examples where the relief for an infringement of a socio-economic right was limited to the particular litigants include the orders in *Stanfield* op cit note 113; *Bon Vista Mansions* op cit note 76 and the pre-constitutional vindication of a legitimate expectation to receive treatment in *Applicant v Administrator Transvaal* op cit note 54 - see *Applicant* (ibid) at 739H; 741D as well as remarks of Van Wyk op cit note 15 at 393.

[143]*Van Biljon* op cit note 107 at paras 33-37; 61.

medically indicated.[144] Indeed, the order in *TAC2* was at least partly directed at removing bureaucratic restrictions that prevented doctors in the public health care system from prescribing Nevirapine in accordance with their clinical diagnoses and the dictates of medical ethics.[145]

Courts obviously lack the scientific knowledge to decide on diagnosis, prognosis, suitable treatment options and necessity of treatment.[146] This does not mean that they are necessarily ill-equipped to review such decisions, as attested by their scrutiny of and conclusions from medical expert evidence in a variety of cases.[147] However, their obvious lack of medical expertise justifies significant deference to clinical decisions taken by health care professionals. Possible dangers of awarding a wide margin of discretion to health care professionals in this respect are ameliorated by the existence of various legal and extra-legal frameworks through which the acceptability, integrity and efficacy of such clinical decisions may be tested.[148] It is accordingly believed that clinical decisions which are rationally arrived at and consistently applied should not be interfered with, as long as courts remain vigilant to the possibility of subliminal racism, sexism and other forms of bias in such decisions.[149]

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[144]*TAC* High Court op cit note 35 at 387A; *TAC2* op cit note 3 at para 135(3)(b). See also Chetty op cit note 125 at 249. In *TAC1* op cit note 4 at para 16, the Constitutional Court found that a drug is to be considered as 'medically indicated' where 'a consulting medical practitioner considers that a patient he or she is treating would in all the circumstances of health and social circumstances benefit from the administration of the medication'.

[145]See *TAC1* (ibid) at para 18 as well as *TAC* High Court (ibid) at 362I-J; 363I-J; 374H and the discussion in Heywood op cit note 137 at 279; 288; 291; 293-294; 312-313.

[146]See *Van Biljon* op cit note 107 at paras 33-34; Mark A Hall & Gerard F Anderson 'Health insurers' assessment of medical necessity' (1992) 140 *Univ Pennsylvania LR* 1637 at 1650; 1675; Ngwena op cit note 126 at 470; Scott & Alston op cit note 13 at 243.

[147]See for instance conclusions drawn from medical evidence in *Hoffmann v South African Airways* 2001 (1) SA 1 (CC) at para 15; *TAC2* op cit note 3 at para 59.

[148]These include the doctrine of informed consent, the law relating to medical negligence, legal provisions relating to privacy and confidentiality, rules and standards of professional monitoring bodies and codes of professional ethics. See Gregg M Bloche 'The invention of health law' (2003) 91 *California LR* 249 at 271-272; Mark A Hall 'Rationing health care at the bedside' (1994) 69 *New York Univ LR* 693 at 756; David Mechanic 'Professional judgment and the rationing of medical care' (1992) 140 *Univ Pennsylvania LR* 1713 at 1747-1748; 1750-1751; John A Siliciano 'Wealth, equity, and the unitary medical malpractice standard' (1991) 77 *Virginia LR* 439 at 452; SA Strauss 'Geneesheer, pasient en die reg: 'n Delikate driehoek' (1987) *TSAR* 1 at 3-4.

[149]See Hall op cit note 148 at 715; Hall & Anderson op cit note 146 at 1698-1700; Christof Heyns & Danie Brand 'Introduction to socio-economic rights in the South African Constitution' (1998) 2 *Law, Democracy & Development* 153 at 164; David Orentlicher 'Destructuring disability: Rationing of health care and unfair discrimination against the sick'

This, however, does not mean that all decisions involving health care professionals should be sacrosanct. Specifically, health care-related rationing decisions, such as that challenged in *Soobramoney*, are *not* clinical, but political in nature. There is no reason why such decisions should not be subjected to the same level of scrutiny as that appropriated in cases involving 'purely' political decisions - '[w]hile it may be the case that lawyers should not make medical decisions, we might equally suppose that doctors should not make social decisions'.[150] Indeed, courts should guard against political actors attempting to shield their decisions from judicial scrutiny by depicting them as clinical or scientific. The *Soobramoney* court arguably fell into the trap of falsely equating a rationing decision (neither taken exclusively by health care professionals nor based predominantly on medical criteria) as a medical/scientific one, and accordingly unjustifiably subjected the decision only to limited scrutiny.[151]

Whereas individual entitlements flowing from rights to access health care services may accordingly be limited by medical judgments as to whether such care would be beneficial to a particular patient, the mere fact that health rights implicate medical issues need not preclude either the judicial interpretation of rights (a legal, and not medical, function) or the judicial scrutiny of decisions and policies which are not purely clinical in nature. Just as the constraints posed by the separation of powers and by the polycentricity of health rights matters, those implied by the medical/scientific elements of such matters do not explain the

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(1996) 31 *Harvard Civil Rights Civil Liberties LR* 49 at 51-52; 59; 61-62; 71; Alan Parkin 'Allocating health care resources in an imperfect world' (1995) 58 *Modern LR* 867 at 870; 877; Scott & Alston op cit note 13 at 243; Siliciano op cit note 148 at 480.

[150]Parkin op cit note 149 at 870. See also ibid 867; 878; Einer Elhauge 'Allocating health care morally' (1994) 82 *California LR* 1451 at 1458; 1495-1496; Leonard M Fleck 'Just health care rationing: A democratic decisionmaking approach' (1992) 140 *Univ Pennsylvania LR* 1597 at 1599; Mechanic op cit note 148 at 1734; Charles Ngwena 'Access to antiretroviral therapy to prevent mother-to-child transmission of HIV as a socio-economic right: An application of section 27 of the Constitution' (2003) 18 *SA Public Law* 83 at 88; Orentlicher op cit note 149 at 60.

[151]See *Soobramoney* High Court judgment op cit note 10 at 435D-E; 437E-G; *Soobramoney* op cit note 2 at paras 29-30 (per Chaskalson P); 40; 45 (per Madala J); 58-59 (per Sachs J) as well as arguments of Fleck op cit note 150 at 1606-1607; Dieter Giesen 'Health care as a right: Some practical implications' (1994) 13 *Medicine & Law* 285 at 293; Parkin op cit note 149 at 870-871; 878. In *TAC2* op cit note 3, government unsuccessfully argued that the policy decision not to supply Nevirapine at sites other than those designated rested on medical/scientific determinations that rendered it unsuitable for judicial deliberation. See Klug (*SAJHR*) op cit note 51 at 118; Klug (*Vermont LR*) op cit note 51 at 811-812.

overly restrictive approach that the Constitutional Court has adopted towards the interpretation and enforcement of health rights, even as they justify certain restrictions inherent in the *TAC2* order. Overall, it would appear that the Court's refusal to award enforceable core content to health rights, its refusal to acknowledge that certain aspects of s 27(1)(a) are independent of s 27(2) and its negative textual inferentialism in relation to the entitlements afforded by ss 27(3) and 28(1)(c) of the Constitution are not necessitated by institutional constraints.

(b) Beyond institutional constraints

It would seem that the institutional obstacles referred to by the Constitutional Court as justification for its restrictive approach towards socio-economic rights adjudication are, at best, significantly exaggerated. This makes it all the more peculiar that the Court, despite its ostensible commitment to the actualisation of socio-economic rights and despite the significant leeway it is afforded by the text of the 1996 Constitution to interpret and enforce these rights in a manner reflective of their rights-based status, is nevertheless choosing to restrict their benefit-rendering potential.

In interrogating a similarly peculiar tendency of the South African Land Claims Court to reject plausible 'pro-poor' arguments in certain of the cases before it, Theunis Roux showed that much of the unexpected 'anti-poor outcomes' in these cases could be attributed to the influence of South African legal culture on the manner in which judges negotiate 'doctrinal gaps' when called upon to decide issues of substantive justice.[152] While it may not be the only reason behind the overly restrictive aspects of the Constitutional Court's socio-economic rights jurisprudence, it is worth considering whether this culture is having a similarly debilitating effect on the benefit-rendering potential of health-related rights.

[152]Theunis Roux 'Pro-poor court, anti-poor outcomes: Explaining the performance of the South African Land Claims Court' (2004) 20 *SAJHR* 511-543.

South African legal culture shares the classical liberal foundations of Anglo-saxon legal culture, which are not favourably inclined towards the notion of enforceable socio-economic rights. Accordingly, arguments that socio-economic rights amount to vague, politically loaded and resource-intensive aspirations that are ill-suited for judicial deliberation, despite having been conclusively refuted, are bound to resonate with the ideological sensibilities of many South African lawyers.[153] Furthermore, South African legal culture is often described as being characterised by an almost peculiar formalism, which has in the pre-constitutional dispensation been accompanied by a culture of virtually limitless deference to the executive and legislative branches.[154] Given that South African judges were schooled in and influenced by this legal culture, it is possible that they may intuitively experience ideological discomfort with enforcing socio-economic rights and would attempt to allay such discomfort by deferring to the legislative and executive branches.[155]

This instinctive reaction is likely to be fuelled by the fact that judges, in most societies, are simply not used to enforcing socio-economic rights, which remain non-justiciable in the majority of contemporary legal systems. Given the novelty of having to vindicate justiciable socio-economic rights and the concomitant lack of historical or comparative precedent to guide this task, South

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[153]Shown, in relation to liberal legal cultures generally, by M Dlamini 'The political nature of the judicial function' (1992) 55 *THRHR* 411 at 418; KD Ewing 'Social rights and constitutional law' (1999) *Public Law* 104 at 110-111; 122-123; Holmes & Sunstein op cit note 121 at 29; Klare op cit note 134 at 152; 166-167; Liebenberg op cit note 140 at 84; Dikgang Moseneke 'The fourth Bram Fischer memorial lecture: Transformative adjudication' (2002) 18 *SAJHR* 309 at 315-316; Ziyad Motala 'Socioeconomic rights, federalism and the courts: Comparative lessons for South Africa' (1995) 112 *SALJ* 61 at 68; 71; 74; Pieterse op cit note 50 at 397-399; Ruti Teitel 'Transitional jurisprudence: The role of law in political transformation' (1997) 106 *Yale LJ* 2009 at 2056; 2075; Robin West 'Rights, Capabilities and the Good Society' (2001) 69 *Fordham LR* 1901 at 1931. See also chapter 1 note 12 and accompanying text.

[154]These aspects of South African legal culture are discussed by, for example, Edwin Cameron 'Legal chauvinism, executive-mindedness and justice - LC Steyn's impact on South African law' (1982) 99 *SALJ* 38 at 52-62; Alfred Cockrell 'Rainbow jurisprudence' (1996) 12 *SAJHR* 1 at 35; Dlamini op cit note 153 at 420; John Hlope 'The role of judges in a transformed South Africa - Problems, challenges and prospects' (1995) 112 *SALJ* 22 at 24-26; Klare op cit note 134 at 168; Moseneke op cit note 153 at 316; Donald Nicholson 'Ideology and the South African judicial process - Lessons from the past' (1992) 8 *SAJHR* 50 at 63-65; Pieterse op cit note 50 at 396-399; Roux op cit note 152 at 531-536.

[155]See Bollyky op cit note 135 at 182; De Vos op cit note 16 at 69; 74-75; Klare op cit note 134 at 168; 170-171; Scott & Macklem op cit note 120 at 136-137; 148; Van Wyk op cit note 15 at 395.

African judges are thus bound to experience socio-economic rights matters as overly complex and intricate, and as posing insurmountable institutional challenges. Given further that the very notion of rights-based judicial review was altogether alien to South African law as recently as 1993, we may accept that contemporary South African courts remain more comfortable with solving disputes of 'formal justice', rather than with settling issues of 'substantive justice' which seem alien to them.[156] It may therefore be expected that, in instances where courts are faced with giving effect to claims which appear alien to their preconceived notions of rights, justice and their own institutional capacity, and where they are granted the latitude to decide on the manner in which to do so, they would instinctively hark back to formalist modes of legal reasoning.[157] This may ultimately impact negatively on the extent to which socio-economic rights render tangible benefits.

It indeed seems possible to attribute the Constitutional Court's reluctance to opt for a rights-based approach to socio-economic rights to the lingering belief, explicitly voiced by Madala J in *Soobramoney* that, unlike civil and political rights, socio-economic rights are ideals to be strived for rather than rights to be claimed.[158] In particular, there are many distinct similarities between the Court's objections to recognising minimum core obligations flowing from s 27(1)(a) and the typical (and much discredited) objections by socio-economic rights' ideological opponents to their justiciability. Just as socio-economic rights have been described as overly vague, moral aspirations that impose unaffordable positive obligations on states and that require courts to do more than what they are legitimately capable of, so the Constitutional Court has characterised minimum core obligations as imposing imprecise, positive obligations on the State which are 'impossible' to deliver and which cannot be determined by courts without them transgressing institutional boundaries.[159]

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[156]See, for example, Barber op cit note 124 at 79; Tom Campbell 'Judicial activism - justice or treason?' (2003) 10 *Otago LR* 307 at 324; Mureinik op cit note 124 at 469; Van Bueren op cit note 129 at 58.

[157]Argued in relation to the Land Claims Court by Roux op cit note 152 at 534; 542-543.

[158]See text accompanying note 22 above.

[159]I have also argued this in Pieterse op cit note 11 at 898-899. The Court's objections in this regard are echoed by Albie Sachs 'The judicial enforcement of socio-economic rights: The

Besides at best amounting to a misunderstanding and at worst to a conscious misrepresentation of the role played by minimum core obligations in international law,[160] this characterisation betrays a measure of ideological discomfort with vindicating socio-economic rights that clearly resonates with liberal legal culture's hostility towards the notion of rights-based, redistributive social reform.

It is further telling in this respect that the Court's (however slight) post-*TAC2* departures from *Grootboom* reasonableness related to aspects of socio-economic rights that either coincide with violations of civil and political rights (the simultaneous infringement of the right to equality and the 'everyone' threshold in *Khoza*) or correspond to the nature of infringements typically associated with civil rights (non-compliance with the obligation to respect the right of access to housing in *Jaftha*).[161] Given that the enforcement of civil and political rights rests far more comfortably with the foundations of liberalism, it was perhaps to be expected that the Constitutional Court would feel more comfortable with vindicating those elements of socio-economic rights that correspond to its enforcement of civil and political rights.

If one accepts that, due to the classical liberal undertones of South African legal culture, the Constitutional Court is distinctly uncomfortable with

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Grootboom case' (2003) 56 *Current Legal Problems* 579 at 599.

[160]At least as far as health rights are concerned, there exists a detailed and authoritative elaboration on minimum core content in UNCESCR General Comment 14, the existence of which the Court all but ignores. Furthermore, as chapter 2 has shown, international law does not conceive of minimum core obligations as trump-cards that may, regardless of context or severe resource scarcity, always be enforced against states. See chapter 2 note 66 and accompanying text. Moreover, far from being 'impossible' to deliver, compliance with minimum core obligations imposed by the right to health would seem well within South Africa's current capacity. See Bilchitz (*ESR*) op cit note 42 at 4; Bilchitz (*SAJHR*) op cit note 42 at 17; Audrey R Chapman 'Core obligations related to the right to health and their relevance for South Africa' in Danie Brand & Sage Russell (eds) *Exploring the Core Content of Socio-economic Rights: South African and International Perspectives* (2002) 35 at 49; Scott & Alston op cit note 13 at 250. Finally, courts are perfectly capable of awarding minimum core content to socio-economic rights, as is evident for example from the *Grootboom* High Court's interpretation of children's right to shelter in terms of s 28(1)(c) as requiring, as a 'bare minimum', the provision of tents, portable latrines and safe water. *Grootboom* High Court op cit note 95 at 293A-B. See further Bilchitz op cit note 20 at 487-488; Wesson op cit note 44 at 301.

[161]It is perhaps also instructive to note the affirmative and rigorous relief awarded in *President of the Republic of South Africa v Modderklip Boerdery* 2005 (5) SA 3 (CC), where the housing interests of homeless people coincided with the private property interests of landowners. The order did not, however, flow from a finding that housing or property rights had been breached.

having to vindicate interests associated with rights that it (at least subliminally) views as ill-suited for judicial review, its choice of the essentially procedural standard of *Grootboom* reasonableness to give effect to such rights over a more substantive, rights-based interpretative approach, seems almost predictable.[162] In light of South African legal culture's formalistic undertones, it makes sense for a court faced with (what it perceives to be) novel and potentially acute separation of powers-related tensions, to resort to a familiar (and essentially formalistic) manner of negotiating those tensions.[163] It should therefore come as no surprise that there are close similarities between the judicial role under *Grootboom* reasonableness and that which South African courts have for years played in administrative law, which has always involved walking the tightrope between 'legitimate' review of policy decisions and 'illegitimate' substitution of policy with a judge's personal vision of what such policy should ideally have contained.[164]

Unfortunately, the result of the Constitutional Court's resort to a method of adjudicating socio-economic rights claims that rests comfortably both with the liberal and formalistic leanings of South African legal culture as well as with the historical role of judicial review in such a culture, is that an application of *Grootboom* reasonableness does not yield significantly more tangible benefits than those which would in any event have resulted from applying administrative law principles in a constitutional setting where socio-economic rights had either not been entrenched at all or had functioned only as directive principles of state policy.

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[162]See Bollyky op cit note 135 at 182; De Vos op cit note 16 at 74-75; Klare op cit note 134 at 168; 170-171; Pieterse op cit note 11 at 904; Van Wyk op cit note 15 at 395.

[163]I have also argued this in Pieterse op cit note 11 at 893. See further Bilchitz op cit note 20 at 495-496; Brand op cit note 39 at 42.

[164]Shown also by Sunstein op cit note 52. See discussion on judicial deference in relation to reasonableness review in pre-constitutional administrative law by Lawrence Baxter *Administrative Law* (1984) at 485-487 and in post-constitutional law by Cora Hoexter *The New Constitutional and Administrative Law Volume II: Administrative Law* (2002) at 183. For example, in *Applicant v Administrator Transvaal* op cit note 54 at 738F-G; 739A-C; 741D-E, the court was at great pains to emphasise that its judgment should not be viewed as questioning the substantive motive behind a policy-decision no longer to supply a particular drug in the public health sector nor as supplanting such decision. See discussion of these aspects of the judgment by Frans Viljoen '*Kim Schmidt v Administrator of the Transvaal*' (1993) 26 *De Jure* 207 at 209.

