# DEVELOPING A CONSTITUTIONAL LAW PARADIGM FOR A NATIONAL HEALTH INSURANCE SCHEME IN SOUTH AFRICA

*Dissertation submitted by:*

**PAUL ALLEN WAYBURNE**

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Supervisor: Professor Marius Pieterse

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. This thesis represents the state of the law as at 1 December 2013.

Paul Allen Wayburne

6 June 2014

**בָּרוּךְ אַתָּה ה׳ אֱלֹהֵינוּ מֶלֶךְ הָעוֹלָם שֶׁהֶחֱיָנוּ וְקִיְּמָנוּ וְהִגִּיעָנוּ לַזְּמַן הַזֶּה.**

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## ABSTRACT

The proposed National Health Insurance ('NHI') is the most extensive health policy initiative proposed by the South African government since 1994, to bridge the divide between the private and public health sectors. It is intended that the NHI will fund health care services for the entire population. Yet, despite its laudable goals, the implementation of NHI might be stalled by litigation concerning its constitutionality. In this thesis, I construct a constitutional paradigm within which such challenges can be understood. Departing from the premise that the Constitution places a positive obligation on the state to implement redistributive policies in the health sector in order to progressively realise the right to have access to health care services, the thesis identifies the tensions underlying the proposed implementation of NHI and aligns these to liberty-based and equality-based understandings of the right to health, respectively. This analysis takes place after having considered the history of health care reform in South Africa and debates on the desirability of NHI. The thesis then investigates and sets out the constitutional principles, values and standards embodied by the rights to equality, freedom and security of the person, and access to health care services, and considers the extent to which current the formulation of the proposed NHI adheres to these principles. Potential constitutional challenges to NHI by private sector interest groups are identified. These challenges are primarily concerned with adverse effects that the implementation of NHI may cause to current beneficiaries of private sector health services. It is argued that these adverse consequences will, for the most part, not justify a finding that relevant features of NHI are unconstitutional. This is either because they will not amount to an infringement of the relevant constitutional rights or because such an infringement will be capable of reasonable justification in terms of the general limitations clause. Only where the impairment of existing rights is disportionate or is related to some extraneous purpose inconsistent with constitutional rights and values will NHI not pass constitutional muster. Ultimately, the constitutionality of different features of NHI will depend on how the rights of those who already have access to health care services under the current health financing system are balanced with those who currently lack such access.

# CHAPTER 1
# NATIONAL HEALTH INSURANCE IN THE CONTEXT OF HEALTH POLICY REFORM IN SOUTH AFRICA

## I. INTRODUCTION

The South African health system is beset by deep inequalities reflected in the divide between the public and private health sectors.[1] Private sector health care services are financed by out-of-pocket payments and mutual funds called medical schemes, which purchase private health care on behalf of their members.[2] The state finances health care services in the public sector utilising funds derived from income tax.[3] Health system inequalities can be attributed to explicit and implicit political choices pertaining to the financing and provision of health services.[4] The public-private sector divide, poor governance of the public sector and poverty impact negatively on the health outcomes of the majority of the population. For the most part, poor people access health care in the public sector whilst high-income groups, who are

[1] The public/private sector divide in the South African health system has been an overarching theme of health policy literature for at least the past thirty years. Towards the latter end of apartheid, commentators warned against privatisation policies of the government and also accused it of using the divided system to further buttress apartheid. See for example A Seedat *Crippling a Nation: Health in Apartheid South Africa* (1984) 63-83; M Price 'Health Care as an Instrument of Apartheid policy in South Africa' (1986) 1 *Health Policy and Planning* 158, 161, 168-9; M Price 'The Consequences of Health Service Privatisation for Equality and Equity in Health Care in South Africa' (1988) 27 *Social Science and Medicine* 703; CD Naylor 'Private Medicine and the Privatisation of Health Care in South Africa' (1988) 27 *Social Science and Medicine* 1153. See also some post apartheid analyses: SR Benatar 'Health Care Reform in the New South Africa' (1997) 336 *New England J of Med* 891; H Coovadia, R Jewkes, P Barron, D Sanders & D McIntyre 'The Health and Health System Challenges of South Africa: Historical Roots of Current Public Health Challenges' (2009) 374 *The Lancet* 817.

[2] See H McLeod & S Ramjee 'Medical Schemes' (2007) *SA Health Rev* 47; A van den Heever *Administered Prices Health: A Report for National Treasury* <http://www.treasury.gov.za/publications/other/epir/health.pdf> 12. In this chapter, I use the terms 'private health insurance' and 'medical schemes' interchangeably. Medical Schemes currently operate under the Medical Schemes Act 131 of 1998. Although, strictly speaking health insurance in South Africa refers to health insurance provided for in terms of the Short Term Insurance Act 52 of 1998 and Long Term Insurance Act 53 of 1998. See in this regard H Mcleod 'Mutuality and Solidarity in Healthcare in South Africa' (2005) 5 *SA Actuarial J* 135, 141.

[3] Mcleod ibid 139 para 3.2.5. See also 'South African Human Rights Commission Public Enquiry: Access to Health Care Services' ('SAHRC Report') <http://www.sahrc.org.za/home/21/files/Health%20Report.pdf> 29-31. See also B Ruff, M Mzimba, S Hendrie & J Broomberg 'Reflections on health-care reforms in South Africa' (2011) 32 *J of Public Health Policy* 184, 190.

[4] See L Gilson & D McIntyre 'South Africa: Addressing the Legacy of Apartheid' in T Evans, M Whitehead, F Diderichsen, A Bhuiya & M Wirth (eds) *Challenging Inequities in Health: From Ethics to Action* (2001) chapter 14, 191; J Broomberg 'Bring the NHI Debate into the Public Domain' (2 June 2009) *South African Health News Service* <http://www.health-e.org.za/news/article.php?uid=20032322> .

generally members of medical schemes, access health care services in the private sector. The private sector retains and attracts a disproportionate supply of human, technological and financial resources at the expense of the public sector.[5] This state of affairs is entrenched because wealthier people prefer to access health care in the private sector since it is seen to offer better quality services.[6] Medical professionals also prefer to work there because of better working conditions and income earning opportunities.[7]

The first democratically elected government of the African National Congress ('ANC') inherited this inequitable health system in 1994. Prior to that, successive apartheid governments promoted the idea that individuals and families were responsible for furthering their own access to health care with minimal positive conduct on the part of the state.[8] In doing so, the authorities of the time failed to take into account that not all people are equally capable of accessing health care: some people are poor and cannot afford to pay for health care, while others live far way from hospitals and still others may be too infirm to do anything meaningful to gain access to needed care. This was all in addition to restrictions on movement already in place for non-white persons. Despite significant improvements made since 1994, inequitable access to health care services, reflected in the public-private sector divide, remains entrenched in South Africa. This falls foul of international standards provided for in Article 12 of the International Covenant on Economic, Social and Cultural Rights, which details the right of everyone to enjoy the highest attainable standard of health.[9] This is also inconsistent with sections 27(1) and (2) of the Constitution of the Republic of South Africa, 1996, amongst other rights and obligations.[10]

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[5] SAHRC Report (note 3 above) 29, 34-7; see also H Whadee & F Khan 'Human Resources' (2007) *SA Health Rev* 141, 143-5.

[6] See S van der Berg, R Burger, N Theron, C Venter, M Erasmus & J van Eden 'Financial Implications of a National Health Insurance in South Africa' (2010) <http://www.hasa.co.za/media/uploads/documents/file/2010-04-26/Econex_NHI_Final_Report_March2010.pdf> 22, 44.

[7] Wadee & Khan (note 5 above) 146-7.

[8] M Price *Health Care Beyond Apartheid: Economic Issues in the Reorganisation of South Africa's Health Services* (1986) 53-7; Gilson & McIntyre (note 4 above) 191.

[9] *International Covenant on Economic, Social and Cultural Rights* GA Res 2200A (XXI) (1966); 21 UN GAOR Supp (No 16), 49; UN Doc A/6316 (1966); 993 UNTS 3. For an exposition of the right to health in international law see G MacNaughton 'Untangling Equality and Non-Discrimination to Promote the Right to Health Care for All' (2009) 11 *Health and Human Rights* 47.

[10] Constitution of the Republic of South Africa, 1996, section 27(1)(a) and (2). See Annexure A to this thesis.

An equitable health system is essential in any society built upon the constitutional values of equality, dignity and freedom.[11] A divided health system – one for the wealthy and the other for the poor – is inimical to these values. Therefore, successive ANC governments have attempted to incrementally unify the health system into one that serves the needs of the entire population on a more equitable basis. These attempts have culminated in the National Health Insurance ('NHI') proposal currently being promoted by government. Essentially, NHI is a universal health financing mechanism administered by the state that funds a uniform package of health care services for the entire population regardless of the extent of an individual's contribution.[12] Importantly, NHI is designed to amalgamate private and public sources of financing and health care provision, so that resources and services become accessible to all South Africans regardless of social or economic background.

The introduction of NHI might create conflict between the constitutional rights and interests of the general population and those of private sector beneficiaries. NHI must be capable of progressively realising access to health care services for poor South Africans, whilst still protecting already existing access enjoyed by current beneficiaries of the private sector. Regarding the former, it is impossible to enhance access unless the inequities across the public-private sector divide are reduced. This requires redistributive measures that put finance and health resources within reach of all people by minimising barriers that inhibit access. Integrating the private health sector into the overall health system and lessening the dependence on medical schemes is also central to this objective. If NHI is not capable of reducing the inequities of the health system and enhancing access to health care services then it might not meet the standards required by the Constitution. In this thesis, I consider the positive constitutional rights impacting on these issues as well as the obligations on the state to satisfy these rights.

However, in achieving these objectives, adverse effects might be caused to current beneficiaries of the private health system. This may be so because private hospitals will become more accessible to many newly insured NHI beneficiaries who were unable to access them in the past. As a result, private hospitals may impose more need-based rationing to manage longer queues, waiting lists and a greater demand for expensive procedures. Additionally, a single NHI risk pool for the benefit of the entire population will likely require

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[11] Ibid, section 7(1).

[12] D McIntyre 'National Health Insurance: Providing a Vocabulary for Public Engagement' (2010) *SA Health Rev* 145, 146 fn a; See also D McIntyre & A van den Heever 'Social or National Health Insurance' (2007) *SA Health Rev* 71, 73.

more risk sharing than currently practised by medical schemes because of the inclusion of poor persons in the risk pool. Moreover, many people will effectively be forced to give up their medical scheme membership once mandatory contribution to NHI is phased in. The 'levelling down'[13] of access under NHI also implicates constitutional rights of private sector beneficiaries who already have access to health care services. Sometimes violations of these rights will be justifiable and on other occasions not. In this thesis, I attempt to ascertain the standards for assessing when levelling down is inconsistent with the Constitution.

In Part II of this chapter, I trace the emergence of private health care and financing in apartheid South Africa in order to appreciate the inequities of the health system bequeathed to the newly elected democratic government in 1994. In Part III, I deal with policy and legislative initiatives of the African National Congress ('ANC') and successive ANC ruled governments after 1994, relating to health care and health financing. In Part IV, I contrast arguments of the proponents and opponents of NHI as a way of representing the interests of different income groups. In Part V, I define the scope of this thesis and the contribution it aims to make to the continuing debate on health care reform, particularly in relation in NHI. In Part VI, I explain the broad outlines of the arguments adduced in the following chapters of this thesis.

## II. THE PRIVATISATION OF HEALTH CARE IN THE LATE APARTHEID ERA: THE RISE OF INDIVIDUAL RESPONSIBILITY

Prior to and including the early 1970's, the apartheid government viewed the provision of health care services, at least to white South Africans, as an obligation of the state. In line with this, the government was sceptical of the private sector and imposed regulatory control over its activities.[14] However, from the late 1970's onwards, the apartheid government adopted a policy of health care privatisation in South Africa. In doing so, it elevated the role of individual responsibility in accessing health care.[15] In other words, individuals were required to pay for the health services they received either out of pocket or through medical schemes.

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[13] D Parfit 'Equality and Priority' (1997) *Ratio* 202, 211.

[14] Price 'The Consequences of Health Service Privatisation for Equality and Equity in Health Care in South Africa' (note 1 above) 705.

[15] HCJ van Rensburg 'The History of Health Care in South Africa' in HCJ van Rensburg (ed) *Health and Health Care in South Africa* (2004) 87-8. See also R van Niekerk 'The Evolution of Health and Welfare Policies in South Africa: Inherited Institutions, Fiscal Restraint and the Deracialization of Social Policy in the Post-Apartheid Era' (2003) 88 *J of African American History* 361, 366-8.

This gave rise to a type of 'free market' in health care. One author refers to this as 'consumer driven health care'.[16] This policy initiative was marked by the enactment of the Health Act of 63 of 1977 ('Health Act'), which amalgamated health related legislation and repealed the Public Health Act 36 of 1919, which was the main legislation governing health care until then. Within the framework of the Health Act, as well as the Medical Schemes Act 63 of 1977, the government was able to drive the process of health care privatisation.[17]

The increase of individual responsibility for ensuring the payment of health care costs intensified inequalities between black and white people.[18] Since most South Africans could not afford to pay for private hospital services out of pocket, individuals (mostly white) turned to medical schemes to defray private health care costs. However, health service coverage was generally based on the amount of the contribution made to the scheme. Poor people (mostly black) who could not afford to pay premiums were therefore mostly excluded from medical scheme coverage and private health care.[19] In spite of these gross inequalities, the apartheid government continued to subsidise individual health care through tax subsidies for medical scheme members, which in turn bolstered the private sector and increased the divide between the public and private sectors.[20] Indeed, by putting emphasis on subsidising individual health care as opposed to subsidising health care institutions, individual responsibility continued to dominate health policy during the late apartheid era.[21]

In 1980, the apartheid government appointed a commission of inquiry into the country's health services, presided over by a former treasure-secretary Mr Gerald Browne. The final commission report published in 1986 found that there was not much to be gained by

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[16] TS Jost 'Consumer-Driven Health Care in South Africa: Lessons from Comparative Health Policy Studies' (2005) 1 *J of Health and Biomedical Law* 83.