While this is lamentable, there nevertheless remains hope that, as it is called upon to adjudicate an increasing number of health and other socio-economic rights cases, the Constitutional Court may move towards a more rights-based, and ultimately more benefit-conducive, approach. Given that it may well be a culturally ingrained instinctive response to the nature of health-related rights claims, rather than insurmountable textual or institutional hurdles to their enforcement, that underlies the Court's hesitance to tangibly give effect to the health rights in the 1996 Constitution, the possibility remains that it may over time be persuaded to modify or supplement its current approach. In the following chapter, I attempt to illustrate that such modification or supplementation is possible without requiring courts to depart radically from the adjudicative approaches to which they are accustomed.

CHAPTER 5
ALTERNATIVES AND SUPPLEMENTS TO CURRENT JUDICIAL APPROACHES TO HEALTH RIGHTS

5.1 INTRODUCTION: LOOKING BEYOND *GROOTBOOM* REASONABLENESS

Chapter 4 has shown that certain aspects of South African courts' emerging health rights jurisprudence have the effect of unduly restricting the extent to which tangible benefits may result from successful reliance on health rights in litigation. This is true especially of *Grootboom* reasonableness, the standard developed by the Constitutional Court to measure compliance with all obligations imposed by socio-economic rights in the Constitution. I have argued that, with certain exceptions, *Grootboom* reasonableness leaves socio-economic rights empty of enforceable content and obscures the theoretical basis for those tangible benefits that appear to result incidentally from its application. In addition to precluding meaningful engagement with the content of health rights, *Grootboom* reasonableness also hinders engagement with their limits and their horizontal dimensions, and complicates the development of appropriate remedies to prohibit, correct or compensate for their infringement.

While accepting that *Grootboom* reasonableness will remain the focus-point of the Constitutional Court's socio-economic rights jurisprudence for the foreseeable future, this chapter aims to show that there are viable alternative and/or supplementary approaches to health rights adjudication. These may more readily result in tangible benefits for rights-bearers without requiring a radical overhaul in the manner in which courts conduct themselves in socio-economic rights matters. Nor do the approaches considered here preclude the application of *Grootboom* reasonableness in appropriate matters.

Commenting on the *TAC2* judgment from a remedy-conscious perspective, Jonathan Klaaren suggests that *Grootboom* reasonableness 'does

not entirely shut the door on the direct enforcement of socio-economic rights'.[1] Instead, he claims, *Grootboom* reasonableness allows for three distinct remedial paradigms, none of which preclude the judicial recognition and enforcement of a direct remedy for an infringement of a socio-economic right. These are, first, the judicial evaluation of legislative and other measures for compliance with the reasonableness standard (where the remedy granted essentially amounts to an order that reasonable measures be adopted or that existing measures be modified to comply with the dictates of reasonableness), secondly, the provision of a legal framework for the vindication of health rights through developing the common law and, thirdly, the direct enforcement of particular litigants' rights, through tailoring appropriate remedies in accordance with s 38 of the Constitution.[2]

This chapter engages primarily with the second and third remedial avenues identified by Klaaren. The first, which essentially amounts to a reading of *Grootboom* reasonableness that sees s 27(2) as the remedy intended by s 27(1),[3] is not of direct relevance for my purposes, since tangible benefits would mostly result only incidentally from a remedy that requires legislative or policy measures to adhere to the dictates of *Grootboom* reasonableness. This is not to say that the 'directive principle effect' of *Grootboom* reasonableness is of no concrete value to health rights' beneficiaries or that its incidental benefits may not be substantial. Moreover, there will certainly be matters in which an order that measures be adopted or modified is both appropriate and sufficient from a benefit-focused perspective.[4] My concern here, however, is to elaborate on

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[1] Jonathan Klaaren 'A remedial interpretation of the *Treatment Action Campaign* decision' (2003) 19 *SAJHR* 455.

[2] Ibid 455; 460-461. See also Jonathan Klaaren 'An institutional interpretation of socio-economic rights and judicial remedies after *TAC*' in Henk Botha et al (eds) *Rights and Democracy in a Transformative Constitution* (2003) 105 at 112-113.

[3] See Klaaren op cit note 1 at 465.

[4] The harm suffered by claimants in a particular case may well relate specifically to the manner in which legislation or policy is phrased or implemented. For example, terms of legislation or policy may arbitrarily exclude particular individuals or groups from receiving benefits that would otherwise accrue to them, or may otherwise unreasonably hinder them from accessing particular health-related goods or services. In such circumstances, an order that legislation or policy be modified to comply with the dictates of *Grootboom* reasonableness, if complied with, would correct for the infringement.

alternatives to the remedial paradigm most readily associated with *Grootboom* reasonableness.

Accordingly, section 5.2 below contemplates the direct remedying of health rights infringements, which it links back to arguments that health rights should in appropriate circumstances be interpreted as awarding entitlements and imposing obligations which are immediately enforceable. In addition to arguing that the Constitutional Court should reassess its stance towards the notion of minimum core obligations, I illustrate that there exist several alternative ways of identifying and enforcing core-like entitlements inherent to the health rights package in the 1996 Constitution. These neither involve courts slavishly following the international law understanding of the minimum core concept, nor require of them to ignore the dictates of s 27(2) of the Constitution or to transgress their institutional boundaries.

Thereafter, section 5.3 explores the extent to which tangible benefits may result from the application or development of existing common law principles in matters where health rights are implicated. I argue that there is significant unexplored potential for the actualisation of health rights through their indirect application. This is so firstly because of the fairly extensive body of common law principles applicable to the doctor-patient relationship and other 'special relationships' from which socio-economic obligations may flow. Secondly, South African courts would likely be more comfortable with the evaluative and remedial paradigms associated with common law adjudication than with the direct application of socio-economic rights. Common law not only offers a wide array of potential remedies that may amount to adequate reparation for infringements of health rights, but also provides the ideal environment for an exploration of the horizontal dimensions of health rights in accordance with s 8(3) of the Constitution. I accordingly discuss instances in which the current state of common law adequately serves the interests underlying health-related constitutional rights, as well as instances in which these interests may be furthered through relatively uncontroversial developments to existing common law rules and doctrines.

5.2 DIRECTLY REMEDYING INFRINGEMENTS OF HEALTH RIGHTS: TOWARDS ENFORCEABLE ENTITLEMENTS

Despite the *TAC2* Court's rejection of the argument that s 27(1)(a) of the 1996 Constitution awards an immediately claimable minimum core right outside of the parameters of *Grootboom* reasonableness, Klaaren views the Court's simultaneous affirmation of its powers to order a remedy that amounts to appropriate relief for each infringement of a socio-economic right, as it reserving the option to vindicate individual or group-based entitlements where this is called for in the circumstances of a particular case. Klaaren adds that such appropriate relief may well, in suitable circumstances, correspond to the enforcement of a minimum core obligation, though it would probably follow from a finding of unreasonableness under subsec 27(2) of the Constitution, rather than from a finding that subsec 27(1)(a) thereof has been breached.[5]

While the direct remedying of health rights infringements in this manner would be welcome, the basis of a direct judicial remedy for the infringement of a health-related right would remain concealed unless it is related specifically to an understanding of the entitlements awarded by the right in question and of the extent to which these may be claimed or limited in particular circumstances. Declining to situate a remedy within such an understanding would complicate the monitoring of its effectiveness, through obscuring the links between such a remedy and the needs that underlie the right it serves to vindicate. Moreover, detaching remedy from right in this manner would fail to provide any practical guidance to applicants in future health rights matters as to the extent of their entitlements and to their likelihood of success. Given the onerous burden of proof that such applicants face under *Grootboom* reasonableness and given that '[t]he stakes are high for the individuals and groups who approach the Court for relief, entailing threats to life, health and the ability to function in society',[6]

[5]Klaaren op cit note 1 at 461; 464; 467; Klaaren op cit note 2 at 113.

[6]Sandra Liebenberg 'The value of human dignity in interpreting socio-economic rights' (2005) 21 *SAJHR* 1 at 22.

uncertainty as to whether the relief they seek is actually capable of resulting is bound to impact negatively on such applicants' willingness to assert their rights through the judicial process. The argument therefore remains that, if its jurisprudence is to have any tangible significance for socio-economic rights' beneficiaries, the Constitutional Court needs to reverse its stance against the recognition of enforceable claims.[7]

In particular, the Court's reasons for rejecting the argument that s 27(1)(a) of the Constitution encompassed an enforceable minimum core obligation simply do not hold water. Contrary to the Court's assertions, affirming the existence of minimum core entitlements would not require respondents immediately to satisfy claims to core goods or services, even in circumstances where this would patently be impossible or would lead to injustice. It would merely require the Court to insist that respondents justify the non-satisfaction of core needs, and to pronounce on the constitutional acceptability of such justification, in exactly the same manner as it decides and pronounces on the justifiability of apparent infringements of civil and political rights.[8] This it could achieve either by viewing non-satisfaction of core needs as an infringement of s 27(1)(a) that requires justification in terms of s 36 of the Constitution[9] or, if it insists on involving s 27(2), by viewing such non-satisfaction as triggering a presumption of

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[7]See also Sandra Liebenberg 'South Africa's evolving jurisprudence on socio-economic rights: An effective tool in challenging poverty?' (2002) 6 *Law, Democracy & Development* 159 at 188 ('recognising an individual entitlement to ... relief would be of immense practical benefit to litigants who seek the courts' assistance in situations of severe socio-economic deprivation. They would not be required to review a wide range of measures adopted by the state and to assess their reasonableness in the light of its available resources. Instead they would enjoy the benefit of a presumption that placed the burden on the state to justify why it is unable to provide direct relief. Furthermore, it would ensure that, in appropriate circumstances, they are entitled to direct individual relief').

[8]Argued also by Darrel Moellendorf 'Reasoning about resources: *Soobramoney* and the future of socio-economic rights claims' (1998) 14 *SAJHR* 327 at 331-332 and, in relation to minium core entitlements specifically, by David Bilchitz 'Towards a reasonable approach to the minimum core: Laying the foundations for future socio-economic rights jurisprudence' (2003) 19 *SAJHR* 1 at 16-18; Kevin Iles 'Limiting socio-economic rights: Beyond the internal limitations clauses' (2004) 20 *SAJHR* 448 at 458; Liebenberg op cit note 7 at 188; Liebenberg op cit note 6 at 25.

[9]See, for example, Iles op cit note 8 at 463-465; Marius Pieterse 'Towards a useful role for section 36 of the Constitution in social rights cases? *Residents of Bon Vista Mansions v Southern Metropolitan Local Council*' (2003) 120 *SALJ* 41 at 45-48; also chapter 3 notes 85-86 and accompanying text.

unreasonableness in terms of s 27(2).[10] Moreover, in circumstances where adequate justification for non-satisfaction of core needs is lacking, the Court would retain the flexibility to minimise any unreasonable, unrealistic or otherwise undesirable consequences of a finding to this effect, through tailoring the remedy it awards to suit the circumstances of the case and the interests of justice.[11]

I concede that it may possibly be unwise for South African courts blindly to incorporate the UNCESCR's understanding of the minimum core content of the international law right to health into an interpretation of s 27(1)(a) of the 1996 Constitution, since the latter provision operates in an entirely different legal, institutional and social context from article 12 of the ICESCR.[12] However, there is nothing that prohibits domestic courts from themselves incrementally awarding context-sensitive and need-specific core content to s 27(1)(a) on a case-by-case basis.[13] Whereas I would still argue that UNCESCR's elaboration of the core content of the right to health provides invaluable guidance for courts in this respect, several other interpretative options also present themselves.

For instance, courts could choose to align their understanding of core entitlements in terms of s 27(1)(a) to the understanding evident from legislation or health policy that confers health care-related benefits upon citizens. For

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[10]As suggested by Liebenberg op cit note 6 at 23. Whereas such a presumption would serve to relieve applicants of the unfair burden of proof they currently bear in terms of a *Grootboom* reasonableness analysis, it would nevertheless amount to a less stringent insistence on justification than a s 36 inquiry. Given the vitality and urgency of the interests at stake, Liebenberg accordingly suggests that an inquiry into the rebuttal of the presumption approximates a proportionality analysis in terms of s 36. Ibid at 24; 27-28.

[11]See Bilchitz op cit note 8 at 18; Liebenberg op cit note 7 at 175fn90; also chapter 3 note 24 and accompanying text.

[12]Murray Wesson '*Grootboom* and beyond: Reassessing the socio-economic jurisprudence of the South African Constitutional Court' (2004) 20 *SAJHR* 284 at 303-305 for instance argues that the UNCESCR conception of minimum core excludes many needs of vulnerable sectors of South African society, inflexibly prescribes the State's response to social needs and frustrates the satisfaction of legitimate needs that UNCESCR regards as falling outside of the minimum core. See also Liebenberg op cit note 6 at 31. Furthermore, it may be argued that it is unwise to incorporate an interpretation of a provision in a treaty that Parliament has not ratified and that is enforced by way of a reporting mechanism only, into a justiciable constitutional right of which the content corresponds only partially to the treaty-provision.

[13]Liebenberg op cit note 7 at 174; Sandra Liebenberg 'The interpretation of socio-economic rights' in Stuart Woolman (ed) *Constitutional Law of South Africa* (2ed; 2003) ch 33 at 31.

example, s 4(3)(b) of the National Health Act 61 of 2003 determines that the State must provide free primary health care services to all persons except to those who are members of medical aid schemes or to their beneficiaries, or to persons receiving compensation in terms of relevant occupational health laws. Section 4(3)(a) of the same Act determines that the State must provide free health services (ie extending beyond primary care) to all pregnant and lactating women and to all children below the age of six years, subject to similar limitations. Viewing the entitlements conferred by provisions such as these as constituting the enforceable core of s 27(1)(a), would minimise the (already slight) separation of powers tensions that may otherwise be occasioned by this interpretative exercise. However, adopting such an approach obviously runs the risk of depicting core entitlements as being contingent on the existence of the legislative provisions or policy documents in question. Nor would such an approach assist in relation to the satisfaction of those vital and urgent needs that are not similarly the subject of legislative or policy provisions.

Alternatively, should courts insist on adopting a holistic approach to the health rights package in the 1996 Constitution, it would appear possible for them to locate the core of the right to health outside of s 27(1)(a). As chapter 3 has shown, the constitutional scheme as a whole supports the prioritisation of certain essential health services, regardless of resource limitations, the dictates of progressive realisation or the existence of reasonable measures. The absence of a s 27(2)-style modifier in ss 12(2)(a), 24(a), 27(3), 28(1)(c) and 35(2)(e) could therefore be read to suggest that the minimum core of the right to health in South Africa could be viewed as entailing entitlements to emergency medical treatment for all, basic health care services for children, adequate medical care for detainees, such services as are necessary to constitute an environment that is not harmful to health and such reproductive health care services as are necessary for the unfettered exercise of the right to reproductive freedom. In line with the two-stage approach to adjudication, non-satisfaction of such core needs would be capable of justification only in terms of s 36 of the Constitution.[14]

[14]Section 28(1)(c) is viewed as illuminating part of the core content of s 27(1)(a) in this

Constructing a 'constitutional core' for the right to health in this manner would seem to serve the same purpose as the minimum core approach in international law. Following this approach would also minimise separation of powers tensions inherent in the recognition and enforcement of minimum core entitlements since courts are, under this approach, deriving their conception of core entitlements from the explicit provisions of the constitutional text. However, much like *Grootboom* reasonableness and the 'negative textual inferentialism' that characterises the Constitutional Court's current approach to 'priority' health rights, this approach appears to drain s 27(1)(a) of independently enforceable content. While the argument that access to particular health care services implied by s 27(1)(a) may not immediately be claimed unless it is also guaranteed by another, unlimited, provision of the Constitution, is certainly plausible in light of s 27(2), it may be criticised for unduly restricting the benefit-rendering potential of s 27(1)(a).

Accepting therefore that the rights guaranteed in ss 12(2)(a), 24(a), 27(3), 28(1)(c) and 35(2)(e) of the Constitution are capable of resulting in the population obtaining access to the health-related benefits they promise, regardless of whether a minimum core approach is adopted in relation to s 27(1)(a), it should nevertheless be possible to award a measure of claimable content to the latter right, over and above the entitlements associated with the obligation to respect it and with its egalitarian threshold. Even on a conjunctive reading of ss 27(1)(a) and 27(2), courts should at least be capable of delineating a set of circumstances in which entitlements implied by s 27(1)(a) could be viewed as immediately claimable.

In an attempt to establish when direct, mandatory relief would amount to an appropriate remedy to correct for the infringement of a socio-economic right, Thomas Bollyky examined a range of orders made by the Constitutional Court in cases involving civil and political, as well as socio-economic rights. He

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manner by Craig Scott & Philip Alston 'Adjudicating constitutional priorities in a transnational context: A comment on *Soobramoney*'s legacy and *Grootboom*'s promise' (2000) 16 *SAJHR* 206 at 260; Geraldine Van Bueren 'Alleviating poverty through the Constitutional Court' (1999) 15 *SAJHR* 52 at 57. See further Liebenberg op cit note 13 at 49.

concluded that the Court would go beyond ordering mere declaratory relief in circumstances where the egregiousness of the constitutional violation outweighed the sum-total of the budgetary and political consequences of the order in question.[15] If Bollyky is correct, it should be possible to derive a set of circumstances under which tangible relief may be expected to result from reliance on s 27(1)(a), through engaging with the manner in which the Constitutional Court struck the balance between these competing normative values in *TAC2.* This is so because, even as its use of *Grootboom* reasonableness in *TAC2* obscured the basis for its order that restrictions on the provision of Nevirapine must be lifted and that its provision must under certain circumstances be permitted and facilitated, that order resulted in a measure of tangible relief for HIV-positive pregnant women. It should therefore be possible to recast the terms of the *TAC2* order, read with the Court's justifications for its finding of unreasonableness in that case, in terms that reflect a notion of entitlement at the core of s 27(1)(a).