[17] Van Rensburg (note 15 above) 87-8. There were regulations promulgated under the Health Act of 1977 entitled 'Regulations Governing Private Hospitals and Unattached Operating-Theatre Units' published in Government Gazette 6832 GN R158 (1 February 1980). These were the regulations governing the establishment of private hospitals. They were amended on three different occasions in 1980 (Government Gazette 6928 GN R696, 3 April 1980); 1990 (Government Gazette 12842 GN R2687, 16 November 1990) and 1993 (Government Gazette 14653; GN R434, 19 March 2003). These regulations remain in force today. See *Phodiclinics (PTY) Ltd v Pinehaven Private Hospital (PTY) Ltd* (594/10) [2011] ZASCA 163.

[18] Price 'Health Care Beyond Apartheid' (note 8 above) 10, 18-9; Van Niekerk (note 15 above) 366-8.

[19] See N Söderlund, G Schierhout & A van den Heever 'Private Health Care in South Africa - Technical Report to Chapter 13 of the 1998 SA Health Review' <http://www.hst.org.za/sites/default/files/private_98.pdf> 3; Seedat (note 1 above) 71-2.

[20] See McLeod (note 2 above) 139 para 3.2.5. and 159 para 7.2.1. See also Söderlund ibid 16. These tax subisidies remain in force today. See JC Heunis 'Hospitals and health reform in South Africa' in HCJ van Rensburg (ed) in *Health and Health Care in South Africa* (2004) 484.

[21] Van Rensburg (note 15 above) 96.

the general population from the extensive privatisation of health care.[22] Despite this, the final report recommended increasing privatisation of health care, by encouraging the establishment of private for-profit hospitals operating with business principles as well as the privatisation of some public hospitals.[23] It was clear that the report failed to adequately address the impact that a large private sector would have on the equity of the health system in general.

The 'White Paper on the Report of the Commission of Inquiry into Health Services 1986 ('1986 White Paper') contained the state's responses to the Commission Report. In the 1986 White Paper, the desirability of privatisation was evidenced by the fact that government saw privatisation as being central to reducing state responsibility for health care. For example, the Commission recommended that employers, in consultation with medical scheme administrators, should be free to decide the extent of coverage given to employees. The government rejected this and held that minimum benefits had to be prescribed, 'otherwise those members who do not have minimum cover would simply turn to the state for assistance.'[24] The point of having prescribed minimum benefits was primarily to keep patients out of the public system, where the state would have to be responsible for their health care. Similarly, the reliance on medical schemes to subsidise individual health care effectively meant that health care users would bear the primary responsibility for ensuring their own access because the state wanted to relieve itself of that burden.

In another recommendation, the Commission advised that in mixed-race schemes, the premiums of non-white members should be less than those charged to white members because non-whites generally made fewer claims. The government rejected this proposition and held, rather ironically, that differential pricing of premiums based on race violated the principle of non-discrimination.[25] Had this recommendation been accepted, it would have been easier for black people to become members of medical schemes thus giving them access to private hospitals. Therefore, not only was government trying to avoid responsibility for the health care needs of black persons through the policy of separate development and the homelands policy, it also made it difficult for black persons, who were substantially poorer than white persons, to have medical scheme membership. Nevertheless, medical schemes

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[22] Commission of Inquiry into Health Services Final Report (1986) cited in Naylor (note 1 above) 1162. Naylor cites 32-3 of the Report

[23] See Van Rensburg (note 15 above) 90-1 referring to the Commission of Inquiry into Health Services Final Report.

[24] 'White Paper on the report of the Commission of Inquiry into Health Services (The Browne Report)' (1986) Government Printer 33 para 7.6.1, 7.6.2.1.

[25] Ibid 34 paras 7.9.1.1 and 7.9.2.1.

were very popular amongst upper income white South Africans, since schemes enabled access to private hospitals for those who could not afford to pay for services out of pocket.

There is a further aspect of the 1986 White Paper deserving mention, which highlights the difficulties of policies that prioritise individual responsibility. The Commission recommended that private hospitals set their own tariffs. The government seemed to agree and held the view that private hospitals must fix and publish their own tariffs.[26] This implied minimal regulatory control and oversight over the pricing of essential treatments in private hospitals. This resulted in the relatively unhindered escalation of costs in the private sector, which had a detrimental impact on access to health care, especially for poor and black persons. However, in spite of these problems and the inability of many to benefit from private health care and medical schemes, the private health care industry grew, attracting to it a scarce supply of human, technological and financial resources.

Private hospitals multiplied in the 1980s, with the number of private hospital beds doubling between 1988 and 1993.[27] Benatar described the emergence of the private sector during the 1980s and 1990s as a 'large uncontrolled entrepreneurial industry with no public accountability.'[28] Private hospitals were also open to all races at the time and services were provided in a non-segregated environment.[29] However, as van Rensburg points out, the more sinister motive behind health care privatisation was to differentiate between users on the basis of purchasing power as opposed to race.[30] In other words, government policy was to retain a generally segregated health system by masking race discrimination as an affordability barrier, thereby preventing black persons, who were mostly poor, from being integrated into the mainstream health system.

Despite having the face of a racially neutral policy with mixed race wards, private hospitals were strategically placed in urban white suburbs that were geographically and financially inaccessible to the majority of black South Africans.[31] Moreover, in spite of an increase in utilisation of private hospitals by black persons from urban areas who could

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[26] Ibid 40 paras 9.6.1.a and 9.6.2.a.

[27] Coovadia (note 1 above) 826.

[28] Benatar (note 1 above) 891.

[29] See Price 'The Consequences of Health Care Privatisation' (note 1 above) 703.

[30] Van Rensburg (note 15 above) 95.

[31] See Seedat (note 1 above) 63-64 and 71-72; Naylor (note 1 above) 1158; Van Rensburg (note 15 above) 90.

afford such care, the majority of black persons could not.[32] Therefore private health care and financing entrenched the racial divisions of health care utilisation in South Africa because of geographical and income inequities between white and non-white South Africans.

Additionally, public hospitals continued to practice racial segregation, with white parts of public hospitals receiving the lion's share of state resources.[33] Although segregation in public hospitals was abolished in 1989 and 1990, income inequalities amongst different sectors of South Africans and the private-public sector divide reflected the inequalities of the past.[34] These inequalities were manifested in the under-performance of the public sector relative to available resources and restricted access to the private sector.[35] Indeed, an increasing number of poor persons were dumped on the public sector by private hospitals and medical schemes, both toward the end of apartheid and after 1994.[36] Thus public hospitals and health care centres became inundated with patients requiring primary health care services, emergency health care and expensive secondary and tertiary procedures.[37] The demand for health care services in the public sector exceeded the limited ability of the sector to supply adequate health care. Patients presenting themselves at private hospital emergency wards were sent off to public hospitals for treatment after their condition had stabilised. At the same time, public hospitals became increasingly beleaguered with maladministration, rude staff, bad working conditions, resource scarcity issues and long queues at emergency wards.[38] Moreover, less money from medical schemes and private individuals flowed into the public system beyond general income tax revenue, because members of medical schemes and those who could pay for services out of pocket predominantly chose to access health care

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[32] See Price 'The Consequences of Health Service Privatisation' (note 1 above) 703.

[33] See Seedat (note 1 above) 64-5.

[34] See *Inquiry Into the Various Social Security Aspects of the South African Health System: Based on the Health Subcommittee Findings of the Committee of Inquiry into a Comprehensive System of Social Security* (14 May 2002) <http://www.integratedhealingmbs.com/#/historic-nhi-resources/4522627788> 10.

[35] See DE McIntyre & JE Doherty 'Health Care Financing and Expenditure: Progress Since 1994 and Remaining Challenges' in HCJ van Rensburg (ed) in *Health and Health Care in South Africa* (2004) 378-9.

[36] C Botha 'Introducion' in C Botha & M Hendricks *Financing South Africa's National Health System through National Health Insurance* (2008) xiii; J Doherty & H McLeod 'Medical Schemes' (2002) *SA Health Review* 41, 42; 55; Y Pillay, N Marawa & P Proudlock 'Health Legislation' (2002) *SA Health Rev* 3, 26; M Price 'The Consequences of Health Service Privatisation' (note 1 above) 703, 707.

[37] See C Bateman 'Crowded Wards, Lousy Admin Contribute to Death and Suffering' (2010) 100 *SA Medical J* 414-8.

[38] R Burger 'How Pro-poor is the South African Health System' *Stellenbosch Economic Working Papers: 06/07* <www.ekon.sun.ac.za/wpapers/2007/wp062007/wp-06-2007.pdf> 11 cited by S van der Berg (note 6 above) 24. See also TC Cimona-Malua 'Waiting time of patients who present at Emergency department of Saint Rita's Hospital, Limpopo Province, South Africa' (2010) University of Limpopo <http://ul.netd.ac.za/bitstream/10386/539/1/Part-2-Dissertation-Dr%20Cimona-Final.pdf>.

services within the private sector.[39] This increasing demand for private health care by more affluent sectors of society, coupled with better working conditions existing within the private sector lead many public sector medical practitioners to establish practices within the private sector.[40]

As a result of this, the South African health system continued to be divided between a generally well-resourced private sector for more affluent sectors of society and an over-burdened public sector for the poor. Private for-profit hospitals and medical schemes continued to control the lion's share of health resources in South Africa to the detriment of the public sector and the majority of the population. In addition, the state exercised minimal regulatory oversight and control over pricing and geographical distribution of private health care services. This state of affairs had adverse implications for the equity of the health system.

## III. THE TRANSFORMATION OF THE HEALTH SYSTEM POST-1994 AND THE RISE OF STATE RESPONSIBILITY

The divide between the private and public sectors as it existed at the time of the transition to democracy was both unsustainable and untenable. Radical transformation of the health system was necessary and inevitable. The status quo was inconsistent with international human rights norms, including the right to the highest attainable standard of health protected under Article 12 of the ICESCR. In addition to this, the inequity of the divide was to become inconsistent with rights and values of the 1996 Constitution, once promulgated. Transformation of the health system meant that it had to become more responsive to the needs of the majority of the population. Resources had to be redistributed from the private sector to the public sector, while the private sector was required to play a greater role in the financing and delivery of health care.

For these reasons, immediately upon assuming power in 1994, the ANC government sought to transform the health system by progressively unifying the private and public sectors into a national health system or NHS. The evolution of health policy eventually culminated in the National Health Insurance proposal, which became the official position of the

[39] See Van der Berg (note 6 above) 24-5.

[40] HCJ van Rensburg 'The Health Professions and Human Resources for Health – Status, Trends and Core Issues' in HCJ van Rensburg (ed) *Health and Health Care in South Africa* (2004) 351-2; 354-67 (See specifically at 365-6 in portion entitled 'Work Ethos, Morale and Productivity').

government. The NHI policy was proposed by the ANC and the government on a number of occasions, but most recently in the ANC National General Council Discussion Document on National Health Insurance and the National Health Insurance Green Paper.[41] This policy evolution took place within the context of the reform of the legislative framework of the health system with the promulgation of the National Health Act 61 of 2003 ('NHA') and the Medical Schemes Act 131 of 1998 ('MSA'). In this section, I describe various government documents published since 1994 showing the progression of health system policy. I also detail relevant aspects of the NHA and MSA to the extent that this has relevance to NHI and health system policy reform.

### (a) ANC National Health Plan, 1994

Upon taking power in 1994, the ANC published a policy document entitled 'National Health Plan for South Africa' ('ANC Health Plan / Plan'). Unlike the Health Plan of 1986, the ANC Health Plan promoted communal values and state responsibility with a particular focus on vulnerable groups. Its central aim was the creation of a single national health system ('NHS') integrating both private and public sectors. It was clear that the ANC intended to transform all constituent parts of the health sector so that it would function in an integrated and coordinated manner. Central to this was the identification of government as a 'provider' of health care services, as opposed to a bystander which left the health care market to operate unhindered. Fundamental to this new health policy was that access to health care services was regarded as a right rather than as a privilege that depended on one's ability to pay for such services.[42]

In order to achieve these objectives, the ANC Health Plan contained many recommendations relating to different features of health care delivery. Amongst these were policy preferences pertaining to the relationship between the public and private sectors and general health financing. Specifically, the Plan indicated that the private sector would not be subsidised by the state and that alternatives to the fee-for-service paradigm for private health care establishments would be considered. The purpose of this was to ease the incentive of

[41] 'ANC National General Council 2010 – Additional Discussion Documents – National Health Insurance' (2010) <http://www.anc.org.za/docs/discus/2010/aditionalo.pdf>. The Green Paper is entitled *National Health Insurance in South Africa – Policy Paper* (12 August 2011) <http://www.info.gov.za/view/DownloadFileAction?id=148470>.

[42] 'A National Health Plan for South Africa' (May 1994) <http://www.anc.org.za/show.php?id=257> chapter 1 under headings 'Priorities' and 'National Health System'.

private health care practitioners to over-service in order to maximise profit. Similarly, conflicts of interest giving rise to over and under-servicing, where the financial interest of a practitioner or health institution is elevated above patients' interests, would be minimised. In keeping with its apprehension regarding profit motives, the Plan also indicated that it would be impermissible for medical practitioners to own shares in private hospitals and clinics.[43]

The recommendations of the ANC Health Plan on health financing were far-reaching and have served as a general basis for health reform since then. Recognising the impediment of the fee-for-service paradigm prevailing principally in the private health sector, the Plan indicated the ANC's commitment to 'the provision of free health care at the point of service for all citizens of South Africa.' However, patients who were members of medical schemes were not to be afforded this right. Indeed, the aim of 'free health care at the point of service' is the basis for the Plan's postulation of a National Health Insurance. In this regard, the Plan recommended the appointment of a commission of inquiry to examine the 'crisis in the medical aid sector' and to investigate the economic workability of an NHI in South Africa. The Plan envisioned that the commission would conduct planning to enable implementation of an NHI.[44]

The essential character of the future NHI was not certain. The Plan suggested various possibilities including that the state, a parastatal or private parties might be given the responsibility of running NHI. Additionally, it also considered the possibility that medical schemes could become the conduits through which financing would pass from the citizenry to a central fund. The Plan seemed to accept the latter as the most likely scenario, given the framework that would inform the work of the commission of inquiry. In terms of this framework, the Plan proposed that all formally employed persons and their dependants be required to become members of NHI accredited medical schemes. There would be open enrolment of all persons regardless of pre-existing health conditions. The NHI would be financed by contributions determined by the extent of one's income. These contributions would be channelled to what essentially is a central risk equalisation fund that facilitates risk sharing between medical schemes. Moreover, medical schemes would be free to offer supplementary cover for treatments or conditions not covered in the basic package. All this

[43] Ibid chapter 5 under headings 'Health Care Financing' and 'Sources of Finance' and chapter 4 under heading 'Private Facilities and Institutions'.

[44] See ibid chapter 5 under headings 'Health Care Financing' and 'A National Health Insurance'.

was the first step in a process culminating in universal coverage of all citizens regardless of employment and income status.[45]

The guiding principles of the future NHS considered in the ANC Health Plan demonstrated a social solidarity-based approach to health reform. The Plan endorsed principles that better protected individual interests when considered within a communal context. It did this by recognising the necessity for redistribution and the sharing of health care resources in a more equitable way. Indeed, inherent to the Health Plan was a recognition that the health system at the time of the transition to democracy was wholly unsustainable, because vulnerable persons had difficulty accessing health care services. As a result, the ANC pointed to the state as the only entity capable of facilitating access for all persons, as long as the state was the primary coordinator of all aspects of the health care system.[46]

### (b) The White Paper for the Transformation of the Health System, 1997

The White Paper for the Transformation of the Health System of 1997 ('White Paper') was the first comprehensive health policy document of the newly elected ANC government. It was the first health policy document published after the commencement of the 1996 Constitution and its codification of a justiciable health right in section 27. The White Paper is to be understood as a general continuity of the solidarity-based principles articulated in the ANC Health Plan. The White Paper recognised the inadequacy of access to health care by the majority of the population. It reiterated the policy of a unified health system based on the principles of universal accessibility of primary health care services at the 'first point of contact', with a special emphasis on vulnerable persons. Central to this was the promotion of equity between the private and public health sectors and improving access to health care services in rural areas. To coordinate and manage the delivery of health care, the White Paper indicated that the respective departments of health should be restructured into national, provincial and district levels of government. All levels would prioritise the delivery of primary health care services. The White Paper also called for the integration of private health care practitioners into the public system.[47]

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[45] Ibid chapter 5 under heading 'A National Health Insurance'.

[46] Ibid under heading 'Executive Summary'.

[47] 'White Paper for the Transformation of the Health System in South Africa' (1997) <www.info.gov.za/whitepapers/1997/health.htm>, chapter 1 paras 1.1, 1.1.2.b and 1.1.2.c, chapter 2 paras 1 and 2.4.(a). Quote at introduction to chapter 1 at point (e).

In order to achieve the goal of a unified NHS, the White Paper acknowledged the need for redistribution of public health resources in the public sector from better-resourced hospitals to lesser-resourced ones. This is in addition to redistributing resources from the private sector to the public sector. The White Paper's endorsement of the prioritisation of primary and preventive health care as part of this redistribution meant that high technology and curative health care demanded by middle class persons could be lessened. In the light of this, it envisioned the opposition of middle class persons when the redistribution 'begins to bite.' Similar opposition would invariably surface against the proposed regulation of the private sector. Such regulation would take the form of 'controlling prices, quantity, distribution and location of private sector [hospitals]' and the regulation of the quality of services.[48]

In the context of health financing, the White Paper recommended the adoption of a *social* health insurance ('SHI'). This meant that all formally employed people and their families would be required to have health insurance for services performed in public hospitals. There was no suggestion of a single-payer national health insurance administered by the state, nor was there any statement that an SHI would eventually lead to the establishment of an NHI covering all people including the unemployed. Indeed, SHI was intended to deal with problems in the medical schemes environment, such as requiring high income and healthy people to join medical schemes. The problem was that persons who could afford to become members of medical schemes did not do so and therefore turned to state hospitals for health care services. The second problem was that medical scheme benefits would dry up as health care costs of members exceeded the amounts that schemes were willing to cover. This caused members of medical schemes to become reliant on the state. An SHI system would solve these problems by requiring people to subscribe to medical scheme policies that covered public sector health care.[49]

Regardless of the differences between the ANC Health Plan and the White Paper, there was consistency in the general position that there had to be significant transformation in the health sector. This meant that the inequities of the divide between the public and private

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[48] Ibid chapter 3 paras 3.3, chapter 2, para 2.4.

[49] Ibid chapter 3 paras 3.3, 3.5.2, 3.10.5, Van den Heever and McIntyre explain SHI as a system where 'only certain groups are legally required to become members and where only those who make insurance contributions are entitled to benefit from, or are covered by, the insurance scheme' See Van den Heever & McIntyre (note 12 above). See also H McLeod 'Glossary of Health Care Financing Terms – Innovative Medicines South Africa – National Health Insurance Brief Series' (2009) <http://www.imsa.org.za/download/nhi_policy_briefs/NHI%20Policy%20Brief%20Glossary/IMSA%20NHI%20Glossary%20vF4%2027%20October%202009.pdf> 4.

sector had to be reduced so that more people, especially those disadvantaged by past discrimination, could access health care. None of this could happen unless national framework legislation pertaining to medical schemes and the provision of health care services was enacted. I now consider two primary pieces of legislation, namely the Medical Schemes Act 131 of 1998 and the National Health Act 61 of 2003. The former is the main legislation governing medical schemes and the latter is the framework statute for the provision of health care.

### (c) Medical Schemes Act, 1998

Medical schemes are the primary financing vehicles of the private sector. For this reason, the first democratically elected government was required to make far-reaching changes to legislation governing medical schemes. This was necessary to reduce the inequities of the divide between the private and public health sectors. In this regard, the government enacted the Medical Schemes Act, 1998, which repealed the Medical Schemes Act, 1967.[50] Currently, all medical schemes in South Africa operate in terms of the 1998 Act as amended and its accompanying regulations. The overarching purpose of the Act is to make medical schemes more responsive to the needs of their members and also to make the schemes' general contribution to health financing more equitable.[51] To this end, the government wanted to modify the behaviour of medical schemes toward their members and applicants, by enforcing risk management requirements that made schemes more efficient, affordable, equitable and beneficial, but that also did not threaten the stability of the risk pool.[52]

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[50] See Medical Schemes Act schedule 1.

[51] The preamble of the Medical Schemes Act provides that one of its purposes is 'to protect the interests of members of medical schemes'

[52] In order to understand medical scheme reform brought about by the Medical Schemes Act of 1998 it is necessary to briefly categorise insurance into two different forms, namely 'mutuality' and 'solidarity'. When premiums are paid to a common risk pool by applicants for insurance and the amount owing is calculated according to individual risk at the time of the application – this is referred to as 'mutuality'. In other words, individuals pay according to the level of risk that they bring to the overall stability of the risk pool at the time of application. In the health insurance context, sick persons will pay more than healthy persons because sick persons are more likely to need health care finance. An insurance system based on 'solidarity' is one where the liability of the insurer is based on the needs of the insured, and the extent of the liability of an individual to contribute to the risk pool is not based on individual risk but the risk posed by the general community (community rating). Suffice it to say that the Medical Schemes Act is based on solidarity principles because it obliges medical schemes to apply community rating and open enrolment to applicants and members of medical schemes. The explanation given here on mutuality and solidarity is based on a lecture given by David Wilkie to the Royal Society in 1996. The text of the lecture can be found at D Wilkie 'Mutuality and Solidarity: Assessing Risk and Sharing Losses' (1997) 352 *Philosophical Transactions: Biological Sciences* 1039, 1042. The

Government wanted to reduce cream skimming[53] and adverse selection[54] activities that were deliberately designed to exclude or prevent the elderly and the sick from joining medical schemes.

The essential characteristics of the 1998 Act and its amendments are the introduction of open enrolment, community-rating, and prescribed minimum benefits.[55] Each of these is dealt with in turn:

Firstly, assuming that applicants for health insurance can afford to pay the premium for their choice of cover, there is guaranteed acceptance of all applications. This is known as open enrolment.[56] Section 29(3)(a) of the Medical Schemes Act prohibits an open medical

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discussion here regarding Wilkie's classifications of insurance is based on an article by Heather McLeod in McLeod (note 2 above) 135-6.

[53] D Pearmain 'Impact of Changes to the Medical Schemes Act' (2000) *SA Health Rev* 183, 184. Pearmain explains that 'schemes designed their benefit structures so as to attract the young and healthy and in some cases actively discouraged membership by high-risk individuals through contribution loadings on the basis of risk profile'. See M Tshabalala-Msimang 'Health within a Comprehensive System of Social Security' in C Botha & M Hendricks *Financing South Africa's National Health System through National Health Insurance* (2008) 11 where the former South African National Health Minister states 'Cream skimming or risk selection occurs through the manner in which medical schemes design their benefit packages, which may be attractive to young and healthy people. This undesirable business practice results in risk splitting, weakening of risk pools and further undermining risk-related cross-subsidies from low-risk to high risk individuals.'

[54] See P Siegelman 'Adverse Selection in Insurance Markets: An Exaggerated Threat' (2004) 113 *Yale LJ* 1223 where the author explains that adverse selection in relation to life insurance occurs when applicants hide private knowledge from the insurer in order to become liable to pay a premium that is not associated with his *actual* risk. However, in health insurance markets, the term denotes the practice of buying medical insurance, which is advantageous to the insured and not the insurer that is when healthy people enrol for cheaper options. This undermines cross subsidisation for sick people. See McIntyre & Van den Heever (note 12 above) 73 where the authors explain that adverse selection occurs when those with higher risk of succumbing to illness are more likely to join a medical scheme than relatively healthy and younger individuals. To avert the adverse affects of this to the risk pool, insurers try to attract healthier individuals to join their medical schemes and, if permitted, would also exclude those with the greatest need from becoming members.

[55] See Doherty & McLeod 'Medical Schemes' (note 36 above) 42-3.

[56] See ibid 42. Prior to the promulgation of the Medical Schemes Act of 1998, medical schemes were not barred from prescribing far-reaching conditions governing the admission of new members. Section 19(f) of the Medical Schemes Amendment Act 23 of 1993 did not qualify the conditions that schemes could impose on the admission criteria of new applicants. It provided simply

> '(20) No Medical Scheme shall be registered… and no registered scheme shall carry on any business unless provision is made in the rules
>
> …
>
> (a) for the terms and conditions applicable to the admission of members and dependants of members'

Section 20(f) of the Medical Schemes Act 72 of 1967 in its original form provided for open enrolment. It stated:

> '(20) No medical scheme shall be registered under section 15 unless provision is made in the rules
>
> …
>
> (f) for the admission to the scheme as a member thereof, subject to the terms and conditions applicable to the admission of other members, but without a waiting period or the imposition of new restrictions on account of the State of his health or the health of any of his dependants…'

scheme[57] from enacting rules which exclude any applicant or dependant from becoming a member of a scheme. Section 29(3)(b) prohibits a restricted scheme from excluding applicants or their dependants on the basis of risk and who otherwise qualify for membership.[58] However, medical schemes could impose certain waiting periods on persons who have not been members of a medical scheme for up to 90 days.[59] In this regard, such members would not be entitled to claim benefits for the first three months of membership and claim benefits for a pre-existing condition for a period of 12 months.[60] The purpose of these waiting periods is to discourage people from only joining medical schemes once they become sick and terminating membership once the health condition has been successfully treated.

Secondly, the legislature introduced community risk rating, as opposed to individual risk rating, so that those who present a greater personal risk of death, disease or injury are not overburdened with excessive premium payments.[61] In terms of section 29(1)(n) of the Act,

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For academic and industrial commentary see Review performed by the Department of Health and the Health task group of the Committee of Inquiry into Comprehensive System of Social Security (note 34 above) 26, 144 and McLeod 'Mutuality and Solidarity' (note 2 above) 144; See also Doherty & McLeod (note 36 above) 41-2 and Pearmain (note 53 above) 184.

[57] An open scheme is one open to all members of the public.

[58] A restricted scheme is one that is not open to the general public. For example there can be a restricted scheme that is only open to professionals or people who work for a specific company.

[59] See Medical Schemes Act 1998 section 29A(1).

[60] Ibid section 29A(1)(b)

[61] The Medical Schemes Amendment Act 383 of 1993 allowed for individual risk rating in the following terms:

> '(20) No medical scheme shall be registered under section 15 unless provision is made in the rules
> …
> (b) for the minimum and maximum benefits to which its members and their dependants and, *if applicable, different categories of such members or dependants are entitled* (my emphasis).
>
> (bA) for the payment of such benefits according to—
> (i) a scale; or
> (ii) specific directives
> set out in the rules
> (bB) if any membership fee is payable, the amount thereof of the basis on which it is to be calculated.'