In his critique of the 'proceduralising' effect of *Grootboom* reasonableness as evident from *TAC2*, Danie Brand remarks that the *TAC2* Court's finding of unreasonableness was essentially motivated by its dissatisfaction with the lack of rational coherence of the challenged policy. The perception that the policy lacked rational coherence, argues Brand, was in turn based on the fact that the policy prohibited the drug being administered in situations where it was medically indicated and where the capacity to administer it clearly existed, despite the drug being affordable, safe and efficacious.[16] That

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[15]See generally Thomas J Bollyky 'R if C > B + P: A paradigm for judicial remedies of socio-economic rights violations' (2002) 18 *SAJHR* 161 at 163-177. Bollyky expresses this paradigmatically in algebraic terms as R if C > B + P (where R = remedy; C = constitutional violation; B = budgetary implications and P = Policy implications). He summarises the paradigm as follows: 'The "positive" mandate created by the constitutional violation (C) - as a product of its quantitative and qualitative elements - is weighed against the "illegitimacy" of a court issuing the relief - as defined by the sum of its qualitative and quantitative interference in policy and budgetary decisions (P + B). The common unit, or the basis of comparison, for the variables in this paradigm is whether they add, or detract, from the legitimacy of granting that form of relief. Judges intuitively weigh these competing normative values and ultimately make an assessment of remedies based on their proportionality'. Ibid 175.

[16]Danie Brand 'The proceduralisation of South African socio-economic rights jurisprudence, or "what are socio-economic rights for?"' in Botha et al (eds) op cit note 2, 33 at 50-51. See also Kathryn Garforth 'Canadian "medical necessity" and the right to health' (Dec

this indeed appears to have been the basis for the *TAC2* decision is borne out by several passages from the judgment and the order.[17]

It is possible to recast this basis of the *TAC2* finding as an entitlement to receive safe and efficacious medical treatment where such treatment has been medically indicated, as long as the treatment is affordable and where capacity to administer it exists.[18] A basic entitlement to medically indicated, safe and efficacious treatment (s 27(1)(a)) is thus carved down by restraints imposed by affordability and capacity (s 27(2)). Whereas this conception of the s 27(1)(a) entitlement may easily be reconciled with the distinction between primary, secondary and tertiary care (in that claims to be provided with primary health care services will more often succeed on this model than claims for secondary and tertiary care), it is also consistent with the progressive realisation standard and with the principle of non-abandonment,[19] in that it does not rule out direct

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2003) 8(3) *Canadian HIV/AIDS Policy & Law Review* 63 at 67-68 (reaching a similar conclusion after probing the judgment and order in *TAC2*).

[17]See, for example, *Minister of Health v Treatment Action Campaign (no 2)* 2002 (5) SA 721 (CC) (*TAC2*) at paras 48 ('[i]n deciding on the policy to confine Nevirapine to the research and training sites, the cost of the drug itself was not a factor'); 64 ('[h]owever, this is not a reason for not allowing the administration of Nevirapine elsewhere in the public health system when there is the capacity to administer it and its use is medically indicated'); 80 ('[a] potentially lifesaving drug was on offer and where testing and counselling facilities were available it could have been administered within the available resources of the State without any known harm to mother or child'); 120 ('we were informed ... that the government has made substantial additional funds available for the treatment of HIV, including the reduction of mother-to-child transmission'); 125 ('[w]e have held that its policy fails to meet constitutional standards because it excludes those who could reasonably be included where such treatment is medically indicated to combat mother-to-child transmission of HIV'); 135(2)(c) ('[t]he policy ... fell short of compliance with [the Constitution] in that ... [d]octors at public hospitals and clinics other than the research and training sites were not enabled to prescribe Nevirapine ... even where it was medically indicated and adequate facilities existed for the testing and counselling of the pregnant women concerned'); 135(3) ('Government is ordered without delay to:(*a*) Remove the restrictions that prevent Nevirapine from being made available for the purpose of reducing the risk of mother-to-child-transmission of HIV at public hospitals and clinics that are not research and training sites. (*b*) Permit and facilitate the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV and to make it available for this purpose at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendent of the facility concerned this is medically indicated, which shall if necessary include that the mother concerned has been appropriately tested and counselled. ... (*d*) Take reasonable measures to extend the testing and counselling facilities at hospitals and clinics throughout the public health sector to facilitate and expedite the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV').

[18]Klaaren op cit note 2 at 113 adds that the Court will likely order direct relief in these circumstances only where there is sufficient information before it to justify the order and where there is not a significant 'diversity of needs and claimants'.

[19]The principle of 'non-abandonment', which is sometimes advanced as an appropriate

relief for claims to more sophisticated forms of treatment where this is within the State's financial and human resource capacity. Explicitly enunciating and demarcating an entitlement to direct relief under s 27(1)(a) in such terms would be consistent with the refusal of such direct relief in *Soobramoney* (where treatment was neither effective nor affordable). It would further resonate with findings such as that in *Van Biljon* (where the provision of expensive and complex treatment was ordered since it was medically indicated and efficacious, and because the State could not show that it was unaffordable) and in the pre-constitutional *Applicant v Administrator Transvaal* (where a decision not to provide a patient with medically indicated and beneficial treatment within the financial capacity of the respondent was overturned), despite the very different remedial contexts of these decisions.

The nature and extent of the entitlement inherent in s 27(1)(a) admittedly remains relatively vague and unspecific in terms of this interpretative approach. The approach also does not assist courts in devising a sufficiently robust standard of scrutiny for assessing resource-availability and capacity. However, making the implicit basis for the *TAC2* judgment explicit in this manner provides a discernible foundation from which future courts may depart in their efforts to tease out the enforceable content of the right of access to health care services on a case-by-case basis. Using this foundation, rather than *Grootboom* reasonableness, as the point of departure in cases where access to a particular form of medical treatment is claimed would serve to focus the attention of the judicial inquiry on factors directly related to the claim (the medical appropriateness, safety, efficacy and affordability of treatment claimed by the applicant and the financial and other capacity of the respondent to provide it) rather than on abstract overarching policy factors which are only of indirect relevance to the claimant. It would also force courts to articulate their findings in terms reflecting either an entitlement to particular forms of care or the limits

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directive for health resource rationing processes, involves that, despite an emphasis on the satisfaction of primary health care needs, a health system should not abandon attempts to satisfy more complex health needs where it is capable of providing more advanced secondary and tertiary health services. See Willem A Landman & Lesley D Henley 'Rationing and children's constitutional health-care rights' (2000) 19 *SA Journal of Philosophy* 41 at 43-44.

of such entitlement, which will be more conducive than *Grootboom* reasonableness to the incremental development of a health rights jurisprudence that is sensitive to need.

Whereas the minimum core approach to s 27(1)(a) of the Constitution and all of the other approaches to interpreting the subsection discussed here may all have their drawbacks, it is clear that, over and above enforcing the entitlements to specific kinds of health care services afforded by several other constitutional provisions, there are a variety of ways in which courts could interpret s 27(1)(a) that would amount to the recognition of an individual entitlement to direct relief that effectively and adequately compensates for infringements of the right. Courts should accordingly be encouraged to look beyond *Grootboom* reasonableness in appropriate cases and to engage instead in the incremental development of an entitlement orientated approach to s 27(1)(a), as well as to other health-related rights. Such an approach would not only assist present and future applicants who would in appropriate circumstances be able to assert their rights with greater ease, but would prove beneficial also to respondents, who would have a clearer notion of what is expected of them under each of the implicated rights.

An approach to health rights that vindicates core-like entitlements, such as those discussed here, would neither exclude the application of *Grootboom* reasonableness in appropriate cases (such as challenges to the form and content of particular health-related legislation or policies), nor require a drastic reconceptualisation of the manner in which courts conduct themselves in socio-economic rights matters. It would merely expect of courts to explicitly articulate the basis of their findings and to situate this within an entitlement-based and need-sensitive interpretation of the rights concerned. Not only are courts perfectly institutionally capable of awarding such content to rights through interpretation, they also remain empowered under an entitlement-orientated approach to limit the extent of health rights' enforcement where this is called for. They further retain the flexibility to award less than tangible relief in circumstances where, all factors considered, the interests of justice dictate that

this is appropriate.

A finding that a legitimate health-related entitlement has been limited in particular circumstances, or that tangible relief is not appropriate (notwithstanding the infringement of a health-related right) admittedly involves a loss or an empty victory for a particular claimant. However, the articulation of this loss or empty victory in entitlement-orientated or benefit-centered terms remains preferable over *Grootboom* reasonableness' denial of the existence of a valid, claimable entitlement in the first place. As David Bilchitz explains:

> 'The idea that people have rights even when these are not presently capable of being fulfilled thus helps to express the idea that there is a moral loss, something deeply disturbing that occurs when not all can be provided with life-saving health care, food, water, and shelter. It enjoins us to change this situation as soon as we can so that people can be given what they are entitled to. Without such a recognition, the failure to meet basic needs under conditions of scarcity does not violate any claim people have. The situation does not demand reform as it does in a position where people have rights that are not fulfilled. The recognition that a person's fundamental rights are being abrogated ... thus provides a strong sense that there is some injustice or moral tragedy involved in the inability to realise those rights.'[20]

Recognising the existence of a valid and enforceable entitlement inherent to a right, even in circumstances where the right is considered to have been limited, or where it is not appropriate to directly remedy its infringement, further opens the door for future applicants to succeed with similar claims in different or altered circumstances (eg where resources have become available, where relevant policy measures have been put in place, etc). Were courts to indicate that they regard particular aspects of health-related rights as being enforceable (whether or not they are actually enforced in a particular case), this would likely also have positive 'directive-principle'-like spinoffs, in that the other branches of government would be given an incentive to satisfy the needs in question in order to avoid future litigation.[21]

Overall, there appears to be sufficient textual backing and institutional leeway for courts directly to remedy infringements of particular health-related rights in appropriate circumstances, whether or not such remedies flow from

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[20]Bilchitz op cit note 8 at 21.
[21]See further ibid 21-22.

endorsement of the minimum core standard as enunciated in international law. It is hoped that courts would, where the circumstances of a particular case lend themselves to this, venture beyond *Grootboom* reasonableness to directly enforce certain health-related rights, or aspects of a particular health-related right. This would significantly enhance the practical relevance of their judgments for the intended recipients of the protection awarded by health rights in the Constitution, without diminishing the judiciary's institutional integrity.

5.3 GIVING EFFECT TO HEALTH RIGHTS THROUGH DEVELOPING THE COMMON LAW

In addition to an order that requires the State to adopt reasonable measures aimed at progressively realising a socio-economic right, or an order that directly remedies an infringement of such right, it is possible for a court indirectly to give effect to the interests served by a particular socio-economic right, by making an order that amounts to a development of the common law in terms of s 39(2) of the Constitution. Klaaren argues that, on a reading of the phrase 'reasonable legislative and other measures' in s 27(2) of the Constitution as including also judicial measures, it is possible to view the judicial task under s 27(2) of the Constitution as in addition comprising an obligation to ensure that the common law, as part of the general legal framework for the realisation of socio-economic rights, is 'reasonable'. Hence, courts are constitutionally required to develop the common law in situations where this is necessary for the effective enjoyment of socio-economic rights.[22]

It is further generally accepted that development of the common law is the preferred avenue through which to give horizontal effect to human rights. Given the prevailing opposition to applying socio-economic rights directly in private disputes, it may be expected that their horizontal dimensions will for the foreseeable future, be limited either to the vindication of statutory socio-economic duties against private entities or to the development of relevant

[22]Klaaren op cit note 1 at 460-461. See also Klaaren op cit note 2 at 112.

common-law rules or doctrines that regulate private relationships.[23] A survey of South African common law reveals that it gives effect to health rights to an extent far greater than what is acknowledged by most critics of horizontal application of socio-economic rights.

Given that South African courts have for many years engaged in developing the common law in accordance with the changing social mores and are now under an explicit constitutional mandate to ensure that the common law resonates with the spirit, purport and objects of the Bill of Rights, they should be able to fulfill the remedial aspects of their role in this regard with relative ease. While an attempt to allign the common law regulating contractual exclusion clauses with the values associated with s 27(1)(a) of the Constitution in *Afrox Healthcare v Strydom*[24] ('*Afrox*') was ultimately unsuccessful, that case illustrates that it would be possible for courts to enforce certain aspects of health rights in such an indirect manner, without straying too far from their institutional comfort zone.[25]

This section will show that there are a significant number of instances in which courts may adequately give effect to health rights through applying and/or developing the common law. Courts are accordingly encouraged to explore the remedial avenue of 'law provision' or development more closely, as it presents a potentially viable supplement to *Grootboom* reasonableness, especially in cases where there is an attempt to assert a health-related right in a 'private' relationship.

The examples of common law developments discussed here are not exhaustive of the possibilities posed by this remedial avenue for the actualisation of health rights. Nor are they held forth as the only, or necessarily the best, manner in which the relevant common law provisions may be altered

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[23]See chapter 3 notes 10-11 and accompanying text.

[24]2002 (6) SA 21 (SCA).

[25]See also remarks of Iain Currie 'Bill of Rights jurisprudence' (2002) *Annual Survey of SA Law* 36 at 74; Klaaren op cit note 2 at 115. Apart from *Afrox,* health rights were relied on in *Ntsanwisi v Mbombi* 2004 (3) SA 58 (T) at 61G where it was argued that enforcing a restraint of trade clause on a health care professional would impact detrimentally on patients' right to access health care services. However, the judgment nowhere addresses this argument.

to give effect to particular health-related interests, or to facilitate access to direct, tangible remedies for successful claimants. In *Carmichele v Minister of Safety and Security*, the Constitutional Court determined that any court which is called upon to develop the common law in accordance with s 39(2) must first establish whether and to what extent the current state of the common law requires development, in light of the circumstances of the case. Thereafter, it should decide on the manner in which developments that are necessary for the common law to reflect the spirit, purport and objects of the Constitution should be effected in the context of the particular matter.[26] The examples provided here present but some of the spectrum of possible common law developments which may result in more tangible benefits in matters where health-related rights are directly or indirectly implicated.

(a) The common law and s 12(2)

As set out in 3.3(a) above, the health-related freedoms protected in terms of s 12(2) of the Constitution include a right to individual control over physical and mental health status. One way in which individuals exercise such control is through making informed and independent lifestyle-related choices that impact on their personal health status. These include the choice to seek medical attention in the event of illness. Where medical attention is sought, health-related autonomy finds expression within the doctor-patient relationship through patients' participation in decisions by health care professionals as to whether patients should receive particular forms of medical treatment. In order for this aspect of health-related autonomy to have practical significance for patients in this context, legal mechanisms are necessary not only to prevent the unjustified infringements of health-related autonomy interests by health care professionals, but also to compensate patients for damage suffered in cases where such infringements have occurred.

One such mechanism is to be found in the common law, which has long

[26] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC) at para 40.

regarded physical and mental health as part of the individual's physical integrity, which is in turn recognised and protected as a personality right that is capable of infringement by public or private actors.[27] Further linked to this understanding of physical integrity is the notion of individual autonomy and self-determination, which common law in turn views as encompassing the doctrine of informed consent to medical treatment. Accordingly, where a patient receives medical treatment without her informed consent, this is viewed as an actionable breach of her physical integrity, which may found delictual liability and may accordingly warrant an award of compensatory damages against a medical practitioner.[28]

The legal position in this regard has authoritatively been set out in *Castell v De Greef*, where Ackermann J spoke of the requirement that medical treatment may proceed only with the informed consent of a patient, as flowing from a patient's 'fundamental right to self-determination' and 'rights of bodily integrity and autonomous moral agency'.[29] He found that, for consent to constitute a defence against a delictual claim arising from medical treatment, the medical practitioner in question must have informed the patient, as fully and clearly as is practicable, of her diagnosis and prognosis, as well as of the nature, importance and effects of proposed treatment.[30] Patients would further be

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[27]See J Neethling; JM Potgieter & PJ Visser *Neethling's Law of Personality* (1996) 29-30; Christa Van Wyk 'Die regte van gevangenes met HIV' (1997) 60 *THRHR* 699 at 704.

[28]See *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) at 721B-E, also Dieter Giesen 'From paternalism to self-determination to shared decision-making' (1988) *Acta Juridica*107 at 109; DJ McQuoid-Mason & SA Strauss 'Medicine, dentistry, pharmacy and other health professions' in WA Joubert & JA Faris (eds) *The Law of South Africa Volume 17* (1st Reissue 1999) 129 at 146 and authorities cited there; Charles Ngwena 'Health care decision-making and the competent minor: The limits of self-determination' (1996) *Acta Juridica* 132 at 134-135; FFW Van Oosten '*Castell v De Greef* and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy' (1995) 28 *De Jure* 164 at 166-167.

[29]*Castell v De Greef* 1994 (4) SA 408 (C) at 420J and 421C-D respectively. See also 427D-E, where the doctrine is described as follows: 'It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away'. For discussion of these dicta, see Van Oosten op cit note 28 at 176; 178-179. *Castell*'s understanding of informed consent as integral to autonomy has been endorsed in the post-constitutional era in *C v Minister of Correctional Services* 1996 (4) SA 292 (T) at 300F-H; *Christian Lawyers Association v Minister of Health* 2004 (10) BCLR 1086 (T) at 1092H-1095J; *Oldwage v Lourens* [2004] 1 All SA 532 (C) at paras 87-91.

[30]*Castell* op cit note 29 at 425G-J; 426F-H. For a detailed exposition of the common-law position in this regard, see NJB Claassen & T Verschoor *Medical Negligence in South Africa*

regarded as having consented to treatment only where they have understood and appreciated any material risk relevant to it.[31] Where a medical practitioner proceeds with treatment without a patient's informed consent, thus understood, her conduct is regarded as wrongful and can accordingly found delictual liability, unless the medical practitioner can show that she was justified in the circumstances, to proceed with treatment notwithstanding the lack of informed consent.[32]

The legal position in this regard has recently been supplemented by the provisions of ss 7-9 of the National Health Act 61 of 2003, which set out the consent-related duties of parties to the doctor-patient relationship and list circumstances in which treatment may proceed without informed consent.[33] While these provisions therefore function both as a statutory expression of patients' right to bodily integrity in terms of s 12(2) of the Constitution and as a limitation on its ambit, they seemingly do not add any rights or obligations to those identified in *Castell*. They further appear not to provide an independent remedial avenue for patients whose integrity-related rights have been infringed in the rendering of medical treatment. Such patients will likely still make use of the common law to attain compensation for damages suffered as a result of having received medical treatment without their informed consent. The current state of common law, as set out in *Castell*, clearly allows for adequate reparation in this regard.