Sections 20(c)(bA) and (bB) were inserted whilst section 20(b) was substituted. Section 20(b) of the Medical Schemes Act of 1967 stated:

> '(20) No medical scheme shall be registered under section 15 unless provision is made in the rules
> …
> (b) that its members are entitled to such minimum benefits as may from time to time be prescribed.'

the rules of a scheme must include enrolment terms and conditions, in terms of which member contributions can be determined by income and the number of dependants. However, the conditions of admission as a member of a scheme and the factors that are considered in determining premiums may not include 'any other grounds, including age, sex, past or present state of health, of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependants other than for the provisions as prescribed.'[62] Therefore, in terms of this provision, old persons, unhealthy persons and frequent users of health care services may not be charged different rates to young, healthy and infrequent users of health care services.

Thirdly, every option or plan, even the lowest cover plan, offered to applicants and members of medical schemes must comprise a set list of 'prescribed minimum benefits' otherwise abbreviated as PMBs.[63] PMBs are provided for in section 29(1)(o) of the Act. This provision prescribes that the rules of medical schemes must provide for '[t]he scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed.' Section 8 of the regulations promulgated under the Act, provides that for any option, medical schemes must pay for the diagnosis, treatment and care costs of PMBs in full, without co-payment or the use of deductibles.[64] This allows for medical schemes, in terms of some options, to mandate members to access a PMB service at designated health care providers.[65] The purposes of the PMB requirement are twofold: First, it ensures that members of schemes are afforded a substantial range of benefits regardless of the option chosen; secondly it ensures that schemes do not avoid coverage of certain debilitating conditions in order to maximise profit; and thirdly, it is aimed at preventing the private sector from referring patients to the public sector.[66]

Despite these beneficial amendments to the Medical Schemes Act, the medical scheme industry cannot provide health financing on a universal basis because poor persons

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[62] Medical Schemes Act, section 29(1)(n).

[63] See Pearmain (note 53 above) 184.

[64] Regulations in terms of the Medical Schemes Act GG 20556, GN R1262, GN R 6652 (20 October 1999).

[65] See ibid sections 8(2)(a) & (b).

[66] See D Chida 'Outpatient perception of service quality and its impact on satisfaction at Gauteng Public Hospitals' unpublished masters thesis (1 December 2008), University of South Africa, 2. See also McIntyre & Douherty 'Health care Financing and Expenditure' (note 35 above) 404.

cannot afford the required premiums.[67] Therefore, these persons, who constitute most of South Africa's residents, remained unable to access health care available in the private sector, making them reliant on an overburdened public sector struggling with human, technological and financial resource shortages as well as inefficient administrative governance.

**(d) National Health Act, 2003**

The second primary piece of legislation central to this thesis is the National Health Act ('NHA'). This is the framework legislation for the provision of health care and the structures that need to be in place for access to health care services, as envisioned by the Constitution, to be possible. The NHA replaced the Health Act 63 of 1977.[68] The NHA was enacted pursuant to the government's obligations in terms of sections 7(2) and 27(2) of the Constitution.[69] The preamble of the NHA states that the purposes of the NHA are, amongst other things, to promote and improve the health system by uniting the NHS; to provide for 'cooperative governance' and 'management' of health care services according to 'national guidelines, norms and standards'; to create a health system according to the principles of equity, efficiency, sound governance and participation; and to promote the 'spirit of co-operation and shared responsibility among public and private health professionals and providers'. These concepts are echoed in the objectives of the NHA, where it is stated that the NHS comprises public and private health service providers and that the NHS must provide the best possible health care services in an equitable manner and within available resources.[70]

It is clear from the NHA's preamble and objectives that it is designed to transform the health system by giving the state primary responsibility for ensuring access to health care services for all residents of South Africa. Indeed, the National Minister of Health ('Minister') and the National Department of Health ('Department') are tasked with the implementation of health policy and ensuring the provision of essential health services.[71] Unlike the fragmented

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[67] There was a report published inquiring into the feasibility of low-income medical schemes entitled 'Consultative Investigation into Low Income Medical Schemes' <http://www.medicalschemes.com/publications/ZipPublications/Low%20Income%20Medical%20Scheme%20Publications/LIMS%20Final%20Report%20Draft%2028-2-06.doc>. These recommendations have not been adopted by government.

[68] Despite this, some provisions of the Health Act of 1977 still remain in operation. See NHA (note… above), section 94.

[69] Sections 7(2) and 27(2) of the Constitution. See Annexure A of this thesis.

[70] NHA preamble section 2.

[71] See ibid chapter 3 and specifically section 3 of the NHA on the Minister's duties.

management of health services under apartheid, the NHA allocated clear responsibilities to the national, provincial and local governments.[72]

Although the NHA does not deal with health financing directly or indicate mechanisms for unifying the divide between the private and public sectors, it contains detailed provisions aimed at enhancing the equity of the health system. For example, section 4 of the NHA provides for mechanisms that allow vulnerable persons free access to public health centres. Pursuant to this, public health establishments must provide free health services to pregnant and lactating women, children under six years of age, all persons who are not members of medical schemes, and women requiring or requesting legal abortions. Section 5 provides that health providers, workers and health establishments, be they public or private, may not refuse to provide emergency medical treatment as required by section 27(3) of the Constitution.[73]

In addition to these, there are other provisions, which have not yet been proclaimed, dealing with the power of the Minister to classify health establishments according to various criteria. These include the following: their role and function in the health system as a whole; the size of the populations they serve; their ability to provide health care services of a particular level and type; their location and the extent to which people have access to them and, in the case of private establishments, whether they are profit or non-profit establishments.[74] These classifications, once proclaimed, will enable the authorities to monitor the distribution of health care establishments in a more consistent way. Moreover, sections 36 to 40 of the NHA deal with the law pertaining to certificates of need, which are essentially licences to establish and operate health care centres and medical care practices. Once proclaimed, these provisions will prevent an over-saturation of health care establishments and professionals in affluent areas at the expense of the poor and those who live in rural areas.[75]

Section 45 of the NHA is more specifically designed to bridge the divide between the public and private sectors. Once proclaimed by the President, section 45(1) empowers the Minister of Health to prescribe mechanisms enabling private and public health establishments

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[72] Ibid chapter 3 (national); chapter 4 (provincial) and chapter 5 (local).

[73] Ibid sections 4, 5. The Choice on Termination of Pregnancy Act 92 of 1996 regulates abortion in South Africa.

[74] See 'Policy on the Management of Public Hospitals' Government Gazette 35101 GN R 186 (2 March 2012). This notice details government policy on the management and classification of public hospitals amongst other issues.

[75] NHA, section 36(3)(b).

to have co-ordinated relationships for the delivery of health services. Section 45(2) empowers the national and provincial health departments as well as municipalities to enter into agreements with private health practitioners and establishments to facilitate access to health care. For example, the government may contract private industry actors to provide services. Despite not being in force, this section signifies a policy of integrating private and public health services in a manner suggesting mutual responsibility for the health of the population.

### (e) National Health Insurance Plan for South Africa, 2009

The National Health Insurance Plan for South Africa ('NHI Plan') is a comprehensive document, authored by the Task Team on National Health Insurance on behalf of the Health and Education Sub-Committee of the ANC, describing a future health system of South Africa. It recognised health system challenges including inequity of access between private and public health sectors; inadequate funding of heath care in the public sector; and insufficient access to medicines and health care practitioners in the public sector. The NHI Plan accused the private sector of operating well below its capacity threshold by failing to bear a proportional burden of overall demand for health care especially in relation to tuberculosis, and for absorbing the overall majority of skilled health care professionals away from the public sector. In dealing with these deficiencies, the NHI Plan proposed an overhaul of the system through the introduction of NHI.[76]

The NHI Plan explained the rationale for NHI as the improvement of cross subsidisation in the 'overall' health system by having a single 'integrated funding pool'.[77] It stated that a National Health Insurance Authority ('Authority') would be established with national, provincial and district offices. The Authority would receive funds collected from

[76] National Health Insurance Plan for South Africa (16 February 2009) <http://wlstorage.net/file/za-anc-health-plan-2009.pdf>17-26 paras 1.4.1-1.4.2. The copy I obtained was marked 'Confidential and not for Distribution'. Unlike other government documents, this one was leaked and so is not an authoritative source of government or ANC policy.

[77] Ibid 28 para 2.1. At 52 para 3.1. the NHI Plan defines the process of pooling as 'the accumulation and management of the revenue with the purpose of ensuring that the risk of having to pay for health is collectively shared by all in the pool and not by an individual.' At 55 para 3.3.1. the NHI Plan explains the purposes of having a single risk pool in the following terms: A single fund would ensure that proper income and risk subsidisation of the health system takes place. It would enable the NHI Authority to negotiate standards and costs of care with both public and private health care providers from a strong position of bargaining power. This, in theory, will reduce prices of health care and promote geographical equity. A single fund would also enable cost-effective health financing. In addition to these, the plan explains that a single risk pool for the entire population creates '*maximum redistribution of income/financial burden*' (emphasis in original) between rich and poor and low and high-income areas. Moreover, economies of scale would be improved allowing the maximisation of benefits.

mandatory health taxes and general tax revenue that will then be placed in a common risk pool. Using the funds, the Authority would purchase health care on behalf of the population.[78] In doing so, the Authority would be required to promote the optimal usage of financial resources when drawing from tax revenue and mandatory contributions. The NHI Plan required the Authority to guarantee fairness in the collection and allocation of these resources and to adhere to the principle of fiduciary responsibility.[79]

The NHI Plan required the Authority to work towards ensuring that all South Africans and permanent residents have access to a comprehensive set of health care services. There would be equal entitlement of access despite the fact that each person's liability to contribute would be proportional to one's income. In this way, poor persons who do not contribute to the Authority at all would be entitled to receive the same benefits as wealthier persons. Ultimately then, the Authority would adhere to the principles of social solidarity where there is risk sharing between the wealthy and the poor, the healthy and the sick, and those in diverse geographic areas. In addition, the Authority would ensure that cost effective treatments are given to patients, without there being excessive expenditure that is not justified by the benefit received. In doing all this, the Authority would be well-placed to facilitate free access to health care services at the first point of contact with the health system without there being a need to turn away persons on account of their inability to pay. However all of this would be dependant on the ability of health care providers to be held accountable by the Authority so that the health system could be guided by the best interests of the patients.[80]

It appears that, according to the NHI Plan, private hospitals would continue to exist alongside public hospitals. Both private and public hospitals would be accredited to provide NHI funded services and would receive funding from provincial and district health authorities. Funds would be provided to these hospitals according to their relative needs, in order to avoid over-saturation of funds in some hospitals at the expense of others. Non-accredited public hospitals would also receive funding so that they can become accredited within a short space of time. The NHI would not be obliged to fund non-accredited private providers, nor would it be permitted for the NHI to enter into agreements with them.

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[78] Ibid 28 para 2.1 and 6, 52 paras 3.2.1 – 3.2.3.

[79] Ibid 33 para 2.2.3 and 46 para 2.4. See also ibid 59-60 para 4.5. I use the words 'equity' and 'fairness' interchangeably. At 86, the NHI Plan explains equity as meaning 'those with greater need for services should be accorded sufficient opportunity to ensure that they access and benefit from services as demanded by their needs and those with less need for services should actually benefit to that same extent.' For more on these two concepts see M Price 'Health Care Beyond Apartheid' (note 1 above) 51.

[80] Ibid 33-4 para 2.2.6 a-m.

Although such providers would be permitted to charge for their services and receive reimbursement from medical schemes, it appears that their proposed exclusion from playing any role under the NHI system was intended to incentivise them to meet accreditation criteria and join the NHI umbrella.[81] Ultimately then, the central purposes of NHI were to make the state the primary funding and provisioning entity for health care in South Africa, and also to integrate the private sector into a unitary health system.

### (f) ANC National General Council – Discussion Document on National Health Insurance, 2010

The next clear statement of policy on NHI to be issued was a discussion document attributed to the ANC General Council ('Discussion Document'). The Discussion Document sets a number of goals for NHI. These include: universal health insurance coverage for all persons regardless of employment status; equity and solidarity in risk pooling management; accelerated reform and improvement of the public health sector; better positioning of NHI as a purchaser when negotiating with private health care providers; a single NHI fund able to fund high cost care, primary health care and NHI research; and the promotion of effective care in the private and public sectors. Resources would be pooled in an 'NHI Fund', fulfilling similar functions to the NHI Authority proposed in the NHI Plan, by purchasing services on behalf of all residents of South Africa.[82]

The Discussion Document also had much to say about the nature of the health care system under the proposed NHI. First, NHI would focus on the delivery of primary health care, reversing the emphasis currently placed on tertiary and curative interventions. Secondly, there would be a role for the private sector in providing health care as private doctors and health care centres would be contracted to provide services. Thirdly, there would be coverage of a comprehensive package of services for all legal residents defined in terms of 'norms' instead of listed treatments.[83]

Despite the focus on primary health care, the Discussion Document stated that the comprehensive package of care would include primary, secondary and tertiary treatments. These services would include 'primary care and preventive services, inpatient care, outpatient

[81] Ibid 61-2 para 4.6.

[82] Discussion Document (note 41 above) 22 paras 68-9.