(1992) at 59-71; Murray Earle ' "Informed consent": Is there room for the reasonable patient in South African law?' (1995) 112 *SALJ* 629-642; Van Oosten op cit note 28 at 170-171.

[31]The Court further indicated that it would regard a risk as 'material' where, in the circumstances of the case, 'a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or ... the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it'. *Castell* op cit note 29 at 426F-H. The import of a patient-orientated test for determining whether informed consent was present in a particular matter has been hailed as a triumph for patient autonomy over medical paternalism in South African law. See Van Oosten op cit note 28 at 176.

[32]For instance, common law regards it as lawful to proceed with treatment in the absence of informed consent where this is necessary for the protection of public health, or where assistance is rendered in a medical emergency. See Giesen op cit note 28 at 123-125; Van Oosten op cit note 28 at 172. *Castell* furthermore does not exclude the withholding of health-related information where disclosure would do more harm than non-disclosure. *Castell* op cit note 29 at 426H; Van Oosten op cit note 28 at 172; 177.

[33]See provisions discussed in chapter 3 notes 32-33 and accompanying text.

(b) The common law and s 27(1)(a)

(i) Access to care

An obvious barrier to accessing health care services, especially in the private health care sector, occurs where health care practitioners or establishments refuse to render treatment to particular patients or groups of patients. Such refusal is typically justified on a variety of grounds, including the failure by patients to satisfy hospital admission requirements (such as having to produce proof of medical aid membership or having to sign indemnity forms), the inability of health care practitioners or facilities to render treatment of the kind requested, the inability of patients to pay for treatment and health care professionals' conscientious objection to rendering particular forms of treatment. It is conceivable that, whereas such a denial of care would often be legitimate, it may sometimes be viewed as an unjustifiable barrier to accessing health care services and accordingly as an infringement of s 27(1)(a) of the Constitution.

At common law, a health care professional is as a general rule free to refuse to accept a particular person as a patient.[34] Once accepting a patient however, a contractual, moral and ethical duty obliges the health care professional to continue providing treatment, unless it can feasibly be left to another health care professional who is willing to treat; or sufficient instructions for further treatment are issued; or further treatment is medically unnecessary, futile or likely to do more harm than good; or the patient refuses further treatment; or the practitioner gives the patient reasonable notice of her intention to discontinue treatment while simultaneously ensuring that alternative treatment options are available.[35] It is thus possible to hold a health care professional delictually liable for withholding treatment unreasonably, in circumstances where

[34]See McQuoid-Mason & Strauss op cit note 28 at 143 and authorities cited there; SA Strauss 'Medical and health law' in Francis Bosman (ed) *Social Welfare Law* (1982) 511 at 519.

[35]Factors listed by McQuoid-Mason & Strauss op cit note 28 at 145. See also *Magware v Minister of Health* 1981 (4) SA 472 (Z) at 475A-B; Dieter Giesen 'A right to health care? A comparative perspective' (1994) 4(2) *Health Matrix* 277 at 290; Aart C Hendriks 'Patients' rights and access to health care' (2001) 20 *Medicine & Law* 371 at 376; Bruce E Leech 'The right of the HIV-positive patient to medical care: An analysis of the costs of providing medical treatment' (1993) 9 *SAJHR* 39 at 48; Strauss op cit note 34 at 517.

a doctor-patient relationship has come to be established. In determining whether or not a refusal of treatment was reasonable, courts must take into account factors such as the doctor's knowledge of the patient's condition, the nature and seriousness of the patient's condition, the ability of the doctor to assist the patient, the availability of alternative treatment, the interests of the doctor's other patients as well as ethical considerations.[36]

The constitutionalisation of health rights must necessarily influence the above assessment. I would argue that the right to have access to health care services challenges the foundation of the common law position that health care professionals are regarded as always being free to refuse treatment, unless a doctor-patient relationship has already been established. At the very least, the horizontal operation of the right to equality and the concomitant equality guarantee underlying the right of access to health care services should have the effect of precluding any arbitrary refusal of treatment or any refusal that is motivated by unfair discrimination.[37] The common law should accordingly be developed to reflect this. In addition, I would argue that the values associated with the right to have access to health care services would be better served by reversing the starting point of the common law inquiry. This would entail that a health care professional is regarded as duty-bound to provide treatment, regardless of the presence of a pre-existing doctor-patient relationship, unless he or she can offer constitutionally acceptable justification for refusing to do so. Accordingly, health care professionals would incur delictual liability for damages suffered as a result of an unjustifiable refusal to render treatment.

Developing the common law in the manner described here would serve either to secure access to health care services for patients who were at risk of being denied access without constitutionally acceptable justification, or to tangibly compensate such patients for damages suffered as a result of such denial of access. Whereas there obviously has to be guarded against placing an undue burden on health care professionals to render care regardless of the

[36]McQuoid-Mason & Strauss op cit note 28 at 145.
[37]See in this regard also Hendriks op cit note 35 at 377; Leech op cit note 35 at 67.

circumstances or their reasons for refusal, it is submitted that health care professionals' interests in this regard could be adequately protected by developing rules of common law to limit patients' right of access to care, in accordance with s 8(3)(b) of the Constitution. The accepted common law grounds of justification for refusal to continue treating existing patients and the factors to be taken into account in determining the reasonableness or otherwise of such refusal, could serve as a useful starting point in this respect.

An inquiry into the reasonableness and justifiability of a refusal to render particular treatment would often boil down to weighing interests of health care professionals against those of their would-be patients. One particularly controversial example of this is where the refusal to treat relates to a health care professional's moral, religious or ethical objection to rendering particular treatment. The context in which such conscientious objection appears to arise most often is the provision of abortion services under the Choice on Termination of Pregnancy Act 92 of 1996. Especially in rural areas, several instances of health care professionals refusing to perform abortions out of moral or religious objection have been documented. This has resulted in a de facto denial of access to termination services in situations where the requested treatment is not accessible or available elsewhere in the vicinity.[38] An inquiry into the constitutional acceptability of justification for refusing to perform a termination of pregnancy due to conscientious objection must necessarily involve a balance between the implied right of health care professionals to conscientious objection (derived from the right to freedom of conscience, religion, belief and opinion in s 15 of the Constitution) and the express right of patients to have access to reproductive health care services.[39]

The Choice on Termination of Pregnancy Act does not indicate how this balance should be struck, though the determination in s 6 that women who

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[38]See cases discussed by C Ngwena 'Conscientious objection and legal abortion in South Africa: Delineating the parameters' (2003) 28(1) *Journal for Juridical Science* 1 at 4.

[39]Ngwena (ibid) at 9-10. See also remarks of Stephen Ellmann 'A constitutional confluence: American "State-action" law and the application of South Africa's socio-economic rights guarantees to private actors' in Penelope Andrews & Stephen Ellmann (eds) *The Post-Apartheid Constitutions: Perspectives on South Africa's Basic Law* (2001) 444 at 458.

request termination services should be informed of their rights in terms of the Act does impose limited restrictions on rights of conscientious objection. Similarly, Charles Ngwena argues that refusal to perform a termination of pregnancy out of conscientious objection would generally amount to a reasonable and justifiable limitation on the right of access to reproductive health care services, unless the termination is required as a matter of medical emergency. However, Ngwena regards health care professionals as duty-bound, notwithstanding their rights of conscientious objection, to refer the patient to a facility where a termination service may in the alternative be accessed. Ngwena further hints that rights of conscientious objection may more readily be limited in rural areas where such alternative facilities are not available or accessible.[40]

I would go further to suggest that, in circumstances where a refusal to provide medical treatment due to conscientious objection amounts to a de facto denial of access, implied rights of conscientious objection should be overruled by the express right of access to health care services. In other words, the interests of patients should generally outweigh those of medical practitioners in this context. Refusal to treat due to conscientious objection would, on my suggestion, be regarded as reasonable and justifiable only in circumstances where alternative services are practically available and accessible to the patient and where the patient was alerted to such options by the health care professional.

(ii) Quality of care

As shown in 3.3(d)(i) above, the s 27(1)(a) right to have access to health care services must necessarily imply a justiciable standard of quality of care, for it to comply with relevant international human rights norms and to have practical significance for those who suffer damages through receiving negligent or substandard care. Furthermore, the State's duty to protect citizens from private

[40]See Charles Ngwena 'Accessing abortion services under the Choice on Termination of Pregnancy Act: Realising substantive equality' (2000) 25 *Journal for Juridical Science* 19 at 39; Ngwena op cit note 38 at 5; 9; 11-13; 16.

infringements of the right to have access to care requires the presence of effective and practicable remedial avenues which ensure that rights-bearers are in the position to demand that the health care services they receive satisfy at least minimum standards of professionalism and scientific appropriateness. Patients should further be entitled to adequate compensation for damages suffered as a result of receiving care which falls short of such standards. There have been welcome obiter remarks by South African High Courts which acknowledge that the actual enjoyment of the right of access to health care services is significantly compromised where quality standards are not adhered to or are not enforced.[41]

The task of establishing when the quality of treatment received is to be regarded as adequate, so as to satisfy the quality standard inherent in s 27(1)(a), has been significantly simplified by the development of a quality yardstick in common-law cases dealing with medical negligence. This standard involves that failure by a health care professional to exercise a degree of skill and care that may reasonably be expected of the average, reasonably skilled practitioner in his or her field of medical expertise in similar circumstances, can lead to contractual or delictual liability.[42] I would submit that the implied standard of 'reasonable care' is sufficiently flexible to accommodate quality concerns in relation to s 27(1)(a), while simultaneously remaining realistic and sensitive to the context within which health care services are rendered. The standard thus strikes a fair balance between the competing interests of health

[41]See *Strydom v Afrox Health Care* [2001] 4 All SA 618 (T) at 626b-e; 627f-g; *Korf v Health Professions Council of South Africa* 2000 (1) SA 1171 (T) at 1179B-D.

[42]See, for example, *Esterhuizen v Administrator, Transvaal* op cit note 28 at 723C-E; *Blyth v Van den Heever* 1980 (1) SA 191 (A) at 193B-194A; 221A; 221D-E; *Magware v Minister of Health* op cit note 35 at 477A-B; *Correira v Berwind* 1986 (4) SA 60 (ZHC) at 63E-F; I; 66C-D; *S v Kramer* 1987 (1) SA 887 (W) at 893E-894J; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W) at 385A-D; 396H-I; *Applicant v Administrator, Transvaal* 1993 (4) SA 733 (W) at 738D-F; *Collins v Administrator, Cape* 1995 (4) SA 73 (C) at 81J-82B; *Oldwage v Lourens* op cit note 29 at paras 40-46; *Van der Walt v De Beer* 2005 (5) SA 151 (C); also Claassen & Verschoor op cit note 30 at 13-14; McQuoid-Mason & Strauss op cit note 28 at 152-153; 198-199; SA Strauss *Doctor, Patient and the Law* (3ed 1991) at 95-96; 252; Strauss op cit note 34 at 517; Neil Van Dokkum 'Hospital consent forms' (1996) 7 *Stellenbosch LR* 249; Neil Van Dokkum 'The evolution of medical malpractice law in South Africa' (1997) 41 *J of African Law* 175 at 190; Ferdinand Van Oosten 'Financial resources and the patient's right to health care: Myth and reality' (1999) 32 *De Jure* 1 at 4-5; 8.

care professionals and patients in this regard. Common law accordingly presents a viable remedial avenue for recipients of negligent or substandard care.

However, there are practical impediments regarding the application of the common law quality standard to concrete cases, that significantly restrict its remedial potency and accordingly diminish its effectiveness. The spirit, purport and objects of a Constitution which takes health rights seriously require that these be acknowledged and addressed, either through a development of the relevant legal principles or through a change in the manner in which courts currently apply these principles.

One such impediment, relating to the application (rather than the content) of the medical negligence standard, is occasioned by the inherent imbalance in scientific knowledge (and other resources) between patients and doctors. This imbalance, coupled with the discipline-specific and scientific nature of a test inquiring into 'reasonable care' rendered by a 'reasonable practitioner', make it notoriously difficult for a patient to prove negligence or wrongdoing on the part of a health care professional.[43] An obvious manner in which to alleviate this difficulty would be to apply the maxim of res ipsa loquitur in medical negligence cases where an inference of negligence seems justified by the circumstances of the case. However, South African courts have historically been unwilling to apply the maxim in cases of alleged medical negligence, out of deference to the medical profession and in empathy with the often difficult conditions under which health care professionals operate.[44]

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[43]See Claassen & Verschoor op cit note 30 at 27; Lorraine Hebblethwaite 'Mishap or malpractice? Liability in delict for medical negligence' (1991) 108 *SALJ* 38 at 38-39; 43. On the various difficulties associated with the imbalances in knowledge and bargaining power in the doctor-patient relationship see also Einer Elhauge 'Allocating health care morally' (1994) 82 *California LR* 1451 at 1542; David M Frankford 'Privatizing health care: Economic magic to cure legal medicine' (1992) 66 *Southern California LR* 1 at 15-16; 55-57; 59-60; 93; Paul Gertler & Jacques Van der Gaag *The Willingness to Pay for Medical Care: Evidence from Two Developing Countries* (1990) at 16-17; 21; Giesen op cit note 28 at 114; Mark A Hall 'Rationing health care at the bedside' (1994) 69 *New York Univ LR* 693 at 700-701.

[44]See *Mitchell v Dixon* 1914 AD 519; *Van Wyk v Lewis* 1924 AD 438; also authorities cited and discussed by PA Carstens 'Die toepassing van res ipsa loquitur in gevalle van mediese nalatigheid' (1999) 32 *De Jure* 19 at 21-24; Claassen & Verschoor op cit note 30 at 28-20; McQuoid-Mason & Strauss op cit note 28 at 204.

Whereas one must remain sympathetic to these circumstances, I agree with suggestions that res ipsa loquitur should, at least where 'the prejudicial result is clearly in contrast with the acknowledged therapeutic objectives and technique of the operation or treatment in question', find application in cases of alleged medical negligence.[45] This is required not only by the constitutional guarantees of equality and a fair trial,[46] but also by the values associated with s 27(1)(a). The application of the maxim in such cases would significantly enhance the potential of s 27(1)(a) to address the imbalances in power inherent to the doctor-patient relationship and to result in adequate compensation for those whose rights to receive care of an appropriate quality have been infringed.

A further, and arguably more pernicious, impediment to the effectiveness of the relevant common law principles in securing tangible relief for patients whose rights to receive care of an adequate quality have been infringed, is that the principles are increasingly excluded from application in the majority of doctor-patient relationships in the private health care sector. The great majority of private health care institutions indemnify themselves against damages resulting from substandard or negligent care administered by their personnel, by insisting that patients waive their remedies in this regard upon entering into a contract of admission to the institution. So prevalent is this practice that virtually no patient of a private health care institution can nowadays successfully hold the institution liable for rendering negligent or substandard care.[47]

In *Afrox Healthcare v Strydom*, the SCA overturned a finding of the High Court that the terms of such an exclusion clause were contra bonos mores and unenforceable by virtue of infringing s 27(1)(a), since it felt that the terms of the

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[45]Claassen & Verschoor op cit note 30 at 28. See also authorities cited there. Carstens op cit note 44 at 21-22; 24; 26 further lists several examples of cases clearly calling for application of res ipsa loquitur. These include cases where there has been physical injury to a body part other than that which was treated, where the wrong body part was treated, where the wrong limb was amputated, where there is operated on the wrong patient or the wrong operation is carried out on a patient, where a patient is given the wrong medication or an over-dosage of medication, or where medical instruments are left inside the body after an operation.

[46]As argued by Carstens (ibid) at 26-27.

[47]See Danie Brand 'Disclaimers in hospital admission contracts and constitutional health rights' (2002) 3(2) *ESR Review* 17 at 18. For an exposition of the relevant principles from the common law of contract applicable here see Van Dokkum (1996) op cit note 42 at 250-253.

exclusion clause did not deny access to treatment and did not explicitly allow for the rendering of negligent or substandard care. The argument that s 27(1)(a) presupposed a minimum level of care was accordingly held not to be relevant in the circumstances.[48] While the Court was arguably correct that exclusion clauses do not themselves deny access to care or condone negligent or substandard care,[49] it failed to appreciate that such clauses prevent patients from availing themselves of their only meaningful remedy where the quality guarantee underlying their right to have access to health care services has been dishonoured.[50] This is patently incompatible with the ethos of a Bill of Rights that entrenches justiciable health rights and promises appropriate relief for their infringement.

Such a de facto expurgation of the common law pertaining to medical negligence from private doctor-patient relationships may clearly be avoided, by limiting the ambit of the common law understanding of freedom of contract in order for it to resonate with the values associated with s 27(1)(a) of the Constitution. It has for example been argued that, given that exemption clauses amount to a de facto waiver of the quality-guarantee underlying the right of access to health care services, private hospitals should be under an obligation to alert prospective patients to their existence.[51] I would, however, argue that exclusion clauses in hospital admission contracts should per se be viewed as being against public policy (given that the concept of public policy must be understood as also embodying the values underlying the rights in the Bill of Rights, including the various rights associated with the right to health) and as

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[48] *Afrox* op cit note 24 at paras 13; 15; 19-21. The SCA emphasised that s 27(1)(a) would not preclude private hospitals from charging fees or from setting conditions for rendering care. See also remarks of Pieter Carstens & Anton Kok 'An assessment of the use of disclaimers by South African hospitals in view of constitutional demands, foreign law and medico-legal considerations' (2003) 18 *SA Public Law* 430 at 439.

[49] Refusing to admit a patient who refuses to agree to an exclusion clause may however fall foul of s 27(1)(a). Carstens & Kok (ibid) at 441; 444.

[50] See Brand op cit note 47 at 18; Carstens & Kok op cit note 48 at 444; 452; RM Jansen & BM Smith 'Hospital disclaimers: *Afrox Healthcare v Strydom*' (2003) 28(2) *Journal for Juridical Science* 210 at 215; Patrick van den Heever 'Exclusion of liability of private hospitals in South Africa' (April 2003) *De Rebus* 47 at 47-48. Such disclaimers are also incompatible with medical ethics. Carstens & Kok op cit note 48 at 450.

[51] See Jansen & Smith op cit note 50 at 218.

accordingly being unenforceable.[52] It is hoped that *Afrox* will not be the last word on the constitutionality of such exclusion clauses and that the SCA or the Constitutional Court will adopt an approach that is more sympathetic to the dilemma of individual patients attempting to assert their health rights against the powerful collective of the private health care sector.

(c) The common law and s 27(3)

Due to the nature of medical emergencies and the urgency of receiving appropriate treatment during such emergencies, the consequences when such treatment is refused or cannot be obtained are often severe. Vindication of the right not to be refused emergency treatment will therefore often involve ex post facto claims for compensation in relation to damages suffered as a result of having been denied necessary emergency treatment. As such, the common law of delict seems to be the logical route for obtaining appropriate relief.

However, like English law, South African common law does not recognise the existence of a blanket duty to act in order to prevent harm to another person.[53] Instead, whether or not a person should have acted to prevent harm to another is determined on a case-by-case basis with reference to the boni mores, taking into account all relevant circumstances of the matter, including whether a 'special relationship' could be said to exist between the parties in question.[54] Like in England, this general position has always been regarded

[52]See also ibid 215-216 and authorities there cited. For a pure contract-law argument to the same effect, see Tjakie Naude & Gerhard Lubbe 'Exemption clauses - A rethink occasioned by *Afrox Healthcare Bpk v Strydom*' (2005) 122 *SALJ* 441 at 456-457. Carstens & Kok op cit note 48 at 455 call on the legislature to outlaw disclaimers in standard-form hospital admission contracts. The position of patients in this regard will likely be ameliorated somewhat by the National Health Act 61 of 2003, s 46 of which determines that '[e]very private health establishment must maintain insurance cover sufficient to indemnify a user for damages that he or she might suffer as a consequence of a wrongful act by any member of its staff or by any of its employees'.

[53]On the English position, see Kevin Williams 'Medical samaritans: Is there a duty to treat?' (2001) 21 *Oxford Journal of Legal Studies* 393 at 393-394; Kevin Williams 'Doctors as good samaritans: Some empirical evidence concerning emergency medical treatment in Britain' (2003) 30 *Journal of Law & Society* 258 at 258-259.

[54]The common law position is set out in *Minister van Polisie v Ewels* 1975 (3) SA 590 (A). See also PQR Boberg *The Law of Delict Vol 1* (1984) 211 and authorities cited there; J Neethling; JM Potgieter & PJ Visser *Law of Delict* (3ed 1999) 56-57 and authorities cited there.

with a measure of moral (and legal) unease.[55] This unease is especially acute in the case of medical emergencies, with (all too often true) urban legends describing patients in desperate need of medical attention being ignored by health care professionals in the vicinity, or being turned away by hospital emergency rooms for failure to indicate ability to pay for treatment.[56]

The English legal position in this regard (from which several commonwealth countries, such as South Africa and Australia, have derived the same stark general rule) may rightly be described as peculiar and as by far the most patient-unfriendly in a continuum of approaches to the issue of 'medical samaritans'. In several European countries for instance, public and private health care professionals are under a statutory duty to render emergency care when circumstances require them to do so, breach of which leads to civil liability, or even criminal sanction. In the United States, several state legislatures have similarly codified a duty to treat in medical emergencies, whereas others have taken a more passive approach of encouraging emergency assistance, by statutorily indemnifying health care professionals from possible malpractice liability arising in the process of rendering emergency care.[57] Even in England and Australia, recent years have seen reported cases of private health care institutions which were in the physical proximity of a medical emergency and were able and qualified to render care, being held liable for failing or refusing to do so.[58]

In South Africa, there is a well-established moral and ethical duty on

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[55]See Williams (2001) op cit note 53 at 395; 413.

[56]See for instance the events detailed by SA Strauss 'Twee mediese regsvrae: Die aanspreeklikheid van private hospitale met ongevalle-afdelings en die aanspreeklikheid van sportpromotors en skeidsregters teenoor beseerde spelers' (2000) *TSAR* 205 at 209-210, recalling the death of a Pretoria cyclist who sustained critical injuries in a road accident. The cyclist was brought by a passer-by to an emergency room of a private hospital, where staff refused to admit him, since his identity could not be established. The cyclist was subsequently admitted to a public hospital, where he died shortly after arrival.

[57]The European and American positions are discussed by Dieter Giesen 'Health care as a right: Some practical implications' (1994) 13 *Medicine & Law* 285 at 287-288. See also the various authorities cited there.

[58]*Kent v Griffiths* [2000] 2 WLR 1158 and *Lowns v Woods* [1996] Aust Tort Reports 81-376, as discussed by Williams (2001) op cit note 53 at 401-402. On the requirement of physical proximity generally, see Williams (ibid) 401-403; 409-410; Williams (2003) op cit note 53 at 271; Giesen op cit note 57 at 287-288.

health care professionals to provide emergency medical treatment to strangers,[59] although such a duty is not legally enforceable. Even before the advent of the constitutional era, there were several calls for doctors (or, at least, emergency rooms in private hospitals) to be held delictually liable, in accordance with the common law position set out in *Minister van Polisie v Ewels*,[60] for failing to render emergency medical treatment in circumstances similar to those in the English and Australian cases mentioned above. It has been argued that the contemporary boni mores requires from persons who are able and qualified to render emergency medical assistance without harming themselves, to do so, regardless of the prospective patient's personal characteristics or ability to pay for treatment, unless it is reasonable to refuse care in the circumstances of the case.[61] Suggested factors influencing a determination of the reasonableness of refusing to render treatment in a medical emergency include the health care professional's knowledge of the patient's condition, the urgency of the condition, the health care professional's expertise in treating similar cases, the possibility of alternative treatment and ethical considerations.[62]

As set out in 3.3(d)(ii) above, s 27(3) of the Constitution's determination that no one may be refused emergency medical treatment is generally accepted to be horizontally applicable to private emergency services and hospitals. This is affirmed by the National Health Act 61 of 2003, which determines in s 5 that '[a] health care provider, worker or health establishment may not refuse a person emergency medical treatment'. The Act's definitions of the terms 'healthcare provider', 'health worker' and 'health establishment' include private health care professionals and establishments. The existence of a statutory duty to provide

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[59]McQuoid-Mason & Strauss op cit note 28 at 193-194. On the existence of a similar ethical duty on English and European doctors, see Giesen op cit note 57 at 287; Williams (2001) op cit note 53 at 413; Williams (2003) cit note 53 at 259; 270; 275; 280.

[60]Op cit note 54.

[61]See Leech op cit note 35 at 48; McQuoid-Mason & Strauss op cit note 28 at 193 and authorities there cited; Strauss op cit note 34 at 519; Strauss op cit note 42 at 90-91; Strauss op cit note 56 at 208; 210. As regards payment, the renderer of emergency care would be able to claim payment under negotiorum gestio. Strauss op cit note 56 at 210.

[62]Strauss (ibid) at 208; Strauss op cit note 34 at 519.

emergency medical care therefore now counteracts the common law presumption against holding health care professionals or institutions liable for failure to render such care. But even beyond the parameters of this statutory duty, I would argue that, in order for the common law of delict effectively to provide a remedy for patients who have been denied emergency medical treatment, a complete overhaul of the basis of an inquiry into the reasonableness or otherwise of such a denial is required by the constitutional presence of s 27(3).[63] It would appear necessary to start from the premise that emergency services, private hospitals and health care professionals in the vicinity of medical emergencies should be regarded as duty-bound to render emergency medical assistance. Failure to render such treatment should accordingly be viewed as unlawful, unless it can be shown to have been reasonable in light of the boni mores. The boni mores should in turn be recast to represent the legal and moral convictions of a community in which health rights, and specifically the right not to be refused emergency medical treatment, are constitutionally enshrined. In other words, instead of the absence of a duty to render emergency medical treatment being presumed and the presence of a duty having to be established with reference to the boni mores, an inquiry reverberating with the values associated with s 27(3) would presume the exact opposite.

Lest such a position appear overzealous or unrealistic, it needs to be remembered that it will remain possible (and arguably easy) to escape liability by showing that a duty of care did not reasonably arise in the circumstances of a particular case. Further, a finding of wrongfulness based on non-compliance with a duty to render emergency care would satisfy but one of the requirements for delictual liability. Health care professionals who are unable to show that they were absolved of the duty to render care in accordance with the boni mores will therefore be held liable only if the other requirements (such as the presence of an omission, damage suffered and causation) are also satisfied.

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[63]For a similar argument in the English context (in light of the domestic force of the European Convention on Human Rights), see Williams (2001) op cit note 53 at 393; 395; 400; 413.

(d) The common law and s 28(1)(c)

(i) Parental responsibility for child health

Section 4.2(d) above criticised the *Grootboom* decision for its restrictive delineation of the interaction between parental and State responsibility for child welfare. While *Grootboom* acknowledges that orphans and abandoned children have an unspecified entitlement to socio-economic support from the State, it excludes children who are in the care of their parents from such entitlement. Instead, *Grootboom* depicts such children as only being able to enforce their constitutional claims for nutrition, shelter, basic health care services and basic social services against their parents. I criticised this finding for placing an overly onerous burden on indigent parents and for effectively barring children in poor households from meaningfully exercising their s 28(1)(c) rights.

Grootboom's acknowledgment that parents bear some responsibility for the socio-economic welfare of their children does, however, present a useful starting point for thinking about the horizontal dimensions of s 28(1)(c) within the parent-child relationship. Whereas these dimensions indeed need to be explored, it is necessary to keep in mind that, despite an inherent power imbalance in the parent-child relationship, parents are often in a similarly vulnerable position to their children in relation to the State and to other powerful private actors. For this reason there should be guarded against holding parents responsible for facilitating the exercise of their children's health rights in circumstances where, due to their own socio-economic vulnerability, they are unable to do so. This said, where parents are in the position to provide for their children, it makes sense to hold that they are responsible for meeting their children's health needs. Productive ways of transgressing the law's reluctance to intervene in the private sphere of the family environment, in order to enforce the duties of parents in this respect, must be sought. The current state of common law presents a useful starting point.

Common law provides that parents are, by virtue of their duty of support towards their children, responsible for their children's physical welfare and

socio-economic well-being. This obligation includes facilitating access to health care services for their children, and providing for their other health-related needs.[64] Whereas common law has thus always allowed for the horizontal application of children's socio-economic rights against their parents, the obligation that this imposes on parents has always been regarded as limited by the extent to which parents are capable of providing for their children's needs. Where parents can prove that they do not have the means to fulfill the obligations associated with their duty of support, they are relieved of the duty, which then vests instead in the State.[65]

Unlike *Grootboom* therefore, common law awards an enforceable entitlement to be provided with basic health care services against the State to all children who find themselves unable meaningfully to enforce this entitlement against their parents, regardless of whether they are in the care of their parents. The common-law position is therefore capable of resulting in tangible benefits for a whole additional category of children (those in poor families) than those who stand to benefit from the *Grootboom* interpretation of s 28(1)(c). It is also more realistic, in line with relevant international law authority[66] and sensitive to the reality in which parents and children find themselves than *Grootboom*'s stark demarcation of public responsibility for children's socio-economic needs. The position subsequently taken by the Constitutional Court in *TAC2*, which appears to depart from the *Grootboom* interpretation of s 28(1)(c) and instead bears

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[64]See Brigitte Clark 'Duties of support of living persons' in Belinda Van Heerden; Alfred Cockrell; Raylene Keightley et al *Boberg's Law of Persons and the Family* (2ed 1999) 233 at 243-244 and Roman-Dutch authorities cited there; also Brigitte Clark 'Child support: Public or private?' (1992) 55 *THRHR* 277 at 278; Brigitte Clark 'Children's right to support - a public responsibility?' (1996) *Acta Juridica* 82 at 84; Marius Pieterse 'Reconstructing the private/public dichotomy? The enforcement of children's constitutional social rights and care entitlements' (2003) *TSAR* 1 at 7-8; J Sloth-Nielsen 'The child's right to social services, the right to social security, and primary prevention of child abuse: Some conclusions in the aftermath of *Grootboom*' (2001) 17 *SAJHR* 210 at 225; Julia Sloth-Nielsen 'Children' in MH Cheadle et al (eds) *South African Constitutional Law: The Bill of Rights* (2002) 507 at 515. The same applies for other relationships that trigger a common-law duty of support. For instance, in *Thomson v Thomson* 2002 (5) SA 541 (W), it was found that the duty to maintain current or former spouses may include facilitating access to health care. See specifically 545B-546A.

[65]See Clark (1996) op cit note 64 at 84; Clark (1999) op cit note 64 at 245; Pieterse op cit note 64 at 8.

[66]Article 27 of the CRC determines that, while parents bear the primary burden to support their children, they should in appropriate circumstances be assisted by the State.

closer resemblance to the common-law position, is accordingly welcomed.

This is not to say that the current state of common law is always reflective of social reality or conducive to children being able effectively to enforce their entitlements against parents who do not fulfill their socio-economic obligations. Indeed, its effectiveness is significantly compromised by the severe structural deficiencies of statutory mechanisms aimed at ensuring that recalcitrant parents comply with their obligation to support their children.[67] Beyond the obvious urgent need to reform these (the contemplation of which is beyond the scope of this dissertation), attempts should be made to enhance the practical significance of s 28(1)(c) by considering ways in which the common-law position set out here can be coupled with effective and context-sensitive civil remedies against parents who do not fulfill their responsibilities towards their children. In relation to health rights, one option that has been suggested is to explore the question of compensatory remedies against parents where children suffer harm due to a lack of parental responsiveness to their health needs.[68] It has also been suggested that, due to a variety of social realities, thought must be given to extending the common law obligation to satisfy children's socio-economic needs beyond biological parents, to rest also on extended family members and other (non-biological) primary caregivers.[69]

(ii) Parental co-operation in facilitating children's access to health care services

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[67]See, for instance, Clark (1996) op cit note 64 at 83; 86; Clark (1992) op cit note 64 at 280.

[68]See C Nicholson & A Politis 'The life and death lottery: Tipping the scales in favour of the child's best interests' (2001) 34 *De Jure* 594 at 601. It is an offense in terms of s 50 of the Child Care Act 74 of 1983 to let children suffer harm through neglect, which would include neglect of their health-related needs. Parents have been criminally prosecuted under at least two of s 50's statutory predecessors for causing the death of their children by refusing that the children receive medical care. See *R v Botha* 1918 TPD 133 (father convicted for causing the death of child due to father's refusal to let child receive 'conventional' medical care and opting instead for healing through prayer); *S v Fell* 1971 (3) SA 667 (C) (father appeals successfully against conviction for causing death of child by insisting that child receive homeopathic treatment instead of 'conventional' medical care). In cases where children suffer harm other than death through their parents' mala fide neglect of their health-related needs, compensatory or similar relief may sometimes be more appropriate than criminal sanction.

[69]Sloth-Nielsen (2002) op cit note 64 at 515.

Whereas the common law conception of the parent-child relationship may serve as useful basis for enhancing the effectiveness of children's health rights, there are also aspects of the manner in which the common law regulates the interaction between children's rights and parental interests which may conceivably frustrate the exercise of children's health rights. A prime example of this is the extent to which children's access to health care services is dependent on the co-operation of their parents. At the same time as obliging parents to fulfill their children's health-related needs, common law awards them the right to determine the manner in which such needs must be satisfied, within the parameters of the principle that the best interests of a child are paramount. This aspect of parental power prominently includes the principle that parental consent must be obtained before medical treatment may be administered to any minor child.[70] Children's rights of autonomy in health-related decision-making and of access to health care services are thus limited by the extent to which the co-operation of their parents is required before treatment may be obtained.

Whereas the extent of parental power in this respect is carved down significantly by statutory provisions (so for example may children over the age of 14 consent to medical treatment, other than an operation, independent of their parents and may children over the age of 18 independently consent to an operation in terms of s 39(4) of the Child Care Act 74 of 1983[71]), it poses a potentially significant barrier to children (especially younger children) accessing appropriate health care services. While it makes sense to involve parents in decisions concerning their children's health interests and general welfare (since they are usually best placed to ascertain the extent of their children's health needs, as well as to seek and obtain care for their children, and since they typically have the best interests of their children at heart), there are at least two sets of circumstances in which their control over their children's access to health care services is constitutionally problematic.

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[70]See generally *Esterhuizen v Adminstrator, Transvaal* op cit note 28; also McQuoid-Mason & Strauss op cit note 28 at 148 and authorities cited there; Nicholson & Politis op cit note 68 at 597.

[71]On the functioning and impact of these provisions, see Ngwena op cit note 28 at 139; Strauss op cit note 34 at 521.

The first is where parents refuse medically beneficial or necessary treatment on behalf of their children. The right of autonomy in health-related decision-making, as implied by s 12(2) of the Constitution and vindicated by common law, logically includes a right to refuse beneficial, or even necessary or life-sustaining, medical treatment. Given that parental power encompasses the right to consent to medical treatment on behalf of a child, it logically extends also to refusing treatment on behalf of the child. While an individual's choice to waive necessary, life-sustaining or life-saving treatment is often regarded as controversial,[72] this is significantly more so where the rights waived are those of a child who is often powerless to insist on access to health care in contravention of his or her parents' refusal.

At common law, courts attempt to strike a balance between the respective interests of parents and children in this regard by evaluating the reasonableness of the parents' refusal of the treatment in question. Nicholson and Politis argue that courts are today constitutionally mandated to make the best interests of the child the central focus of this inquiry.[73] It may, perhaps uncontroversially, be suggested that parents' right to refuse consent to medical treatment on behalf of their children should accordingly be overruled in favour of a child's right to access care in medical emergencies or in circumstances where the refusal would lead to the death or disability of the child.[74] This view finds support in the recent decision in *Hay v B*, where the WLD ordered that health care professionals could proceed with a blood transfusion on a child (without which it was common cause that the child would likely die) notwithstanding the parents' religious objections against blood transfusions and other subjective fears that motivated them to refuse consent. The Court found that, as upper guardian of all minors, it could overrule parents' refusal to consent to medical treatment on

[72]See, for example, Michael Katz 'The doctor's dilemma: Duty and risk in the treatment of Jehova's Witnesses' (1996) 113 *SALJ* 484 at 492-495.

[73]Nicholson & Politis op cit note 68 at 597; 601-603. See also Gerhard Van der Schyff 'The right to religious objection in South African law' (2002) 119 *SALJ* 526 at 533.