[83] Ibid 33-4 paras 119-26. 18 para 57.

care, emergency care, prescription drugs, appropriate technologies for diagnosis and treatment, rehabilitation, mental health services, the full scope of dental services, substance abuse treatment services, basic vision care and vision correction [and] hearing services...'. Thereafter, the Discussion Document stated that medically unnecessary care and expensive interventions with minimal impact on health would be excluded from coverage. Surprisingly though, in the context of transformation of health care delivery and the emphasis on primary health care, the Discussion Document affirmed that 'services offered to the public cannot be less than what they are currently receiving.'[84]

On the issue of financing, the Discussion Document pointed out that the requirement for co-payments and out-of-pocket payments for hospital services would be eliminated when accessing care. The Discussion Document also stated that medical schemes had become unaffordable for most South Africans and that contribution rates were increasing due to increasing expenditure. The Discussion Document contained two noteworthy points in this regard: first there would be mandatory membership for all South Africans to the NHI and mandatory contributions, while the public would be free to subscribe to voluntary medical schemes only after they had contributed to the NHI; and secondly, the general public wanted an alternative to medical schemes.[85]

The message of the Discussion Document was that the inequity of the divide between the private and public sectors is unsustainable. Too much was being spent by medical schemes per beneficiary and private hospital costs were continuing to rise. In addition, the imbalance of resources between the private sector and the public sector was contributing toward bad health outcomes for poor people. To alleviate this state of affairs, the Discussion Document stated that health system performance would be strengthened during the phasing-in of NHI, over a period of five years from the publication of the Discussion Document. These improvements would focus amongst other things, on the improvement of health care facilities and the improved staffing of the health system with doctors and nurses.[86] Indeed, enhancing overall health system performance under NHI will lessen the inequities of the divide between the public and private sectors.

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[84] Ibid 23-4 paras 74-8

[85] Ibid 12 paras 32-5 and 22-30 paras 93-109.

[86] Ibid 10, paras 21-4, 32-7 paras 114-48.

### (g) Green Paper on National Health Insurance, 2011

The most recent statement of NHI policy is the Green Paper on National Health Insurance ('Green Paper'), issued in late 2011.[87] I deal with the Green Paper in greater detail in chapter 5 of this thesis. Like previous policy documents, the Green Paper recognised the inequity of the public-private divide in South Africa. These inequities related principally to the poor state of the public sector and the high costs of care in the private sector. It also criticised the private sector for its focus on curative care, its hospital-centred orientation and its dependency on medical schemes.[88] The Green Paper proposed NHI as an alternative to the current two-tier system. The main features of NHI would be two-fold: First there would be a universal entitlement to membership of NHI regardless of the ability of a person to pay. Secondly, contributions to NHI, which would be mandatory, would be pooled into a single fund used to purchase health care for the entire population.[89] Unlike the current practices in the private sector, NHI would have a strong primary health care approach.[90] Although medical schemes would continue to exist, it appears that policy makers wanted to make them effectively redundant by offering substantial benefits under NHI.[91]

## IV. ACADEMIC, INDUSTRIAL AND POLITICAL RESPONSES TO THE PROPOSED NHI

Literature on health system reform in South Africa invariably recounts the entrenched and systemic inequalities of access to health services and resources.[92] For legal commentators, the degree of equity in access to health services serves as the point of reference when considering the extent of the state's obligations and the constitutionality of policies designed

[87] Green Paper (note 41 above).

[88] Ibid 5-6 (paras 10-6) and 9-10 (paras 22-3).

[89] Ibid 18 para 52.

[90] Ibid 23-4 paras 66-70.

[91] Ibid 40 para 126.

[92] See for example A Hassim, M Heywood & J Berger *Health & Democracy: A Guide to Human Rights, and Health Law and Policy in Post-Apartheid South Africa* (2007).

to enhance access to care.[93] Health policy specialists evaluate the desirability of NHI based on whether this policy will enhance or frustrate access to health care services.[94] If NHI is capable of increasing the number of people who have access to health care as well as the quality of services, then it would be consistent with the state's constitutional obligation to fulfil access to health care services on a progressive basis as required by section 27(2) read with section 7(2) of the Constitution. Conversely, if NHI undermines existing access by decreasing the number of people who have access to quality care then it would violate negative content of the right of access to health care services under section 27(1). I now consider various opposing positions on this issue.

Supporters of introducing an NHI financed by general tax revenue argue that it will transform the health system by bridging the divide between public and private health financing sectors, because NHI will have a common risk pool.[95] No person will be legally permitted to opt out of contributing toward NHI. These features will facilitate cross subsidisation between the rich and poor and between the healthy and the sick, as funds would be released from the risk pools of medical schemes to a single payer fund.[96] Additionally, health professionals who work in the public and private sectors will likely render more efficient services. In this regard, private sector doctors in accredited hospitals will treat a greater number of people, as patients will have access to health finance to pay for health services. Public sector doctors will also operate under conditions of lesser demand, as patient dumping from the private sector would occur less frequently. The authority that administers the NHI would likely phase-out over-servicing, as payment for services would be strictly controlled to avoid wastage of common financial reserves.[97] Moreover, there will be no

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[93] See for example C Ngwena 'The Recognition of Access to Health Care as a Human Right in South Africa: Is It Enough?' (2000) 5 *Health and Human Rights* 26 30; A Hassim 'National Health Insurance: Legal; and Civil Society Considerations' (2010) *SA Health Rev* 205.

[94] See for example A van den Heever 'A Financial Feasibility Review of NHI Proposals for South Africa' (2010) *SA Health Rev* 157; A van den Heever 'Evaluation on the Green Paper on National Health Insurance' (20 December 2011) <http://www.hsf.org.za/siteworkspace/gp-review-alexvdh-dec2011-vf-1.pdf>; McIntyre 'National Health Insurance: Providing Vocabulary For Public Engagement' (note 12 above) 145.

[95] See D McInytyre 'Why We Need NHI Now' *Health E-News* (17 June 2009) <http://www.health-e.org.za/news/article.php?uid=20032355>; O Shisana 'A National Health System: Opportunities and Challenges for South Africa' in C Botha & M Hendricks *Financing South Africa's National Health System through National Health Insurance* (2008) 4; O Shisana 'Shisana on NHI' *Health-E News* (30 June 2009) <http://www.health-e.org.za/news/article.php?uid=20032371>; T Phadu 'National Health Insurance – COSATU Position' Lecture delivered at AIDS Law Project Seminar (28 July 2008).

[96] O Shisana *Financing South Africa's National Health System* ibid.

[97] For an American perspective on controlling health care costs in the face of improving technology see P Kalb 'Controlling Health Care Costs by Controlling Technology: A Private Contractual Approach.' (1990) 99 *Yale LJ* 1109.

incentive for cream skimming and adverse selection, as there will be universal coverage.[98] In other words, since all residents of South Africa will be entitled to membership of NHI, the idea of avoiding coverage for those who pose a higher health risk will no longer be applicable. In the light of this, access to health care services will be increased and the inequity that currently characterises the health system will be progressively eliminated.

However, there are others who argue that NHI will negatively affect the provision of health care. Central to the argument of these commentators is that the problems with South Africa's health system are principally related to inadequate public health care services and not to inadequate funding. In the view of these commentators, NHI will not address the inadequacies of public health care institutions, which are by far the most preferred health care providers in South Africa. Therefore, they argue that health care reform measures must focus on improving the public sector, instead of allocating more money to it and reducing the capacity of the private sector to offer good quality services.[99]

The socially based argument against NHI is that South Africa cannot afford it, because poverty is too widespread and the tax-base is insufficient to finance cross-subsidisation between the rich, middle-income earners and the poor. Hence, it is argued that NHI could not produce a significant package of benefits that will be sufficient to reduce health disparities and the calamitous health outcomes of the majority of public sector dependants. Broomberg makes a further argument to the effect that, if South Africa had to increase the percentage of gross domestic product ('GDP') spent on health care from 3,5% to 5% and if all this was devoted to the health needs of the entire population, it would only provide a quarter of the benefits currently offered to the average member of a medical scheme.[100] If true, this would have two adverse effects: First, many persons who are currently members of medical schemes who become reliant on NHI funding either voluntarily or because they could not afford supplementary or alternative health insurance would be

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[98] See Tshabalala-Msimang (note 53 above) 11 where the author states 'Cream skimming or risk selection occurs through the manner in which medical schemes design their benefit packages, which may be attractive to young and healthy people. This undesirable business practice results in risk splitting, weakening of risk pools and further undermining risk-related cross-subsidies from low-risk to high risk individuals.'

[99] See for example J Broomberg 'Bring the NHI Debate into the Public Domain' <http://www.health-e.org.za/2009/06/02/discovery-bring-the-nhi-debate-into-the-public-domain/>; H Zille 'Zille Enters NHI Debate' *South African Health News Service* (18 June 2009) <http://www.health-e.org.za/news/easy_print.php?uid=20032357>; M Waters 'NHI Will Prove Disastrous for South Africa' (10 June 2009) <http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71619?oid=132732&sn=Detail>; A Van den Heever 'Insurance Funding Model Doesn't Fit Our Needs' *Cape Times* (9 June 2009) page unknown.

[100] J Broomberg 'Discovery-Bring the NHI Debate into the Public Domain' ibid.

covered for fewer conditions or given lesser treatment for the same conditions than that to which they currently have access. Secondly, those whom NHI is designed to benefit the most would not benefit substantially from it.

Opponents of NHI further tend to be concerned with a deterioration in access and quality of care for those who currently access health care exclusively in the private sector. These adverse effects could come in a number of forms, including the following: First, there may be longer waiting lists for secondary and tertiary services in private hospitals; secondly, longer queues at emergency treatment access points at private hospitals and primary health care facilities may become more common; thirdly, private hospitals may have less excess capacity; and fourthly, the level of secondary and tertiary care available in the private sector might be reduced due to the prominence given to primary health care. Adverse effects on privileged sectors of society are inevitable when implementing redistribution programmes such as NHI. It is thus imperative that these effects be minimised. In this sense, NHI must be able to achieve its objectives without substantially corroding the few positive features of the current health system.

## V. SCOPE AND CONTRIBUTION OF THIS THESIS

The introduction of NHI inevitably implicates constitutional rights and obligations. In this thesis, I analyse the content of relevant constitutional provisions pertaining to the state's duty to redistribute health care resources in order to enhance the equity of the health system and increase access to care. Invariably, these constitutional obligations involve the interpretation and enforcement of constitutional rights, especially the right to have access to health care services, the right to equality and not to be subjected to unfair discrimination, and the right to freedom and security of the person.[101] In analysing these provisions, I propose a constitutional framework for assessing whether NHI is consistent with the Constitution. I do this because health policy commentators fail to place their analyses within the context of adequately theorised conceptions of the relevant constitutional provisions as interpreted by

[101] See Annexure A. Although these are not the only rights implicated by the introduction of NHI, I focus exlusively on these because they clearly have application to issues of resource redistrubution in health care. Other rights, such as the right to choose one's trade, occupation and profession protected under section 22 of the Constitution and the right to lawful, reasonable and procedurally fair administrative action, are listed as areas for further study at the conclusion of this thesis.

the Constitutional Court[102] and in academia.[103] It is important that this be done because, if NHI is in some way inconsistent with the Constitution, its implementation will be forestalled by litigation concerning its constitutionality.

The authors who comment and criticise the Constitutional Court's jurisprudence on health care rights do not typically relate their commentaries to a particular regulatory context. This literature is vital for health policy makers, and other policy makers as well, to be able to properly plan and implement policy programmes in a constitutionally compliant manner. There is a need to bridge this disconnect by analysing health policy, particularly NHI policy, within a properly theorised understanding of the relevant constitutional provisions. It is this void that this thesis attempts to fill. This thesis is therefore not based on economics, actuarial science or health science. Its purpose is to inform judicial adjudication in matters pertaining to the constitutionality of NHI, as well as to guide policy makers in devising and implementing an NHI that is consistent with the Constitution. This analysis reveals that a balance must be struck between competing constitutional claims to health resources by various income groups under NHI. Wealthier groups might challenge the constitutionality of NHI on the basis that its redistributive characteristics may impair existing access to health care services.

In the light of this background, the framework developed in this thesis advances three general propositions: First, redistributive measures aimed at enhancing equality in health care, of which NHI is one example, are in principle required by the Constitution. Failure to implement such measures is generally inconsistent with government's obligations in terms of section 27(2) of the Constitution, and with its commitment to redressing the effects of past discrimination. Secondly, adverse effects generally, and in the context of NHI specifically,

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[102] *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC); *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC); *Minister of Health v Treatment Action Campaign No. 2*; 2002 (5) SA 721 (CC); *Khosa v Minister of Social Development* 2004 (6) SA 505 (CC); *Jaftha v Schoeman* 2005 (2) SA 140 (CC); *Mazibuko v City of Johannesburg* 2010 (4) SA 1 (CC); *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39* 2012 (2) SA 104 (CC).

[103] See for instance D Bilchitz 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-economic Rights Jurisprudence' (2003) 19 *SAJHR* 1; J Klaaren 'A Remedial Interpretation of the *Treatment Action Campaign* Decision' (2003) 19 *SAJHR* 455 / J Klaaren 'An Institutional Interpretation of Socio-Economic Rights and Judicial Remedies after *TAC*' in H Botha, A van der Walt & J van der Walt *Rights and Democracy in a Transformative Constitution* 105; D Bilchitz *Poverty and Fundamental Rights* 1st ed. (2007); S Liebenberg 'Interpretation of Socio-Economic Rights' in S Woolman & M Bishop (eds) (2nd ed. 2003) Chapter 33; M Pieterse 'Resuscitating Socio-Economic Rights: Constitutional Entitlements to Health Care Services' (2006) 22 *SAJHR* 473; M Pieterse 'Health Care Rights – Resources and Rationing' (2007) 124 *SALJ* 514; M Pieterse 'Indirect Horizontal Application of the Right to have Access to Health Care Services' (2007) 23 *SAJHR* 157; 13; P de Vos' '*Grootboom*, the Right of Access to Housing and Substantive Equality as Contextual Fairness' (2001) 17 *SAJHR* 258.

will not always infringe constitutional rights. However, where they do so, these infringements will often be justifiable in terms of section 36 of the Constitution. This is so because measures aimed at enhancing access to health care services for the population as a whole would in most cases be reasonable and justifiable in an open and democratic society based on the values of dignity, equality and freedom. Thirdly, in cases where adverse effects caused by NHI are disproportionate to the overall benefits gained by the population or otherwise fail to enhance access to health care services for the majority of the population, violations of constitutional rights will be unjustifiable.

## VI. ROADMAP OF THE THESIS

In chapter 2 of this thesis, I consider two contrasting approaches to interpreting constitutional health rights. The first approach is an egalitarian approach, which emphasises that persons should obtain the same quality of health care regardless of their ability to pay for it. This is expressed in the dictum of 'equal care for equal need'. The second approach is a libertarian approach, which emphasises the importance of individuals having the freedom to purchase health insurance and health care for themselves and their families with minimal restraint by the state. These approaches are illustrated by the majority and minority judgments in the Canadian Supreme Court judgment of *Chaoulli v Québec (Attorney General).*[104] I summarise these judgments and consider relevant academic criticisms. These criticisms illustrate the interests highlighted by each approach and their shortcomings. I then illustrate the tensions between the two approaches against the background of *Soobramoney v Minister of Health Kwazulu-Natal*[105] emanating from the Constitutional Court of South Africa and the Canadian decision of *Stein v Québec (Tribunal Administratif)* decided in the Superior Court of Québec.[106] I conclude that rigid adherence to either the libertarian approach or the egalitarian approach is unworkable and that balance between them is necessary.

In chapter 3, I consider the constitutional value of substantive equality and the implications that a constitutional understanding of this concept might have in a distributive context. I then apply principles developed here to the prohibition against unfair discrimination in terms of section 9(2) and 9(3) of the Constitution. Here, I argue that section

[104] *Chaoulli v Québec (Attorney General)* [2005] 1 S.C.R. 791; 2005 SCC 35, 254 D.L.R. (4th) 577.

[105] *Soobramoney v Minister Of Health, Kwazulu-Natal* (note 102 above).

[106] *Stein v Québec (Tribunal Administratif)* [1999] R.J.Q. 2416; 1999 CarswellQue 2792.

9(2) permits redistributive programmes despite the adverse effects these may have on more privileged groups. If measures undermine the achievement of equality, or do not alleviate the position of those subjected to past discriminatory laws, then these measures might not pass constitutional muster.

I then consider the value of freedom, the right to freedom and security of the person and the right to physical and psychological integrity under section 12 of the Constitution. I examine the implications of freedom as a constitutional value and argue that it is more aligned with the concept of positive liberty as opposed to negative liberty. I consider various conceptions of liberty by several well-known commentators, including the capability theory of Amartya Sen,[107] to support my argument. Using several cases considered by the Constitutional Court, I attempt to show that the value of freedom imposes a positive obligation on the state to secure access to resources necessary for dignified living, so that all people are able to achieve their potential. I then argue that section 12 of the Constitution can have residual application to the curtailment of the freedom to access health care. Nevertheless, since violations of section 12 must be substantial, NHI is not likely to violate freedom, security and integrity rights.

In chapter 4, I consider the right to have access to health care services under section 27(1)(a), and the obligation on the state to enact reasonable measures aimed at the progressive realisation of the right in terms of section 27(2) of the Constitution. I explain the meanings of the terms 'everyone', 'access' and 'health care services', as well as the relationship between sections 27(1) and 27(2). I then examine the concepts of reasonableness, availability of resources and progressive realisation in section 27(2) of the Constitution. I argue here that the health related interests protected under section 27 of the Constitution impose a positive obligation on the state to implement redistributive measures aimed at enhancing access to health care services. NHI fits within the confines of this obligation. However, in order to be reasonable under section 27, these programmes must be affordable and be capable of facilitating the progressive realisation of the right. I then consider the negative aspect of the right to have access to health care services, and the import this has on preserving existing access.

In Chapter 5, I apply the principles developed in this thesis to the Green Paper on National Health Insurance.[108] I argue that the redistributive character of NHI as articulated in

[107] A Sen *The Idea of Justice* (2010) 231-2

[108] Green Paper (note 41 above).

the Green Paper is consistent with the equality provisions of the Constitution. I also consider whether the Green Paper has proper regard for vulnerable persons such as refugees and undocumented migrants. I further examine whether members of medical schemes and users of private hospitals might be adversely affected by NHI. I consider the ways in which this might happen, such as an increase in need-based rationing, the redistribution of private hospital resources, the diminished role of medical schemes, and the emphasis on primary health care. All these characteristics of NHI might compromise the ability of the health system to deliver secondary and tertiary care to the same extent currently practiced by the private sector. If constitutional rights are violated, such violations will require justification under section 36 of the Constitution. Indeed, if it becomes too difficult for people to access adequate health care that was accessible in the past, this may in some cases be constitutionally impermissible.

# CHAPTER 2

# FINDING A BALANCE BETWEEN LIBERTY AND EQUALITY IN HEALTH CARE

## I. INTRODUCTION

In this chapter, I contrast two different jurisprudential approaches to the right to health and to health financing – a public model based on an equality-centred approach and a private model based on a liberty or freedom-centred approach.[1] Most health financing systems are a hybrid of these models, hardly ever being based on one to the total exclusion of the other.[2] Universal health systems, such as the National Health Insurance ('NHI') system being proposed by the South African government, are defined by the equality-centred approach, according to which, in cases where equality and liberty conflict, equality ought to prevail. Free market health systems are based on the freedom-centred approach, which requires liberty to prevail over equality in cases of conflict. In this chapter, I assume that liberty and equality, as these terms are defined here, conflict with one another in the context of scarcity and unequal distribution of health care resources.[3] This conflict appears to be inevitable because, where liberty is the defining feature of a health system, those who are better situated to exercise their liberties will dictate the kind of distribution that takes place, even if this comes at the expense of equality. In cases where equality is the defining feature of a health system, some individuals may be required to forego their liberty of choosing to purchase certain forms of health care or health insurance. They may also be required to contribute health taxes, even where this limits or eliminates their ability to access health care in other ways.

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[1] For an explanation of this distinction see A Maynard 'How to Defend a Public Health System from Abroad' in C Flood, K Roach & L Sossin (eds) *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (2005) 239.

[2] For an exposition of different types of health systems see analyses of the health systems in various countries at 'European Observatory on Health Systems and Policies – Health Systems in Transition ('HiT Series')' <http://www.euro.who.int/en/who-we-are/partners/observatory/health-systems-in-transition-hit-series/countries-and-subregions>. Examples of countries with predominantly public health systems are Canada, Israel, Australia and England. Other countries which rely heavily on private sector financing and delivery include South Africa and the United States of America. It is beyond the scope of this thesis to discuss various health systems in-depth.

[3] R Dworkin *Sovereign Virtue – The Theory and Practice of Equality* (2001) 128.

The egalitarian approach is premised on the principle of equal access for equal need, or 'equal utilization for equal need.'[4] In terms of this model, all patients should receive the same treatments for substantially the same conditions, regardless of their ability to pay for treatment. Equal preference must be accorded to persons suffering from similar health conditions when deciding their entitlements to specific health care services. This applies both to micro allocation decisions on the rationing of health care and macro policy decisions on health system design. This model is premised on the idea that all members of society must have equal opportunities to access health care because health care is a common good. This is the underlying principle of the proposed NHI in South Africa. The purpose of the scheme is to ensure that all persons have access to a decent package of basic services regardless of income inequalities, gender, poverty or illness.[5]

In terms of the egalitarian approach, private health insurance, private hospitals and care centres would only be permissible when they do not undermine the equity of the health system in a fundamental way, or otherwise significantly hamper the ability of less privileged persons to access health care in the public system. Nevertheless, an egalitarian approach might also have to accommodate private health care and financing in cases of underperformance in the public health system. The importance that the egalitarian approach attaches to public health care, and its suspicion of private systems, is derived from the notion that publicly funded systems administered by the state are more likely to achieve equity within the health system and better health outcomes for the greater part of the population. Indeed, having a predominantly publicly funded and administered health system helps ensure that scarce health resources are not drawn into a private system away from poor persons and more vulnerable sectors of society. Publicly administered systems may also be in a better position to make more efficient and effective allocation decisions and avoid wasteful expenditures, because of the absence of profit motive and the need to preserve scarce resources for more people.

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[4] E Mossialos & S Thomson *Voluntary Health Insurance in the European Union* (2008) 102. See also K Syrett *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (2004) 28; M Price *Health Care Beyond Apartheid: Economic Issues in the Reorganistion of South Africa's Health Services* (1986) 53-7; Maynard (note 1 above) 239.

[5] See 'ANC National General Council 2010 – Additional Discussion Documents – National Health Insurance' <http://www.anc.org.za/docs/discus/2010/aditionalo.pdf> 21-2 paras 65-8.

The main controversy of the public model arises in relation to what I call the 'equality of the graveyard' argument.[6] This type of equality arises where a health system with limited resources makes an equal but inadequate service available to all, rather than to face the choice of who gets an adequate service and who gets none.[7] Put in terms of what has been called the 'levelling down objection'[8]: it is impermissible for the state to level down health care of one group of persons so that they receive the same inadequate services given to another group. In this way, the state perpetuates an 'equality with a vengeance', that puts everyone in the same bad situation.[9] It is nonsensical to have equal access to inadequate health care services that fail to sustain health and life. In other words, inequalities are justifiable when having absolute equality will mean that everyone is similarly worse off.

The libertarian approach values the liberty of the individual to make choices regarding their own health care and how they attain it.[10] This approach, which accords with

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[6] This idea of equality of the graveyard was first used in the South African Constitutional Court by Ackerman J in *National Coalition for Gay and Lesbian Equality v Minister of Home Affairs* 2000 (2) SA 1 (CC) ('*NCGLE*') para 77. In this case, the Constitutional Court 'read-in' the words 'or partner, in a permanent same-sex life partnership' into section 25(5) of the Alien Control Act 96 of 1991 which had the effect of facilitating the immigration of a same sex life partner into South Africa if the other partner was a lawful resident of the Republic. The Court declined to declare the section unconstitutional and then to correct the constitutional defect by depriving heterosexual spouses from benefitting under the Act. This would have the effect that neither persons in homosexual life partnerships nor spouses in heterosexual marriages could benefit from the provisions. This was said to be 'equality with a vengeance' and create 'equal graveyards'. The idea was invoked again in *Minister of Home Affairs v Fourie* 2006 (1) SA 524 (CC) ('*Fourie*') para 149, where the Court per Sachs J declined to strike down the institution of marriage merely because homosexual partners could not get 'married' in the legal sense because this would amount to equality of the graveyard. In writing this, the Court cited N Duclos & K Roach "Constitutional Remedies as 'Constitutional Hints' A comment on *R.* v. *Schachter*" 1991 *McGill LJ* 1. In the context of health care resources, the concept of graveyard equality was implicitly rejected in *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC) paras 26, 53. In this case, which I deal with in more detail below, the applicant attempted to force a public hospital to provide him with renal dialysis which would have prolonged his life for a period of time. In rejecting the claim, a majority of the Constitutional Court, per Chaskalson P, stated at para 26: 'If everyone in the same condition as the appellant were to be admitted [into the renal dialysis programme] the carefully tailored programme would collapse and no one would benefit from that.' Sachs J in a concurring judgment made a similar point when he stated at para 53: 'The inescapable fact is that if governments were unable to confer any benefit on any person unless it conferred an identical benefit on all, the only viable option would be to confer no benefit on anybody.' (footnote omitted) I use the idea of 'graveyard equality' to describe a situation where people have equal but inadequate access to health care services and resources. For a description of the concept on equality of the graveyard in another context see WA Holness 'Equality of the graveyard: Participatory democracy in the context of housing delivery' (2011) 16 *SA Public Law* 1.

[7] See H Frankfurt 'Equality as a Moral Ideal' (1987) 98 *Ethics* 21, 31.

[8] D Parfit 'Equality and Priority' (1997) *Ratio* 202, 210-2.

[9] For the term 'equality with a vengeance' see *NCGLE* (note 6 above) para 77.

[10] The dichotomy of the liberty and equality debate in the Canadian health policy context is expressed by Andrew Petter in A Petter 'Wealthcare: The Politics of the Charter Revisited' in C Flood, K Roach & L Sossin *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (2005) 117 in the following words 'Do we want a country in which health care is viewed as a market commodity, with access determined by one's economic status? Or do we want a country in which health care is viewed as a

theories of individual responsibility, maintains that government may not put obstacles preventing a person from accessing health care, even if other persons cannot access it for whatever reason. Emphasis here is placed on negative liberty, or the extent to which an individual should 'be left to do or be what he is able to do or be, without interference by other persons'[11] or the state. A strict adherence to this approach would allow for the free market to dictate the distribution of health care resources without regard to distributive fairness. Normal supply and demand principles would apply despite health care being a necessary component of meaningful life.[12] The extent of supply, both in terms of the amount of resources available and their geographical distribution, would be determined by the demand of persons who can afford to access and utilise them. The default principle here is that the availability of health care is determined by the ability of patients to pay for services, and not necessarily by the needs of the population or the essential needs of a patient.

Under the libertarian approach, middle and higher income earners are often able to avoid the deficiencies in the public health system by purchasing supplementary or alternative health insurance and accessing private health care. Patients might also be able to access better quality health care in a timelier manner than in the public sector. Moreover, health systems might also reap the advantages of a freedom-centred approach because private health insurance and health care may facilitate an increase in service capacity, supply, and variation. Furthermore, private health insurance, which is fundamental to the libertarian paradigm, helps ensure that there is access to funding for insured services, so that public or private hospitals are actually able to provide the required health services so that patients are not denied treatment on the grounds of their inability to pay for services.[13]

Libertarian and egalitarian approaches differ in their normative conceptions of health care responsibilities and the role of the state in guaranteeing them. They also differ on how much inequality may justifiably exist within a community of persons of differing socio-

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public good, with access determined by one's medical needs? Or do we think that it's somehow possible to have both?'