[74]See David McQuoid-Mason & Lloyd Lotz 'Religious beliefs and the refusal of blood transfusions for children: What should doctors do?' (2005) 68 *THRHR* 315 at 320-321; Nicholson & Politis op cit note 68 at 599; Van der Schyff op cit note 73 at 532-533.

behalf of their children, and that the parents' religious beliefs could not trump the best interests of the child in light of the child's constitutional right to life.[75]

Beyond situations where refusal of treatment would lead to death or disability however, a significant grey area remains, with courts guided only by the notoriously vague and amorphous best interests principle. Factors to be taken into account in determining the balance of interests in such matters should include the consequences of refusing treatment, the extent to which alternative treatment options could accommodate the parents' objections to specific treatment, the wishes of the child (where ascertainable) and the reasonableness of the parents' refusal.[76] Whereas I would argue that the constitutionalisation of health rights should tip the scale in favour of treatment in most cases, the reasons for parents' objection to treatment should nevertheless remain an important factor influencing the inquiry (lest deference to parents' wishes be replaced by deference to the treatment whims of health care professionals).[77]

A second set of circumstances in which the requirement of parental consent for children's access to health care services becomes constitutionally problematic arises in relation to the treatment needs of orphans for whom alternative guardians have not been appointed or in relation to children whose parents or guardians cannot be located. The nature and extent of the HIV/AIDS epidemic has exponentially increased the number of children in this position who, due to the fact that they are frequently themselves HIV-positive, are often also in urgent need of medical attention.[78] The common-law requirement of parental consent to medical treatment for children has, in at least one case, been recognised as posing a significant hurdle to such children acquiring

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[75]*Hay v B* 2003 (3) SA 492(W) at 494H-495E; 495I-J. For discussion of the case, see McQuoid-Mason & Lotz op cit note 74 at 315-316. At common law, the Court's power as upper guardian would extend also to overruling the express wishes of the child on whether or not to receive treatment. Ngwena op cit note 28 at 145.

[76]See McQuoid-Mason & Lotz op cit note 74 at 316-317; Nicholson & Politis op cit note 68 at 599.

[77]On the need to respect parents' position in this context, see Ngwena op cit note 28 at 134.

[78]On the extent of this problem, see Liesl Gerntholtz & Marlise Richter 'Access of abandoned children and orphans with HIV/AIDS to antiretroviral therapy - a legal impasse' (2004) 94(11) *SA Medical Journal* 910.

timeous access to necessary, life-prolonging, medical treatment. In an unreported judgment in *Ex parte Meyers*, the WLD granted consent to a pediatric working group to provide appropriate anti-retroviral treatment to HIV-positive orphans in circumstances where such treatment was medically indicated and where their de-facto caregivers consented to them receiving the treatment.[79]

Whereas courts' common law powers as upper guardians of minors are arguably wide enough to ensure that children receive necessary treatment both in cases where they have been orphaned or abandoned and where their parents unreasonably refuse treatment on their behalf, it is hoped that the constitutionalisation of health rights would lead to the development of more express rules that limit parents' common-law rights to guide their children's exercise of rights to access health care services. The presence of health rights in the Constitution have already been used to justify the limitations on parental power (and the concomitant right to parental care) occasioned by s 5(3) of the Choice of Termination of Pregnancy Act, according to which parental consent is not required where a minor wishes to terminate a pregnancy.[80] They also arguably underlie recommendations by the South African Law Commission that primary caregivers (other than parents) should also be allowed to consent to medical treatment on behalf of children and that the statutory age at which children are allowed to consent to treatment independently of their parents should in appropriate circumstances be lowered to 12 years.[81] Regardless of whether these recommendations become law, there are bound to be circumstances in which courts are called upon to decide whether particular health care services should be provided to children who are for some reason unable to consent to treatment themselves, either in parents' absence or against their express wishes. It is hoped that the inquiry into the children's best interests in these circumstances would afford due weight to their constitutional

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[79] *Ex parte Meyers* WLD29172/03, cited and discussed by Gerntholtz & Richter op cit note 78 at 911-912.

[80] See *Christian Lawyers' Association* op cit note 29 at 1095A-J; 1103 F-J; 1104I-1105B; 1105D-J; 1106A-D.

[81] See clauses 32; 129(2) of the Children's Bill contained in SALC Project 110 Report *Review of the Child Care Act* (2002), discussed by Gerntholtz & Richter op cit note 78 at 912.

health rights.

5.4 CONCLUSION: SUPPLEMENTING *GROOTBOOM* REASONABLENESS

This chapter has explored remedial avenues for infringements of health-related rights outside of the remedial paradigm of policy-formulation or -modification that is most readily associated with *Grootboom* reasonableness. It has shown that courts can significantly enhance the actual significance of health rights by recognising, in appropriate circumstances, that there has been an infringement of an individual, health-related, constitutional entitlement and by remedying such infringement directly where to do so would satisfy the constitutional dictates of appropriateness, justice and equity. It has also explored the possibility of indirectly enhancing the efficacy of health rights in real-life interactions through the application and development of common law rules and principles that impact on the exercise of health rights.

In doing so, the chapter has illustrated that *Grootboom* reasonableness does not entirely shut the door on a benefit-focussed approach to health rights. Neither the vindication of core-like aspects of constitutional health rights nor the development of the common law to reverberate with their spirit, purport and objects preclude or undermine judicial resort to *Grootboom* reasonableness in circumstances where its application is called for. Rather, these remedial paradigms may be seen as viable supplements to *Grootboom* reasonableness, and it is hoped that courts will explore the possibilities posed by them where the circumstances of particular cases allow.

CHAPTER 6

THE IMPACT OF HEALTH RIGHTS

6.1 THE SATISFACTION OF HEALTH-RELATED NEEDS AND THE SOCIO-ECONOMIC TRANSFORMATION OF SOUTH AFRICAN SOCIETY

> 'We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one in which there will be human dignity, freedom and equality, lies at the heart of our new constitutional order. For as long as these conditions continue to exist that aspiration will have a hollow ring'.[1]

This often quoted passage from the *Soobramoney* judgment acknowledges that the adjudication and enforcement of socio-economic rights takes place in the context of, and forms an integral part of, a larger societal transformation 'project'. This 'project' purports, inter alia, to '[h]eal the divisions of our past and establish a society based on democratic values, social justice and fundamental rights' and to '[i]mprove the quality of life of all citizens and free the potential of each person'.[2] The society envisaged as end-product of this transformation is one in which the values of freedom and equality flourish and in which the inherent human dignity of all citizens is equally affirmed and protected. A vital precondition for the achievement of such a society is that citizens enjoy at least a minimal level of material well-being, in the sense that their vital and legitimate material needs are met.[3] The tangible improvement of the living conditions of socially and economically vulnerable members of South African society thus forms a central pillar of the transformation 'project' at the heart of its constitutional dispensation.

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[1] *Soobramoney v Minister of Health, KwaZulu Natal* 1998 (1) SA 765 (CC) at para 8 (per Chaskalson P).

[2] Preamble to the 1996 Constitution.

[3] See chapter 1 note 14 and accompanying text.

Given that health is a highly valued commodity in a society founded on human dignity, equality and freedom, one of the goals associated with the achievement of social justice and the improvement of South Africans' quality of life is the achievement of the highest attainable state of physical and mental health. This dissertation has focused on a specific aspect of this latter objective. It has considered the extent to which the various health-related rights enshrined in the 1996 Constitution can enable citizens to gain access to tangible material benefits that either assist them in their quest for health-maximisation through satisfying their health-related needs, or compensate them for harm suffered through the denial or frustration of such needs.

It has been said that the provisions of the Bill of Rights in the 1996 Constitution contribute to the social and economic transformation of South African society in three ways. First, they do not stand in the way of political projects aimed at social transformation and buttress such projects by affirming the constitutional legitimacy of their objectives. Secondly, they oblige the State to prioritise and actively pursue socio-economic transformation (by, for instance, requiring the State to fulfill the rights in the Bill of Rights and to take reasonable legislative and other measures to achieve the progressive realisation of socio-economic rights). Thirdly, the provisions of the Bill of Rights themselves function as vehicles for transformation through the tangible effects of their interpretation and application by courts in concrete cases.[4] Whereas the first and second contributions listed here may be viewed as the 'directive principle effect' of rights, which may result regardless of whether constitutional guarantees are actually capable of judicial enforcement, the third contribution can only be made where the guarantees in question are articulated as justiciable rights.

Given that the health-related rights in the 1996 Constitution are fully justiciable, they should be capable of contributing to the achievement of the right

[4]See Pierre De Vos 'Substantive Equality after *Grootboom*: The emergence of social and economic context as a guiding value in equality jurisprudence' (2001) *Acta Juridica* 52 at 68-69; Sandra Liebenberg 'South Africa's evolving jurisprudence on socio-economic rights: An effective tool in challenging poverty?' (2002) 6 *Law, Democracy & Development* 159 at 162.

to health (and hence of furthering the constitutional transformation project) both through their 'directive principle effect' and through the concrete impact of their judicial enforcement on the lives of their beneficiaries. This chapter is concerned with the extent to which this has perceptibly been the case. It firstly considers the extent to which constitutional health rights have contributed to the actualisation of the right to health in South Africa through their 'directive principle effect'. Subsequently, it summarises and integrates the findings of this dissertation in an attempt to illustrate the limited extent to which the health rights have functioned as a direct vehicle for the achievement of the right to health. Thereafter, I indicate areas in which further research is necessary in order to overcome theoretical lacunae that continue to inhibit the effectiveness of health rights in this regard. In conclusion, I reiterate the need for courts to overcome their unease with enforcing socio-economic rights and to acknowledge that health rights embody a wide array of individual entitlements that may, in appropriate circumstances, immediately be enforced. Failure to do so, I argue, threatens to deflate the potential of health rights to confront the denial of health-related needs and stifles the ability of the rights to contribute meaningfully to the social and economic transformation of South African society.

6.2 THE 'DIRECTIVE PRINCIPLE EFFECT' OF CONSTITUTIONAL HEALTH RIGHTS

Regardless of whether they are justiciable, constitutional rights demand due consideration of the interests they aim to protect or advance in legislative and policy processes. It is therefore possible that the constitutional presence of health-related rights would have an impact on a wide array of legislative and policy processes relating to the regulation of the South African health system and to the reform of South African health law. This possibility is enhanced by the constitutional directives that the State must respect, protect, promote and fulfill all rights in the Bill of Rights and must adopt measures aimed at the progressive realisation of the right to have access to health care services.

It may therefore be expected that the constitutionalisation of justiciable

health rights would lead to the enactment of legislative and policy measures that award content to, supplement or give effect to particular health-related rights. This seems indeed to have occurred. A myriad of legislative provisions that contribute to the fulfillment of constitutional health rights were enacted subsequent to the adoption of the 1996 Constitution.[5] Many of these create or affirm specific health-related entitlements and many explicitly supplement health rights in the Constitution. Several executive policies that similarly appear to resonate with the spirit, purport and objects of constitutional health rights, have also been issued during this time.[6] Whereas one can only speculate as to whether and to what extent the constitutional presence of health rights indeed motivated or impacted on any one of these statutes or policies, their multitude and their ostensible affirmation of relevant constitutional health rights seem to indicate that the 'directive principle effect' of these rights has not been negligible.

At least, the constitutional presence of health rights and the associated obligations on the State have served significantly to enhance the legitimacy of these legislative and policy measures in the face of challenges to their constitutionality. A prominent 'directive principle effect' of socio-economic rights is that, where State measures aimed at fulfilling such rights infringe upon or limit

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[5]These include the Choice on Termination of Pregnancy Act 92 of 1996 (giving effect to women's right of reproductive freedom and clarifying the right of access to reproductive health care services); the Pharmacy Amendment Act 88 of 1997 and the Medical, Dental and Supplementary Health Service Professions Amendment Act 89 of 1997 (prescribing compulsory community service for medical graduates); the Medicines and Related Substances Control Amendment Act 90 of 1997 (including various initiatives to make medicines more accessible and affordable); s 12 of the Correctional Services Act 111 of 1998 (reaffirming and awarding content to detainees' rights of access to adequate medical care); the Medical Schemes Act 131 of 1998 (having the effect, inter alia, of increased access to medical insurance); the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (bolstering protection of the right to equality in the health care setting, amongst others); the Mental Health Care Act 17 of 2002 (expressing commitment to the provision of appropriate mental health care services) and, perhaps most significantly, the National Health Act 61of 2003 (containing several provisions aimed at increasing the availability, accessibility and quality of health care services and explicitly affirming the State's obligations to respect, protect, promote and fulfill the various health rights in the 1996 Constitution).

[6]These prominently include Department of Health *National Drug Policy for South Africa* (1996); Department of Health *White Paper for the Transformation of the Health Care System in South Africa* (1997) and Department of Health *The Primary Health Care Package for South Africa - a Set of Norms and Standards* (2000), the latter of which contains the Patients Rights Charter (ibid at 10).

other private rights or interests, the State is afforded an opportunity to justify such limitations and/or infringements by arguing that it is constitutionally obliged to increase access to relevant socio-economic amenities and to ensure that private interests do not unreasonably impair the enjoyment of socio-economic rights.[7] Of course, not every such limitation of private rights will pass constitutional muster. Also, the constitutional purpose of legal measures is but one factor to be taken into account when deciding whether a limitation on a constitutional right is permissible in terms of s 36 of the Constitution.[8] Be this as it may, the constitutional presence of socio-economic rights likely allows the State more leeway in limiting private commercial or other interests in pursuit of social justice than would otherwise have been the case.[9] By clothing the purpose of the limitation of private rights or interests in constitutional legitimacy, socio-economic rights play an important role in countering the extent to which civil and political rights may be used to thwart State attempts at social transformation.[10]

As far as health rights are concerned, two examples from recent case-law

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[7]See Danwood Mzikenge Chirwa 'The right to health in international law: Its implications for the obligations of state and non-state actors in ensuring access to essential medicine' (2003) 19 *SAJHR* 541 at 562-563; CH Heyns 'Extended medical training and the Constitution: Balancing civil and political rights and socio-economic rights' (1997) 30 *De Jure* 1 at 14-16; Marius Pieterse 'Beyond the welfare state: Globalization of neo-liberal culture and the constitutional protection of social and economic rights in South Africa' (2003) 14 *Stellenbosch LR* 3 at 13; 26.

[8]See Stephen Ellmann 'A constitutional confluence: American "State-action" law and the application of South Africa's socio-economic rights guarantees to private actors' in Penelope Andrews & Stephen Ellmann (eds) *The Post-Apartheid Constitutions: Perspectives on South Africa's Basic Law* (2001) 444 at 467; Heyns op cit note 7 at 15-16.

[9]See Paul Gertler & Jacques Van der Gaag *The Willingness to Pay for Medical Care: Evidence from Two Developing Countries* (1990) at 15-16; 21-22. Also remarked in relation to the extent of state intervention in the affairs of medical schemes in terms of the Medical Schemes Act by MA Christianson 'Health care' in EML Strydom (ed) *Social Security Law* (2001) 122 at 147-148; Mark Heywood 'Debunking "Conglomo-talk": A case study of the amicus curiae as an instrument for advocacy, investigation and mobilisation' (2001) 5 *Law, Democracy & Development* 133 at 138.

[10]The best known example of this 'legitimating effect' of socio-economic rights in South African case-law is *Minister of Public Works v Kyalami Ridge Environmental Association* 2001 (3) SA 1151 (CC), where the Constitutional Court regarded the State's duties to make housing progressively accessible in terms of s 26(2) as a prominent factor justifying the limitation of environmental and commercial interests of private property owners through the construction of emergency housing for flood victims on adjacent land. See paras 29; 37-39; 51; 68; 103; 107 and 114 of the judgment as well as the discussion of these dicta by Frank I Michelman 'The Constitution, social rights and liberal political justification' (2003) 1 *International J of Constitutional Law* 13 at 17-18.

illustrate that, while not indiscriminately trumping private entitlements or curing all deficiencies in health-related legislation or policy, the obligations implied by ss 7(2) and 27(2) of the Constitution have had the effect of bolstering State attempts at facilitating increased access to health care services.[11]

The first is the litigation between the South African government and the Pharmaceutical Manufacturers Association (PMA)[12] concerning several provisions of the Medicines and Related Substances Control Amendment Act 90 of 1997, the aims of which include facilitating more affordable medicines. In particular, ss 10 and 14 of the Amendment Act (inserting ss 15C and 22F-G respectively into the Medicines and Related Substances Control Act 1 of 1965) allowed inter alia for the limited exhaustion of patents and the parallel importation of patented medicines, the generic substitution of certain patented medicines, a more transparent pricing system for pharmaceutical products and the restriction of profit margins on pharmaceutical products sold in the country. While lauded for its potential to increase access to essential medicines,[13] the provisions of the Amendment Act were also severely criticised for limiting the commercial interests and intellectual property rights of the national and international pharmaceutical industry.[14] The PMA instituted litigation, claiming that the relevant provisions violated the rights of its members to intellectual property under s 25 of the Constitution,[15] to freedom of trade, occupation and profession and to freedom of expression (in that it compelled pharmacists to

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[11]See also Thomas J Bollyky 'Balancing private rights and public obligations: Constitutionally mandated compulsory licensing of HIV/AIDS related treatments in South Africa' (2002) 18 *SAJHR* 530 at 531-532; 539; 556-557.

[12]*Pharmaceutical Manufacturers' Association v President of the Republic of South Africa* TPD 4183/98.

[13]See for instance Pierre De Vos 'So much to do, so little done: The right of access to anti-retroviral drugs post-*Grootboom*' (2003) 7 *Law, Democracy & Development* 83 at 101-102; Sarah Joseph 'Pharmaceutical corporations and access to drugs: The "fourth wave" of corporate human rights scrutiny' (2003) 25 *Human Rights Quarterly* 425 at 442-443.

[14]See for instance APS Van der Merwe 'Amendment of the South African Medicine and Related Substances Control Act in relation to the exhaustion of rights in patent law' (2000) 33 *De Jure* 68-75.

[15]There were significant international law dimensions to this argument, since strong intellectual property rights over pharmaceutical products are awarded by the WTO's TRIPS agreement. The provisions of this agreement and its detrimental impact on the right of access to affordable medicine falls beyond the scope of this dissertation. In any event, most commentators agree that the challenged provisions in the PMA case were TRIPS compliant. See authorities cited in note 16 below.

inform customers of cheaper generic alternatives to prescribed medicines). In reply, the government contended that it was obliged by ss 27(2), 28(1)(c) and the rights to life and dignity to facilitate increased access to essential medicines, and hence to enact the legislation. Crumbling under pressure from worldwide public activism and the strength of these arguments, the PMA unconditionally withdrew its claims, and the matter was accordingly halted.[16] The cost of AIDS medications in South Africa significantly diminished in the aftermath of the litigation,[17] illustrating that tangible benefits can indirectly result from the 'directive principle effect' of health rights.