[11] I Berlin 'Two Concepts of Liberty' in *Four Essays on Liberty* (1969) 121-2 (there is a question mark at the end of this quote in the original). See also JL Hill 'The Five Faces of Freedom in American Political and Constitutional Thought' (2004) *Boston College LR* 499 506 (positive freedom), 524 (negative freedom).

[12] See more generally N Daniels *Just Health: Meeting Health Needs Fairly* (2008) chapter 2. Health care services cannot be compared to milk or beef because without health care, most people will die or be unable to achieve their ends. The unavailability of other commodities like milk and beef may be unpleasant but it will not cause death or prevent the achievement of the good.

[13] See F Colombo & N Tapay 'Private Health Insurance in OECD Countries: The Benefits sand Costs for Individuals and Health Systems' (2004) <http://www.oecd.org/els/healthpoliciesanddata/33698043.pdf> 19-22.

economic circumstances. Whatever the social realities, the extremes of either approach cannot exist within one health system. Inevitably, all health systems are placed somewhere on a continuum between these two paradigms with a leaning towards one or the other. The placement of any particular health system on this continuum will likely correspond to the nature of the right to health in a country's legal and policy system.

An interesting display of the tensions between the libertarian and egalitarian approaches to health financing occurred in Canada in the case of *Chaoulli v Québec (Attorney General)*[14] ('*Chaoulli*') where the majority of the Supreme Court of Canada ('Supreme Court') declared a ban on private health insurance for services offered in the public sector to be inconsistent with the Québec Charter. The majority and minority judgments in *Chaoulli* and the academic debates generated as a result are useful for considering opposing points of view on the conflict between liberty and equality in health care. Indeed, *Chaoulli* represents an important point on the continuum in Canada's recent trend to embrace more liberty in a mostly egalitarian health system. On the other hand, South Africa's health system currently finds itself scaling in a libertarian direction owing to the policies of the apartheid governments described in chapter 1 and the underperformance of the public health system. Nevertheless, the Canadian debate is important to consider because it evinces similar tensions being grappled with in South Africa, albeit from the opposite side of the liberty-equality continuum.

In Part II of this chapter, I summarise the main findings of the respective judgments of the Supreme Court in *Chaoulli*. In Part III, I make and defend the claim that the Supreme Court in *Chaoulli* recognised a latent constitutional right to health care. In the first subsection of Part III, I argue that the majority in *Chaoulli* interpreted the right to health care as being mostly defined by liberty, and in the following subsection I argue that the minority interpreted that right as being defined by equality. In Part IV, I consider critiques of the majority and minority judgments in *Chaoulli* and by doing so, I illustrate the difficulties presented by both the equality and liberty approaches to health resource distribution. These complexities inevitably arise in all health care systems. In Part V I use two cases, namely *Soobramoney v Minister of Health Kwazulu-Natal*[15] and *Stein v. Québec (Tribunal administratif)*[16] to show that a strict adherence to either approach may cause injustice to

[14] *Chaoulli v Quebec* [2005] 1 S.C.R. 791; 2005 SCC 35, 254 D.L.R. (4th) 577.

[15] 1998 (1) SA 765 (CC).

[16] 1999 CarswellQue 2792, [1999] R.J.Q. 2416.

patients. In Part VI, I conclude that in order to avoid these injustices an appropriate balance between liberty and equality must be achieved.

## II. *CHAOULLI* – CONSTITUTIONAL ADJUDICATION ON HEALTH CARE REFORM

In *Chaoulli*, a majority of the Supreme Court declared legislation prohibiting alternative private health insurance for publicly available health care services inconsistent with the Québec Charter.[17] The tensions between liberty and equality in the context of private health insurance, and its impact on the viability of the public health system, featured prominently in the three judgments of the Supreme Court. The two majority judgments showed a clear preference for the libertarian approach while the minority judgment emphasised the importance of equality. I argue that the judgments of the Supreme Court feature implicit but varying conceptions of the right to health in the Canadian and Québec Charters. In this section, I summarise the judgments in *Chaoulli* and in the following section, I analyse latent conceptions of the right to health in the Canadian and Québec Charters as evident from the judgments.

The offending provisions were section 11 of the Hospital Insurance Act ('HOIA')[18] and section 15 of the Health Insurance Act ('HEIA').[19] These provisions were challenged by a disgruntled patient, Mr Zeioltis, and a physician, Dr Chaoulli ('appellants') on the basis that they denied individuals the option of purchasing parallel private insurance for publicly insured services.[20] According to section 11 of HOIA, insurers were not permitted to enter into contracts, renew contracts, or make payments under existing contracts, for services that were also publicly insured hospital services. In terms of section 15 of HEIA, patients were not permitted to enter into, renew, or make payment in terms of a contract of insurance under

[17] There were three judgments in the matter: The first was written by Deschamps J, which declared the offending legislation inconsistent with the Quebec Charter only, having considered it unnecessary to discuss the Canadian Charter. The second judgment was written by McLachlin CJ and Major J with Bastarache J concurring. They concurred in the finding of Deschamps J that the offending legislation violated the Quebec Charter but they also held that the provisions were inconsistent with the Canadian Charter. The third judgment, which was the minority judgment was written by Binnie and Lebel JJ with Fish J concurring held that the legislation did not violate either the Quebec or Canadian Charters. Therefore there was a 4:3 majority that held the legislation was inconsistent with the Quebec Charter and a 3:3 divide on whether the legislation violated the Canadian Charter.

[18] R.S.Q., c. A-28. See Annexure B.

[19] R.S.Q., c. A-29. See Annexure B.

[20] *Chaoulli* (note 14 above) paras 4; 14.

which a publicly insured service was furnished or partly or wholly refunded by the public insurance system. These provisions meant that private health insurance contracts were effectively void and unenforceable.

Although waiting lists are not a problem *per se*, they might present constitutional difficulties in cases when timeliness of access is essential for avoiding adverse health outcomes. Prohibiting parallel private health insurance prevented patients from accessing timely health care in the private sector in cases where the public sector failed to facilitate timely access. Absent these legislative prohibitions, these patients would be able to purchase private insurance enabling them to access private health care. According to one expert witness, a person suffering from cardio-vascular disease could die at any time, and if patients were subjected to waiting lists, some would die as a consequence of not being treated in time.[21] The appellants submitted that this was inconsistent with section 7 of the Canadian Charter and section 1 of the Québec Charter. Section 7 of the Canadian Charter states:

> 'Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.'

Section 1 of the Québec Charter states:

> 'Every human being has a right to life, and to personal security, inviolability and freedom.'

The majority judgment delivered by Deschamps J, in which MacLachlin CJ, Major J and Bastarache J concurred ('majority judgment'), held that the prohibition of purchasing private health insurance for services that were available in the public sector infringed section 1 of the Québec Charter. It was held that, if there was no prohibition of private health insurance, then those Quebeckers who were able to purchase private health insurance should have been allowed do so to avoid suffering the detrimental consequences of waiting lists.[22]

The majority further held that the limitation was not justifiable under section 9 of the Québec Charter. Whilst acknowledging the objective of the statute to promote health care of a high quality to all Quebeckers regardless of ability to pay, the majority held that 'a health care service that does not attain an acceptable level of quality of care cannot be regarded as a genuine health care service. Low-quality services can threaten the lives of users.' The

[21] Ibid paras 37, 40, 103.

[22] Ibid paras 4, 37-45.

majority held further that the prohibition on private insurance created an 'insurmountable' barrier preventing average-income earners from procuring timely health services in the private sector.[23]

The majority downplayed the dangers of a parallel private system. First, it held that even though permitting parallel private insurance would cause health expenditure to increase, that did not matter if costs were borne by individuals, who ought to be free to make their own decisions concerning their finances. Secondly, it held that even if adverse selection or cream skimming occurred, the public sector would be able to handle the more serious cases as it would be relieved of the less serious ones. Thirdly, if there was a danger of doctors moving from the public sector to the private sector, the state could regulate the dealings of such doctors with the health system so as to avoid human resource shortages in the public sector.[24]

After conducting a comparison between the Québec health system and that of other Canadian provinces and OECD countries, the majority concluded that there were other ways to protect public plans short of an outright ban on parallel private health insurance. Therefore, the prohibition on private health insurance impaired the right to personal security more than was necessary.[25] The principal point of the judgment is that if the government failed to provide timely health care services then individuals who could afford to purchase private health insurance should not be prevented from using their own financial resources to secure adequate treatment. Preventing them from doing so unjustifiably violated their right to life, personal security, inviolability and freedom under Section 1 of the Québec Charter.

The concurring majority judgment ('concurring majority') per McLachlin CJ and Major J, in which Bastarache J concurred, held that the prohibition against private health insurance violated Section 7 of the Canadian Charter in addition to Section 1 of the Québec Charter. The concurring majority pointed out the purpose of the Canada Health Act was to 'protect, promote and restore' the health of Canadian residents and 'to facilitate reasonable access to health services without financial or other barriers.' It held that if government imposed a monopoly and then failed to promote reasonable access to health services then this 'trigger[ed] the application of section 7 of the Charter.'[26]

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[23] Ibid paras 46-100.

[24] Ibid paras 65-6.

[25] Ibid para 98.

[26] Ibid paras 105, 102; Canada Health Act R.S.C., 1985, c. C-6 section 3. In saying this, the concurring majority was not pronouncing at this juncture on the constitutionality of the legislation or its effects, but merely saying that a government monopoly that fails to deliver adequate health care may possibly violate section 7 of the Canadian Charter. This may or may not be constitutionally justifiable.

Though private health services were not prohibited in terms of the legislation, by making a contract for parallel private insurance essentially ineffective, the government created a virtual monopoly for the public health system. Therefore, only the '*very rich*, who can afford private care without the need of insurance' (my emphasis) would be able to access private health care. Thus, the concurring majority held that delays within the public system violated section 7 to the extent that this resulted in patients' suffering adverse physical or psychological consequences, including death. The concurring majority held further, on the basis of *R v Morgentaler*, that waiting lists giving rise to psychological and physical suffering possibly violated section 7 of the Charter.[27] Put bluntly in its own words, '[a]ccess to a waiting list is not access to health care'. However, the concurring majority qualified the finding of a violation of section 7 by requiring the impact of the delay to be 'serious' and 'clinically significant'.[28]

In dealing with whether the legislative prohibition was arbitrary under the fundamental justice criterion, McLachlin CJ and Major J rejected the argument that there would be a diversion of resources from the public sector to the private sector if alternative private insurance were permitted. The concurring majority held that if alternative private insurance were permitted, there would be a reduction in the burden on the public sector. This would then allow the majority of Canadians to access additional care within a Canadian private system.[29]

The concurring majority also held that allowing private insurance would not undermine the public system. This conclusion, in its opinion, made the prohibition arbitrary and therefore unjustifiable. The legislative provisions also did not pass the 'minimal impairment' test, nor were they proportional in relation to their intended purpose of preserving the integrity of the public system. Similarly, the effects of the prohibition were serious enough to outweigh the potential benefits. Hence, in the absence of reasonable access to services in the public sector owing to waiting lists and lack of quality services, the prohibition against private health insurance was inconsistent with the Canadian Charter.[30]

The minority judgment per Binnie J and Lebel J with Fish J concurring ('minority judgment') held that the prohibition against parallel private health insurance was consistent

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[27] [1998] 1 S.C.R. 30. In this matter, the Supreme Court held that delays in performing therapeutic abortions generated by the possible imposition of criminal offences on doctors violated section 7 of the Charter.

[28] *Chaoulli* (note 14 above) para 106-23. Quotes in paras 106, 123.

[29] Ibid paras 135-49.

[30] Ibid paras 148-9, 155-8.

with both the Québec Charter and Canadian Charter. It was held further that the prohibition was not arbitrary and conformed with the principles of fundamental justice. In their view, the absence of private health care did not violate the rights of the residents of Québec on an equal basis, because poor persons and others who could not obtain private health insurance were not adversely affected by the legislative prohibition. The 'violation' was only of concern to those Quebeckers who could afford and qualify for private health insurance. In light of this, the minority deemed equality of provision of health services to be of greater importance than individual liberty, even in cases where there might be adverse effects on advantaged persons.[31]

For the minority, the provision of health care amounted to a collective responsibility of all residents; all of whom had a right to equality of access within the health system as a whole. Equality of provision and access is fundamental to the overall purpose and objective of the Canada Health Act. The minority held that the purpose of preventing the emergence of a parallel private system was to protect 'the integrity, functioning and viability of the public system.' This was so because those with sufficient resources would opt out of the public system and create a market for private health care provision. In their view, private insurance enabled the private sector to grow at the expense of the public system.[32]

However, the minority conceded that, if life-saving care was inaccessible and one was prevented from purchasing private health insurance, then there was a potential deprivation of one's personal security in terms of section 7 of the Charter. However, the legislative prohibitions did not violate a principle of fundamental justice and so they passed constitutional muster. The minority accepted that the introduction of a parallel private system would not solve existing problems of delays and access.[33]

The minority held further that the prohibition of parallel private health insurance was not arbitrary, as it was clearly related to the legitimate government objective of preserving a predominantly public health system that did not make access to care conditional upon the ability of a person to guarantee payment for treatments. In other words, the prohibition of private health insurance was directly related to the state interest of 'equal provision of medical services to all residents' and the avoidance of an 'overbuilt' health system. The growth of the private sector would only serve to further establish a health system based on

[31] Ibid para 165-8.

[32] Ibid para 181.