The second example of s 27(2)'s 'legitimating' function relates to the controversial price control regulations recently promulgated pursuant to s 22G of the Medicines and Related Substances Control Act, in terms of which limits are set on the profit margins of retail pharmacists in relation to prescribed medicines.[18] In dismissing a variety of (predominantly administrative law) challenges to the validity of the regulations brought by retail pharmacy chains and the South African Pharmaceutical Society, the Cape High Court affirmed the legitimacy of the purpose of the regulations, which it saw as obviously being aimed at complying with the State's obligations to increase access to medicines through assuring their affordability in terms of s 27(2).[19] The regulations were subsequently invalidated by the SCA for not having adhered to the legality principle and for not having prescribed an 'appropriate' fee for pharmaceutical products. The SCA nevertheless acknowledged the legitimacy of the

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[16]On the arguments advanced in and the outcome of the PMA case, see De Vos op cit note 13 at 102; James Thuo Gathii 'Construing intellectual property rights and competition policy consistently with facilitating access to affordable AIDS drugs to low-end consumers' (2001) 53 *Florida LR* 727 at 767-768; Shubha Ghosh 'Pills, patents and power: State creation of gray markets as a limit on patent rights' (2001) 53 *Florida LR* 789 at 814-816; Heywood op cit note 9 at 135-158; Joseph op cit note 13 at 443; Harrison Mwakyembe & George Mpundu Kanja 'Implications of the TRIPS agreement on the access to cheaper pharmaceutical drugs by developing countries: Case study of *South Africa v The Pharmaceutical Companies*' (2002) 34 *Zambia LJ* 111-147; Yousuf A Vawda 'Tripped-up on TRIPS: The story of shrinking access to drugs in developing countries' (2002) 13 *Stellenbosch LR* 352 at 360.

[17]Shown by Heywood op cit note 9 at 157.

[18]*Regulations relating to a Transparent Pricing System for Medicines and Scheduled Substances* GN R553 (30 April 2004).

[19]*New Clicks South Africa v Tshabalala-Msimang; Pharmaceutical Society of South Africa v Tshabalala-Msimang* 2005 (2) SA 530 (C) at 545F-546C; 570G-571A (per Yekiso J for the majority). See also the minority judgement at ibid 582F-583B.

regulations' purpose in line with s 27(2), stating that the public's constitutional entitlement to access affordable medicines was a crucial interest to be weighed against the commercial viability-interests of pharmacies, in deciding whether the prescribed fees were appropriate.[20] In partially upholding an appeal by the Minister of Health against the SCA judgment, the Constitutional Court stated that, due to the constitutional obligation on the State to progressively facilitate access to health care services, the legitimacy and necessity of the regulations were beyond question. While the Court found that certain of the regulations were defective and had to be modified, it emphasised that to restrict the profit margins of pharmacies, as envisaged by the regulations, was in principle constitutionally permissible.[21]

Apart from the above examples,[22] s 27(2) may be expected to play a similar legitimating role in relation to a range of measures seeking to limit commercial and liberty-interests of health care professionals and other entities that are implicated in the actualisation of health rights. For instance, the view has been expressed that s 27(2) significantly strengthens arguments purporting to justify limits occasioned by statutorily imposed terms of compulsory, remunerated community service[23] on health science graduates' rights of freedom from forced labour, freedom of movement and residence and freedom of trade,

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[20] *Pharmaceutical Society of South Africa v Tshabalala-Msimang; New Clicks South Africa v Minister of Health* 2005 (3) SA 238 (SCA) at para 77. The SCA's finding that the fees were inappropriate was at least in part informed by a belief that the rigidity of the regulations would lead to the closure of pharmacies which would in turn have a detrimental impact on the accessibility of medicines. The Court nevertheless indicated that a more flexible prescribed fee structure (conducive to accessibility as well as affordability of medicines) would survive judicial scrutiny. Ibid paras 79-80.

[21] *Minister of Health v New Clicks South Africa* CCT 59/04, judgment of 30 September 2005 (unreported). See paras 1; 16 (per the entire Court); 32 (per Chaskalson CJ); 437; 514-517 (per Ngcobo J); 650-651 (per Sachs J); 704-706 (per Moseneke J).

[22] See also *Affordable Medicines Trust v Minister of Health* 2005 (6) BCLR 529 (CC), where the legitimacy of measures that restrict the dispensing of medicines by health care professionals, which were aimed at increasing access to safe medicines, was not questioned. See paras 21; 100.

[23] See s 24A of the Health Professions Act 56 of 1974 (introduced by s 22 of the Medical, Dental and Supplementary Health Service Professions Amendment Act 89 of 1997); s 14A of the Pharmacy Act 53 of 1974 (introduced by s 13 of the Pharmacy Amendment Act 88 of 1997), which prescribes compulsory, remunerated community service terms for medical and pharmaceutical graduates respectively.

occupation and profession.[24]

A more controversial current example concerns s 36 of the National Health Act 61 of 2003, which determines that health establishments may not operate without having been issued a certificate of need by the Director General of Health, who must take into account a variety of factors, most of which relate to the transformation of the health care sector, the need to increase the geographical accessibility of health care services and the need to address other lingering inequities in access to care, before issuing or renewing such a certificate. This is bound to spark a constitutional challenge, since the provision appears to entail a significant limitation of health care professionals' rights to freedom of movement and residence and freedom of occupation, trade and profession. The success of a similar constitutional challenge before a Canadian court[25] indicates that the State will have some difficulty in convincing a court that there are no less restrictive means to achieve its purpose of reducing urban/rural discrepancies in the physical accessibility of health care services. However, the fact that, unlike in Canada, the South African government is under a constitutional obligation to address such discrepancies in progressively facilitating the increased accessibility of health care services, may be expected significantly to strengthen the State's defense of the measures.[26]

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[24]See Heyns op cit note 7 at 5-17. These limits are not always extensive, and are counterbalanced by, for example, the limited time period of the service, the remuneration of participating health care professionals, and a measure of choice as to where the community service is performed. In Europe, challenges to community service for legal graduates have been dismissed since the interests limited by the service were found to have been counterbalanced by the right of the indigent to have access to justice. See *Van der Mussele v Belgium* [1983] ECHR 13 and other cases discussed by Heyns (ibid). Provided that conditions of community service are not overly onerous, a similar finding would seem likely in the context of access to health care services in South Africa.

[25]In *Re Wilson and Medical Services Commission of British Columbia* 53 DLR (4th) 171 (1989) the British Columbia Court of Appeal found that a virtually identical provincial regulatory scheme was unconstitutional, for unjustifiably limiting the liberty interests of health care practitioners. The Court emphasised that the finding of unconstitutionality resulted mainly because the State offered no justification for the scheme, because less restrictive means were available to achieve its purpose and because the government could not show that the geographical distribution of health services was so problematic as to require interference with liberty interests. See specifically 174-181; 186-187; 195; 197-198.

[26]Craig Scott & Patrick Macklem 'Constitutional ropes of sand or justiciable guarantees? Social rights in a new South African constitution' (1992) 141 *Univ Pennsylvania LR* 1 at 32 argue that *Wilson* would have been decided differently had the government been able to rely on a constitutional duty in justification of the scheme.

Overall, it would seem that the health rights in the 1996 Constitution have had a discernible 'directive principle effect'. To the (however slight) extent that health rights have served to inspire or direct the content of measures that confer health-related benefits on citizens, they may be said to have indirectly contributed to the attainment of the right to health. More concretely, whether or not they actually inspired or directed the content of the legislative or policy measures in question, health rights have usefully bolstered the social transformation process through clothing the purpose of such measures in constitutional legitimacy, thereby providing a degree of insulation against constitutional attack that the measures would otherwise have lacked.

Through the mere fact of their constitutional presence therefore, health rights may result in some indirect benefit for their subjects. However, if the constitutional drafters intended for the impact of health rights to be limited to this 'directive principle effect', there would have been no need for them to make the rights justiciable. Evaluating constitutional health rights' contribution to the social and economic transformation of South African society, while viewing them as fully justiciable *rights*, must involve more than an assessment of their discursive impact in the political arena. In addition to incidental benefits resulting from their 'directive principle effect', rights should in appropriate circumstances enable their beneficiaries to attain the tangible benefits that are necessary for them to effectively enjoy the rights.

6.3 CONSTITUTIONAL HEALTH RIGHTS AS TOOLS FOR ACHIEVEMENT OF THE RIGHT TO HEALTH: SUMMARY OF THE FINDINGS OF THIS DISSERTATION

Making socio-economic rights justiciable significantly increases their potential to confront denial of the needs they embody. Rather than functioning simply as rhetorical devices that draw attention to particular needs, justiciable rights are capable of being used as tools to attain the satisfaction of such needs. Because justiciable socio-economic rights embody enforceable claims to the goods or services that are necessary to satisfy the needs they represent, their use in

litigation has the effect of disrupting, or at least challenging, existing societal power structures that determine the distribution of such services and goods.[27] As such, their judicial vindication can contribute to the dismantling and reconstitution of such power structures and accordingly to the social and economic transformation of society.

The enforcement of socio-economic rights further tangibly advances a central goal of social transformation - the improvement of the quality of life of the population. This dissertation focused on this latter aspect of constitutional health rights' contribution to the overarching constitutional transformation project. I argued that, because of their status as justiciable rights, successful reliance on health rights should, in appropriate circumstances, produce tangible benefits for individual litigants. This means, I contended, that Courts should in principle regard health rights as enforceable and should award tangible relief that effectively compensates for infringements of health rights unless such infringements can somehow be constitutionally justified or unless it would be demonstrably inappropriate to award tangible relief in the circumstances of the case.

The dissertation accordingly set out to identify the rights that are relevant to the achievement of the highest attainable standard of physical and mental health, to locate these rights within the protection awarded by the South African Bill of Rights and to ascertain the extent to which the benefits implied by them are capable of resulting from South African constitutional litigation.

Chapter 2 showed that the international law right to health consists of an interrelated package of rights, each constituent element of which imposes a myriad of obligations on states and implies a variety of interrelated claims to have access to (and/or undisrupted enjoyment of) health-conducive goods or services. I identified several health-related freedoms, entitlements to a variety of determinants of health, entitlements to various health care services as well as an underlying guarantee of equality as comprising the main constituent

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[27] See for instance KD Ewing 'Social rights and constitutional law' (1999) *Public Law* 104 at 122-123; Sandra Liebenberg 'Social and economic rights: A critical challenge' in Sandra Liebenberg (ed) *The Constitution of South Africa from a Gender Perspective* (1995) 79 at 84.

elements of this package. I further showed that, while not all benefits implied by the right to health may immediately be demanded, rights-bearers are at least entitled to protection of their current enjoyment of health-related rights and to adequate remedies against private infringements thereof. Entitlements to goods, services and facilities aimed at the satisfaction of basic and urgent health-related needs further appeared to be more readily claimable than entitlements to more sophisticated, more expensive and less urgent forms of care.

Moving the focus to the South African context, chapter 3 proceeded to show that the basic features of the Bill of Rights in the 1996 Constitution are conducive to a benefit-orientated approach to socio-economic rights. The structure of the Bill of Rights allows for a broad, permissive and need-focused interpretation of socio-economic rights and requires justification for non-compliance with the obligations they impose. Where such justification is inadequate, the Constitution awards courts significant flexibility to devise remedies that appropriately compensate for infringements of the rights. The Bill of Rights therefore not only requires of courts to effectively enforce health rights, but also awards them the scope to negotiate any institutional tensions that may otherwise have been occasioned by this task.

Thereafter, the chapter showed that all elements of the international law health rights package enjoy adequate constitutional protection in South Africa. I identified and described the interests underlying several constitutional provisions that guarantee different aspects of the right to health and proposed a generous and purposive interpretation of these provisions which enables them to cater effectively for the satisfaction of the needs they represent.

Chapter 4 then evaluated the handful of South African judgments in which health rights have come into play. I argued that the Constitutional Court's socio-economic rights jurisprudence thus far has been overly restrictive of the benefit-rendering potential of health rights. By denying that socio-economic rights embody immediately enforceable, individual claims and by opting instead for an inquiry that focuses on the coherence, rationality and inclusivity of government

policy aimed at giving effect to socio-economic rights, the Court has drained health rights of discernible content and has removed the focus of its inquiry from the needs that the rights aim to satisfy. Moreover, the remedy most logically implied by its approach (namely that legislation or policy be modified in order to conform with predominantly procedural standards) is at most of indirect and marginal relevance to health rights' beneficiaries, whose interests in tangibly improving their living conditions remain sidelined.

I proceeded to explore possible reasons for the overly restrictive aspects of the Constitutional Court's socio-economic rights jurisprudence. I concluded that, whereas constraints imposed by the doctrine of separation of powers, the inherent polycentricity of socio-economic rights matters and the need for judges to respect the specialist knowledge of health care professionals must necessarily impact on the manner in which courts conduct themselves in health rights matters, they do not restrain courts from, in appropriate circumstances, recognising and enforcing individual health-related entitlements. Accordingly, they do not justify the Constitutional Court's overly restrictive stance towards socio-economic rights. Instead, I speculated, this stance is likely attributable to a lingering unease on the part of the Court with enforcing 'positive rights', which the Court seems to have appeased by resorting to an essentially formalist model of adjudication.

Despite this, certain aspects of the Constitutional Court's socio-economic rights jurisprudence, especially when considered in light of the more benefit-conducive approach adopted in some High Court judgments, indicate that the obstacles hindering a need-focused and benefit-conducive approach to socio-economic rights are not insurmountable. In addition, chapter 5 showed that there are viable alternative and/or supplementary approaches to socio-economic rights adjudication which could enhance the benefit-rendering potential of health rights without requiring a radical departure from the manner in which courts currently conduct themselves in socio-economic rights matters.

Overall, in addition to indicating the content and benefit-related implications of the various provisions in the Bill of Rights that award health-

related entitlements, this dissertation has shown that these provisions are capable of being enforced in a manner that delivers the benefits that they promise. Accordingly, the rights in question are capable of being used to satisfy the needs they represent, and hence to function as tools of transformation. Much of their potential to make a concrete difference in the lives of their beneficiaries currently goes unrealised. Even so, there appear to be ways in which this potential can be resurrected or enhanced without sacrificing the institutional integrity of the judiciary.

6.4 TOWARDS A BENEFIT-ORIENTATED APPROACH TO HEALTH RIGHTS: SUGGESTIONS FOR FURTHER RESEARCH

The benefit-focused vantage point adopted in this dissertation has allowed me to demonstrate the remedial possibilities inherent in the health rights contained in the 1996 Constitution and to show, through uniting the various criticisms of South African socio-economic rights jurisprudence, the shortcomings of the Constitutional Court's current approach to their vindication. It also usefully highlights certain lacunae in socio-economic rights theory and scholarship and indicates aspects of the enforcement of socio-economic rights that require elaboration through further research.

First, this dissertation has shown that health rights generate certain immediately claimable benefits and has identified a fair number of these. Further enforceable obligations likely lurk in the non-immediate dimensions of these rights, with which this dissertation has engaged only cursorily. For instance, whereas I have argued that adopting a minimum core approach to s 27(1)(a) read with s 27(2) of the Constitution would provide a discernible starting point for an inquiry into compliance with the progressive realisation standard, further research is clearly necessary on measuring compliance with the standard beyond this baseline.[28] Notwithstanding the significant gains that have been

[28]On the various associated interpretative and logistical problems in the international law context, see generally Audrey R Chapman 'A "violations approach" for monitoring the

made in international law towards countering problems occasioned by the vagueness and context-specific nature of the progressive realisation standard,[29] there is a dearth of domestic scholarship on the development of appropriate benchmarks, time-frames and indicators with which to measure State compliance with the standard.[30] Given that the extent of (secondary and tertiary) benefits that are immediately claimable under s 27(1)(a) is dependent on the progress that has been made towards full realisation of the right, it is important that South African socio-economic rights scholarship show increased engagement with the obligations implied by its progressive elements.

It is further apparent from many of the arguments advanced in this dissertation that there is a need for further clarification of the limits of health rights in various settings. I have shown that it is important to deliberate these limits, both in terms of s 27(2) of the Constitution and under the general limitations clause, because it allows courts to indicate the extent to which benefits implied by a health right may be demanded at a particular point in time and to balance the interests of individual claimants in this regard against competing societal interests. It appears that at least part of the Constitutional Court's hostility towards the notion of enforceable entitlements flowing from s 27(1)(a) of the Constitution is grounded in the fear that this would lead to untenable demands for the benefits implied by the right, regardless of the factual or legal context within which such demands are made and of the availability of human and financial resources to meet the demands. The extent of the Court's discomfort in this regard appears to be fuelled by uncertainty over whether and

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International Covenant on Economic, Social and Cultural Rights' (1996) 18 *Human Rights Quarterly* 23-66. For a discussion of similar problems in relation to the standard as contained in s 27(2) of the South African Constitution, see Sandra Liebenberg 'Violations of socio-eocnomic rights: The role of the South African Human Rights Commission' in Andrews & Ellmann op cit note 8,405 at 422-423; Craig Scott & Philip Alston 'Adjudicating constitutional priorities in a transnational context: A comment on *Soobramoney*'s legacy and *Grootboom*'s promise' (2000) 16 *SAJHR* 206 at 254 and generally Conrad Barbeton '"Progressive realisation" of socio-economic rights: Shifting the focus to outcomes' (1999) 2(2) *ESR Review* (accessed online at <http://www.communitylaw centre.org.za/ser/esr1999/1999nov_progressive.php>).

[29]See chapter 3 notes 69-72 and accompanying text.

[30]On the development and implementation of benchmarks, time-frames and indicators, see Maria Green 'What we talk about when we talk about indicators: Current approaches to human rights measurement' (2001) 23 *Human Rights Quarterly* 1062 at 1080-1081; 1085-1087; 1091.

to what extent the general limitations clause in s 36 of the Constitution may be invoked to limit socio-economic rights claims and, in relation to claims in terms of s 27(1)(a), over how such invocation would dovetail with an internal limitations inquiry in terms of s 27(2).[31]

The application of s 36 to socio-economic rights matters may indeed yield several complications (caused by, for instance, s 36's insistence on a 'law of general application' and its apparent duplication of the 'reasonableness' standard also found in s 27(2)[32]). However, the Court's current alternative approach, which instead restricts the *ambit* of the rights in question, is inimical not only to the benefit-rendering potential of these rights but also to the spirit, purport and object of the Bill of Rights as a whole. Further research on the potential role to be played by s 36 in health rights matters is therefore essential:

> 'For the state to have a proper understanding of its constitutional obligations under the socio-economic rights clauses, for litigants to be able to determine what they are entitled to under the socio-economic rights clauses, and for courts to ensure that socio-economic rights remain meaningful and actionable rights in South Africa, our courts need to be properly aware of s 36's special and limited role in constitutional jurisprudence, and the special relationship between that section and the socio-economic rights clauses'.[33]

Research on the application of s 36 to socio-economic rights matters would further yield increased clarity on the standards of scrutiny to which State justifications for non-compliance with socio-economic obligations should be subjected. This would in turn have the effect of enhancing the contribution of socio-economic rights to achieving the 'culture of justification' envisaged by the 1996 Constitution for all exercises of State power.[34]

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[31]Also argued by Kevin Iles 'Limiting socio-economic rights: Beyond the internal limitations clauses' (2004) 20 *SAJHR* 448 at 464; Marius Pieterse 'Towards a useful role for section 36 of the Constitution in social rights cases? *Residents of Bon Vista Mansions v Southern Metropolitan Local Council*' (2003) 120 *SALJ* 41 at 47. See for instance the remarks of Mokgoro J on behalf of the majority of the Court in *Khosa v Minister of Social Development; Mahlaule v Minister of Social Development* 2004 (6) SA 505 (CC) at para 83.

[32]On the latter issue, see chapter 3 note 85 and accompanying text.

[33]Iles op cit note 31 at 465.

[34]See Liebenberg op cit note 4 at 188; Sandra Liebenberg 'The value of human dignity in interpreting socio-economic rights' (2005) 21 *SAJHR* 1 at 26-27; Pieterse op cit note 31 at 47. On the importance of insisting on justification for rights-violations generally and infringements of social rights specifically, see Etienne Mureinik 'Beyond a charter of luxuries: Economic rights in the Constitution' (1992) 8 *SAJHR* 464 at 471-473; also generally Etienne Mureinik 'A bridge to where? Introducing the interim Bill of Rights' (1994) 10 *SAJHR* 31 at 31-32; 48.

Apart from health rights' constitutional limits, their effective vindication is hindered significantly by the relative dearth of research relating to their horizontal dimensions. The combination of liberal rights discourse's aversion to the horizontal application of fundamental rights and its specific hostility towards socio-economic rights has meant that private violations of socio-economic rights often remain undetected and unremedied. In order for health rights effectively to render the benefits they promise, it is essential that they be capable of enforcement against those who are most directly implicated in their realisation. As the extent of the private sector's involvement in essential service delivery increases, so does the need for research on the horizontal dimensions of socio-economic rights:

> 'Failure to develop and implement practical strategies for holding non-state persons legally responsible for protecting and promoting social, economic and cultural rights would imply that human rights activists are content to allow those who own and control the bulk of the material resources and means of social and economic production to continue operating outside the mainstream of human rights while states that are increasingly losing ownership and control of such resources and means are being pressured to "deliver". It goes without saying that under such conditions the "delivery" would be greatly circumscribed and limited'.[35]

I have shown that there are a variety of private relationships which are integral to the effective enjoyment of health rights and that there exist several common-law rules that may be developed to give proper effect to health rights within these relationships. Further research remains necessary on the kinds of private entities that may be held directly responsible for infringing health rights, the circumstances in which and degree to which they may be held responsible for such infringements and the extent to which they may be co-opted in the

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[35]Shadrack Gutto 'Modern "globalisation" and the challenges to social, economic, and cultural rights for human rights practitioners and activists in Africa' (Oct-Dec 2000) *Africa Legal Aid* 2. See also Danwood Mzikenge Chirwa 'Non-state actors' responsibility for socio-economic rights: The nature of their obligations under the South African Constitution' (2002) 3(3) *ESR Review* 2 at 6; Chirwa op cit note 7 at 559; 561-562; Danwood Mzikenge Chirwa 'Socio-economic rights and the privatisation of basic services in South Africa' (2003) 4(4) *ESR Review* 4 at 6-7; Iain Currie & Johan De Waal *The New Constitutional and Administrative Law: Volume 1 - Constitutional Law* (2001) at 93-94; Sandra Liebenberg 'The interpretation of socio-economic rights' in Stuart Woolman (ed) *Constitutional Law of South Africa* (2ed; 2003) ch 33 at 58-59; Pieterse op cit note 7 at 25-26; Adam McBeth 'Privatising human rights: What happens to the State's human rights duties when services are privatised?' (2004) 5 *Melbourne J of International Law* 133-154.

progressive realisation of health rights.

Both in relation to private infringements and more 'traditional' State violations of health rights, there is a need for increased scholarly engagement with courts' remedial function. This dissertation has shown that the remedial flexibility that courts enjoy in terms of s 38 of the Constitution allows them to devise remedies that would appropriately vindicate the interests of litigants while simultaneously remaining mindful of other compelling societal interests and of the judiciary's institutional limitations. However, it appears that the Constitutional Court has thus far made limited use of the latitude it is afforded by this flexibility in socio-economic rights matters.[36] This is at least in part because its approach to the interpretation of socio-economic rights precludes it from exercising remedial options other than broad declaratory orders that instruct the State to conform to the dictates of *Grootboom* reasonableness.

The content of the remedy awarded in the wake of an infringement of a health-related right and the manner in which compliance with such remedy is secured directly determines the extent to which a successful litigant derives tangible benefit from a 'victory' in a health rights matter. It is therefore essential that further research be conducted into what would constitute appropriate relief for infringements of health rights.[37] Such research should explore the possibilities of productive inter-institutional interaction, the interests of both applicants and respondents in health rights matters, the dictates of the doctrine of separation of powers and manners in which existing remedies (such as interdicts and awards of damages) may be utilised or developed in order to adequately prevent or compensate for infringements of health rights.[38] Given

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[36]See Marius Pieterse 'Coming to terms with judicial enforcement of socio-economic rights' (2004) 20 *SAJHR* 383 at 414-415 and authorities cited there; also chapter 4 note 137 and accompanying text.

[37]On the need for such research, see also Liebenberg op cit note 34 at 29; Mia Swart 'Left out in the cold? Crafting constitutional remedies for the poorest of the poor' (2005) 21 *SAJHR* 215 at 239.

[38]See *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC) at para 19; Thomas J Bollyky 'R if C > B + P: A paradigm for judicial remedies of socio-economic rights violations' (2002) 18 *SAJHR* 161 at 177; Currie & De Waal op cit note 35 at 115-116; Jonathan Klaaren 'A remedial interpretation of the *Treatment Action Campaign* decision' (2003) 19 *SAJHR* 455 at 458; Sandra Liebenberg 'Socio-economic rights' in Matthew Chaskalson et al (eds) *Constitutional Law of South Africa* (RS5, 1999) ch 41 at 52; Kameshni Pillay 'Implementation of *Grootboom*:

further that the *Grootboom* order did not result in any tangible improvement of the successful litigants' living conditions and that the Treatment Action Campaign had to resort to contempt of court proceedings in order to secure compliance with the *TAC2* order,[39] research should further explore ways in which courts may take more effective control over compliance with their orders, both in the remedial stage of proceedings and thereafter.[40]

Whereas it is necessary that court orders are structured in a manner that facilitates legislative and executive compliance, there should simultaneously be guarded against unnecessarily disrupting the already fragile relationship between the courts and the other branches of government. Whereas this dissertation has deliberately under-emphasised institutional dimensions of giving effect to health rights through the judiciary (in its belief that these dimensions have tended, in most literature on the subject, to overshadow the issues of need and entitlement that belong at the centre of a study of health rights), I acknowledge that institutional tensions are bound to arise when courts are empowered to dictate, in however limited a fashion, the terms of socio-economic transformation. Legislative and executive commitment to securing enjoyment of health rights and to co-operating with the judiciary in this regard is essential if the rights are to end up as more than paper guarantees.

Implications for the enforcement of socio-economic rights' (2002) 6 *Law, Democracy & Development* 255 at 259; Craig Scott 'Social rights: Towards a principled, pragmatic judicial role' (1999) 1(4) *ESR Review* 4 at 5; Scott & Alston op cit note 28 at 224; Wim Trengove 'Judicial remedies for violations of socio-economic rights' (1999) 1(4) *ESR Review* 8 at 9-10.

[39]See Mark Heywood 'Contempt or compliance? The *TAC* case after the Constitutional Court judgment' (2003) 4(1) *ESR Review* 7-10.

[40]For discussion of the need to ensure that orders are given effect to and for associated criticism of the *Grootboom* and *TAC2* orders, see David Bilchitz 'Towards a reasonable approach to the minimum core: Laying the foundations for future socio-economic rights jurisprudence' (2003) 19 *SAJHR* 1 at 24-26; Liebenberg op cit note 34 at 30; Pieterse op cit note 36 at 414-416; Pillay op cit note 38 at 276; Theunis Roux 'Understanding *Grootboom* - A Response to Cass R Sunstein' (2002) 12(2) *Constitutional Forum* 41 at 51. In *Kate v MEC for the Department of Welfare, Eastern Cape* 2005 (1) SA 141 (SECLD) at para 25, Froneman J remarked: 'It is one thing to realise the possibility *as a matter of fact* that the Government might refuse to comply with court orders. It is something completely different to hold *as a matter of law* that courts are powerless to devise ways to ensure compliance with court orders in a constitutional State such as ours. In the former case the Government would, in refusing to comply with court orders, place itself outside the ambit of constitutional government and a constitutional crisis would be created. For the courts to do the latter would be to aid and abet unconstitutional government, the very antithesis of the courts' duty in terms of the Constitution'.

Accordingly, it is necessary for a judicial approach to health rights to enable co-operation and ongoing dialogue between all three branches of state.[41] Achieving the appropriate balance between judicial deference and vigilance in structuring and orchestrating this dialogue is bound to prove challenging (though by no means impossible, or even always difficult) and it is hoped that future research on the institutional dimensions of socio-economic rights enforcement will increasingly focus on the achievement of this balance.[42]

Finally, it needs to be remembered that '[f]ocusing only on judicial enforcement will not win the battle for the poor'.[43] Most beneficiaries of health rights will never see the inside of a courtroom and, while the judgments handed down there may vicariously decide their fate, it is whether these judgments actually translate into tangible, ground-level realities that is of interest to them. It is accordingly crucial that the theoretical research conducted here be supplemented by research focusing on the practical implementation of constitutional guarantees and judicial pronouncements, as well as on the role of non-judicial institutions (ranging from constitutionally sanctioned bodies such as the SAHRC, through statutory bodies such as health care professionals' councils to 'private' NGO's and other interest groups) in facilitating, monitoring and ensuring such implementation.[44]

6.5 CONCLUSION

Through ostensibly reconciling notions of right and need, socio-economic rights have the potential to contribute tangibly to the achievement of social justice.

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[41]See Bilchitz op cit note 40 at 25; Christof Heyns 'Taking socio-economic rights seriously: The "domestic reporting procedure" and the role of the South African Human Rights Commission in terms of the new Constitution' (1999) 32 *De Jure* 195 at 209-210; Jonathan Klaaren 'Structures of government in the 1996 Constitution: Putting democracy back into human rights' (1997) 13 *SAJHR* 3 at 26; Liebenberg op cit note 38 at 8; 10; Geraldine Van Bueren 'Alleviating poverty through the Constitutional Court' (1999) 15 *SAJHR* 52 at 64.

[42]See Liebenberg op cit note 4 at 189; Pieterse op cit note 36 at 417.

[43]Bongani Majola 'A response to Craig Scott: A South African perspective' (1999) 1(4) *ESR Rev* 6 at 7.

[44]On the need for such research, see further Dwight G Newman 'Institutional monitoring of social and economic rights: A South African case study and a new research agenda' (2003) 19 *SAJHR* 189 at 190; 194.

However, the success of socio-economic rights in this respect ultimately depends on their potential to improve the quality of life of those whose deprivation and vulnerability they seek to address. Indeed, the legitimacy of the Bill of Rights as a whole depends on whether socio-economic rights are capable of rising to this challenge.[45] This dissertation has shown that the health rights in the 1996 Constitution, despite their inherent capacity to make a tangible difference in the lives of their beneficiaries, have only partially succeeded in delivering what they promise. This has been attributed neither to an inherent flaw in their formulation nor to the existence of insurmountable institutional hurdles to their enforcement, but instead to the hesitance of South African courts to give effect to the rights-based nature of health-related claims.

Discussions of the institutional difficulties associated with giving effect to socio-economic rights often overlook that many features of the judicial process equip courts rather well for this task. While remaining inaccessible to a disconcerting number of people, courts provide an official platform for claimants to articulate their needs and to negotiate the satisfaction thereof with the State, or other powerful entities, on a relatively equal footing.[46] Judges are well-equipped to balance the competing interests arising from such negotiation and to arrive at fair and well-reasoned solutions that give effect to this balance of interests. They are under a constitutional mandate to take rights seriously and are experts at interpreting and enforcing rights. Particularly, courts are able to provide direct, timely and appropriate relief to claimants who can show that their fundamental rights have been infringed or threatened.[47] It would be most unfortunate if courts were to preclude themselves from assisting in the socio-

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[45]See chapter 1 notes 23-24; 39 and accompanying text, and also remarks of Dennis Davis 'Socio-economic rights in South Africa: The record of the Constitutional Court after ten years' (2004) 5(5) *ESR Review* 3 at 5; Sandra Liebenberg 'The right to social assistance: The implications of *Grootboom* for policy reform in South Africa' (2001) 17 *SAJHR* 232 at 233.

[46]See Davis (ibid) at 7.

[47]These and other strengths of the judiciary in this regard are discussed by, for instance, NW Barber 'Prelude to the separation of powers' (2001) 60 *Cambridge LJ* 59 at 79; John Ferejohn 'Judicializing politics, politicizing law' (2002) 65 *Law & Contemporary Problems* 41 at 55; 63; Mario Gomez 'Social economic rights and human rights commissions' (1995) 17 *Human Rights Quarterly* 155 at 156; Liebenberg op cit note 38 at 11; Pieterse op cit note 36 at 395; Ruti Teitel 'Transitional jurisprudence: The role of law in political transformation' (1997) 106 *Yale LJ* 2009 at 2033.

economic transformation of South African society by failing to display these strengths in cases where they are called upon to vindicate socio-economic rights.

It is hoped that courts will become more comfortable with enforcing socio-economic rights as time progresses and will modify their current approach to socio-economic rights adjudication in a manner that reduces the overly onerous burden of proof on applicants and that more readily produces tangible benefits where applicants are successful. In particular, the Constitutional Court should reconsider its stance against affirming the existence of enforceable individual entitlements underlying socio-economic rights, should explicitly articulate the basis of its findings in socio-economic rights cases in rights-terms and should award individual relief for infringements of socio-economic rights in circumstances where this would not be inappropriate or unjust.[48]

Whereas valuable steps have been taken towards building a health rights jurisprudence that resonates with the spirit, purport and objects of the 1996 Constitution, these need to be supplemented by an explicit acknowledgment that health rights generate legally enforceable entitlements and by interpretative, evaluative and remedial judicial practices that enable the vindication of such entitlements in appropriate circumstances. Until this happens, the right to health and the transformative aspirations of the 1996 Constitution will continue to have a 'hollow ring' for those to whom it matters most.

[48]For similar arguments, see Liebenberg op cit note 4 at 188-189; Liebenberg op cit note 34 at 30.

ANNEXURE A

TEXT OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS TREATY PROVISIONS SURVEYED IN CHAPTER 2

Article 12 of the International Covenant on Economic, Social and Cultural Rights:

1. The States Parties to the Present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
   (b) The improvement of all aspects of environmental and industrial hygiene;
   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 2 of the International Covenant on Economic, Social and Cultural Rights:

1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status....

Article 3 of the International Covenant on Economic, Social and Cultural Rights:

The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

Article 12 of the Convention on Elimination of All Forms of Discrimination Against Women:

1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure , on a basis of equality between men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 5(e)(iv) of the Convention on Elimination of All Forms of Racial Discrimination:

In accordance with the fundamental obligations laid down in article 2 of this Convention, States parties undertake to prohibit and to eliminate racial discrimination in all of its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: . . .

e) Economic, social and cultural rights, in particular:...

iv) The right to public health, medical care, social security and social services;....

Article 24 of the Convention on the Rights of the Child:

1. States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) to diminish infant and child mortality;

(b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) to combat disease and malnutrition, including within the framework of primary health care, through *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) to ensure appropriate pre-natal and post-natal health care for mothers;

(e) to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;

(f) to develop preventative health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realisation of the right recognised in the present Article. In this regard, particular account shall be taken of the needs of developing countries.

Article 11 of the European Social Charter:

With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:

1. To remove as far as possible the causes of ill health;

2. To provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

3. To prevent as far as possible epidemic, endemic and other diseases.

Article 13(1) of the European Social Charter:

With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:

(1) To ensure that any person who is without adequate resources and

who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in the case of sickness, the care necessitated by his condition.

Article 11 of the American Declaration on the Rights and Duties of Man:

Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.

Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights:

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.

2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right.

a. Primary health care, that is, essential health care made available to all individuals and families in the community;

b. Extension of the benefits of health services to all individuals subject to the State's jurisdiction;

c. Universal immunization against the principal infectious diseases;

d. Prevention and treatment of endemic, occupational and other diseases;

e. Education of the population on the prevention and treatment of health problems, and

f. Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

Article 16 of the African Charter on Human and Peoples' Rights:

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

(2) States 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.

Article 14 of the African Charter on the Rights and Welfare of the Child:

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

2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:

(a) to reduce infant and child morality rate;
(b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
(c) to ensure the provision of adequate nutrition and safe drinking water;
(d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;
(e) to ensure appropriate health care for expectant and nursing mothers;
(f) to develop preventive health care and family life education and provision of service;
(g) to integrate basic health service programmes in national development plans;
(h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;
(i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and management of a basic service programme for children;
(j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.

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