[33] Ibid paras 181-215.

wealth and the ability of a person to gain access to health insurance. Therefore, the prohibition against parallel health insurance was vital in maintaining the integrity of the public system and its delivery of health care to all. The minority also held that the prohibitions did not violate the Québec Charter, for similar reasons.[34]

## III. THE LATENT RIGHT TO HEALTH CARE IN *CHAOULLI*

In this section, I make two arguments: First, I argue that the Supreme Court in *Chaoulli* recognised a latent right to health care. Secondly, I argue that the majority and minority justices evinced differing values underlying the right, which brought them to interpret the Canadian and Québec Charters as either permitting a legislative prohibition on parallel private health insurance or prohibiting it. The judgments of the Supreme Court reflect a latent understanding of a right to health that is libertarian for the majority and egalitarian for the minority.

There is no explicit right to health care in the Canadian or Québec Charters. Despite this, both the majority judgments and the minority in *Chaoulli* recognised that policies, which might have adverse effects on the psychological and physical health of human beings, implicated the security and freedom rights in the Canadian and Québec Charters. In this sense, they viewed the health right as being organically interdependent on section 7 of the Canadian Charter and section 1 of the Québec Charter, in that it was incorporated within the scope of these rights.[35] Importantly, for the majority in *Chaoulli*, the scope of the health related interests inherent in the relevant constitutional provisions was determined without recognising the import of equality. Rather, the majority's finding that the legislative prohibitions on parallel private health insurance were inconsistent with section 1 of the Québec Charter conformed to an underlying constitutional value of liberty or freedom from interference by the state in the health care decisions of the individual.

Similarly, the concurring majority applied this view to its interpretation of section 7 of the Canadian Charter. This not only comes across in its finding that the legislation was inconsistent with section 7 of the Canadian Charter, but also in its reasoning. In this regard,

[34] Ibid paras 233-79 (Quotes in para 236).

[35] C Scott 'The Interdependence and Permeability of Human Rights Norms: Towards a Partial Fusion of the International Covenants of Human Rights' (1989) 27 *Osgoode Hall LJ* 769, 779. This was also considered in S Liebenberg & B Goldblatt 'The Interrelationship Between Equality and Socio-Economic Rights Under South Africa's Transformative Constitution' (2007) 23 *SAJHR* 335, 339.

the concurring majority stated 'The *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*.'[36] By stating this, the concurring majority emphasised the absence of a positive constitutional obligation by the state to enhance access to health care. Therefore, it may be argued that the concurring majority regarded health-related interests inherent to section 7 of the Canadian Charter as being freedom-based interests that emphasised restraint on the part of the state and the value of individual autonomy. If the state chose to take on the responsibility of providing access to health care services, which it was not obliged to do, then in cases when it failed to offer quality health care services, individuals had to be free to use their own resources to access health care. That freedom included the freedom to purchase private health insurance for publicly insured services that were not sufficiently accessible in the public sector. If this freedom were not respected in cases when the public sector failed to deliver reasonable health care, then this would be inconsistent with the Charter. Therefore, both the majority and concurring majority opted for an interpretation of the Canadian and Québec Charters that favoured state minimalism and restraint rather than state responsibility.

Therefore, for the majority, a market-centred health system where freedom is the central value is consistent with constitutional norms. In this regard, there is an absence of state-imposed constraint, and the right to freedom in determining how and where to access health care is respected even if some people cannot practically exercise that right because they cannot afford it. State intervention is only justifiable when it does not deprive individuals of necessary health care that would likely have been available in the absence of state sponsored programmes. Therefore, the bar of constitutional acceptability is defined in relation to a liberty standard as opposed to an equality benchmark. Consequently, the absence of a positive duty to provide health services, coupled with the negative character of the health right and its freedom-based characteristics, are suggestive of a right to health care that values individual freedom over collective equality. Consequently, the majority viewed the latent health right as a negative one in which the state may not interfere with the ability of individuals to access health care.

The minority took a different position. In essence, it accepted that the prohibition on private health insurance for services offered in the public sector was capable of infringing the right to security of the person for 'some individuals on some occasions.' Similarly, it held

[36] *Chaoulli* (note 14 above) para 104.

that if persons were prevented from obtaining private insurance whilst the public system failed to deliver life-saving care, then 'the individual is potentially caught in a situation that may signal a deprivation of his or her security of the person'. This indicates that the minority also held that the freedom and security rights in the Canadian and Québec Charters protected health related interests. Importantly, however, the minority held that the legislative prohibition did not violate the Canadian Charter, because the appellants failed to show that the deprivation was not in accordance with fundamental justice as required by section 7. In addition, the minority also held that the measure was proportional and rationally related to the objective of protecting the public health system.[37]

The position taken by the minority in *Chaoulli* is reflective of its preference for the egalitarian approach discussed in the introduction to this chapter. In this sense, the health-related interests implicated in the section 1 of the Québec Charter and section 7 of the Canadian Charter are not to be interpreted without reference to the value of equality. The minority would ascribe to the view of John Laws, who stated that 'a society whose values are defined by reference to individual rights is by that very fact already impoverished'.[38] Therefore, the minority viewed the latent health right as a right to equality that prioritised social concerns over individual interests in cases when these might conflict.

Therefore, the crux of the disagreement between the majority and minority justices in *Chaoulli* appears to be over how the state should deal with a scenario of resource scarcity where it cannot fulfil the rights of all Canadians but only some of them. The approach of the majority, which is in line with the libertarian approach, was that it is permissible for the state to allow all people to access higher standards of health care even if wealthier persons are the only people who can afford to do so. It is impermissible for the state to have a policy requiring everyone to access the same inadequate standard of care and then only raise the standard when it can be done for all people at the same time. The minority, on the other hand, viewed the state obligation as requiring it to fulfil the rights of all residents on an equal basis. In other words, if the state only has sufficient resources to raise the standard of care for some people but not for everyone, then no person should be permitted to have a higher standard of care even if this has adverse consequences for the health and wellbeing of people who might want to opt out of the public system.

[37] Ibid paras 167, 200, 203, 269.

[38] J Laws 'The Constitution: Morals and Rights' (1996) *Public Law* 622, 624.

## IV. CRITIQUES OF THE MAJORITY JUDGMENTS AND MINORITY JUDGMENT IN *CHAOULLI*

### (a) An egalitarian critique and the critics of the majority

Academic responses to *Chaoulli* tend to criticise the findings of the majority judgments.[39] Central to the criticisms of these judgments is their failure to adhere to the egalitarian principle that government must show equal concern and respect for all the people it governs.[40] If government shows more concern for the privileged few by enabling them to access a greater share of health resources than the poor, then government is acting disloyally to the value of equality. This is so because the poor are not equally positioned to access health care services. Consequently, if individuals were placed at the centre of the government concern, then control over health resources would be placed into the hands of wealthier individuals, thus negatively impacting the poor. Therefore, for egalitarians, such as the critics of the majority judgments in *Chaoulli*, the obligation to show everyone equal concern and respect requires government to demonstrate social responsibility for *all* people. In order to promote an egalitarian distribution of health care resources, there must be some abstraction by the state from individual needs. Unfortunately, this may adversely affect people who require timeous access or better treatment options. By failing to properly appreciate the impact a parallel private health system might have on the public system, the majority judgments failed to apply the equality principle that all people are to be treated with equal concern and respect.

Critics argue that there are two primary ways in which the majority judgments failed to adequately consider the egalitarian objectives of the Canada Health Act. Firstly, the

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[39] See for Example J King 'Constitutional Rights and Social Welfare: A Comment on the Canadian *Chaoulli* Decision' (2006) 69 *Modern LR* 631; C Manfredi & A Maioni '"The Last Line of Defence For Citizens": Litigating Private Health Insurance in *Chaoulli v Quebec*' (2006) 44 *Osgoode Hall LJ* 250; C Flood '*Chaoulli*'s Legacy for the Future of Canadian Health Care Policy' (2006) 44 *Osgoode Hall LJ* 273; T Marmor 'Canada's Supreme Court and its National Health Insurance Programme: Evaluating the Landmark *Chaoulli* Decision From a Comparative Perspective' (2006) 44 *Osgoode Hall LJ* 311; J Gilmour 'Fallout From *Chaoulli:* Is it Time to Find Cover?' (2006) 44 *Osgoode Hall LJ* 327; M Jackman '"The Last Line of Defence for Which Citizens": Accountability, Equality and the Right to Health in *Chaoulli*'" (2006) 44 *Osgoode Hall LJ* 349; See also various chapters in C Flood, K Roach & L Sossin (eds) *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (2005). See also C Flood & S Xavier 'Health Care Rights in Canada: The *Chaoulli* Legacy' (2008) 27 *Medicine and Law* 617.

[40] See Dworkin (note 3 above) 128 where Dworkin writes of what he calls the abstract egalitarian principle that 'government must act to make the lives of those it governs better lives, and it must show equal concern for the life of each.'

majority and concurring majority supported an under-inclusive order that failed to have regard to poor patients who confront waiting lists in the public sector. For example, Martha Jackman argues that the order of the Supreme Court ultimately benefits rich and healthy persons who qualify and can afford to pay for health insurance. Since vulnerable persons cannot afford health insurance and also may not qualify for it, they cannot benefit from the remedy given by the Supreme Court. In essence, the poor are left to 'languish' on waiting lists, while at the same time, the rich and healthy are able to 'jump the public queue' and access comparatively better services.[41]

Secondly, the majority failed to appreciate the impact its order would have on poor persons. Jeff King advances this argument with the following words: '[the majority] privileged a right to security of the person over the competing interest of providing effective and efficient public health care to those who cannot afford private insurance.'[42] Thus, the majority judgments endorsed a reading of the Canadian and Québec Charters, that in some cases, allows the rights of wealthier persons to trump the needs of the poor when these might conflict. In doing so, the majority endorsed a right to health care services that is contingent on the ability of a patient to pay for health care services.

Similarly, Hutchinson argues that *Chaoulli* is suggestive of an ideology in which individual rights trump social duties, and in which the importance of negative liberties surpasses that of positive liberties. He also argues that the majority assumes that the capability of a person exercising her rights is a question of choice rather than of individual circumstances. Consequently, in his view:

> 'People are treated as rational and private individuals who share little more than an abstract humanity. By treating everyone as the same and equally placed to exercise rights, this political approach ignores the very different material and social conditions in which people live. It depicts a just society as one in which achievement of personal liberty and social justice can be effected without concern for serious economic equality… Indeed *Chaoulli* confirms that the extent of a person's wealth and resources remains the real measure of citizenship.'[43]

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[41] Jackman (note 39 above) 359

[42] King (note 39 above) 639.

[43] A Hutchinson 'Condition Critical: The Constitution and Health Care' in C Flood, K Roach & L Sossin (eds) *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (2005) 109-11 (Quote at 109). See also M Pieterse 'The Interdependence of Rights to Health and Autonomy in South Africa' (2008) 125 *SALJ* 553, 554.

Moreover, in the view of the critics, the reasoning of the majority lends itself to the interpretation that the state has no positive obligation to ameliorate the plight of the poor by facilitating access to care through the redistribution of health care resources.[44] In all countries, the poor and other vulnerable groups are primarily dependant on the state for their basic amenities. Without state intervention, such people cannot participate as equals in society and cannot exercise choices that are inherent in democratic freedoms.

The final criticism of the majority judgments is that they failed to define standards against which the constitutionality of health policy could be assessed. The basis for their conclusion was that it was impermissible for the state to not provide necessary and adequate health care timeously while making it difficult to access the private sector.[45] Indeed they held that the state failed to provide reasonable or adequate health care in the public sector.[46] But, as argued by the minority, the majority judgments failed to define any clear and useful standard of reasonableness or adequacy in assessing the constitutionality of health care services in future cases.[47] By not doing so, the majority made redistributive and equality enhancing programmes that have adverse effects on more advantaged groups more susceptible to successful constitutional challenges.[48] This could slow the pace of redistribution, because policy makers might be too deferential to the rights and needs of wealthier persons. Thus, by not defining such standards, the majority did not appreciate the potential impact that their decision might have on vulnerable persons. By doing so, they failed to adhere to the basic principle that all persons are entitled to equal concern and respect.

### (b) A libertarian critique and the critics of the minority

This section describes criticisms of the minority judgment, which highlight the shortcomings of the egalitarian approach.

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[44] Hutchinson ibid 111.

[45] See P Monahan "*Chaoulli v Quebec* and the Future of the Canadian Healthcare: Patient Accountability as the "Sixth Principle" of the Canadian Health Act" (29 November 2006). <http://www.cdhowe.org/pdf/benefactors_lecture_2006.pdf> 3-4.

[46] This is an explicit finding by Deschamps J in the majority judgment at para 50 and the concurring majority at para 105.

[47] *Chaoulli* (note 14 above) para 163.

[48] See C Flood '*Chaoulli*'s Legacy for the Future of Canadian Health Care Policy' (note 39 above) 298-9. For an analysis of cases litigated after *Chaoulli*, see M Cousins 'Health Care and Human Rights after *Auton* and *Chaoulli*' (2009) 54 *McGill LJ* 717.

Patrick Monahan has argued forcefully for the reasoning adopted by the majority. He argues that academic critics of the decision and the minority failed to consider the justifiability of forcing people to make use of the public system while denying them access to care when they are deathly ill. Indeed, the state cannot justifiably impose a virtual public sector monopoly and at the same time not offer reasonable health care services.[49] The legislative prohibition would make adequate health care inaccessible for middle-income earners, who would otherwise have access to essential care in the private sector.[50] This argument is derived from Immanuel Kant's dignity-related concept that people should be treated as ends in themselves, and not as means to an end.[51] According to Monahan, the legislative prohibitions at issue in *Chaoulli* treated people as a means to an end, by curtailing their liberty to purchase parallel private health insurance in the name of a governmental objective of enhancing equality.

The second main criticism is the failure of the minority to set down constitutional principles governing a situation where the public health system is substantially dysfunctional or resembles an 'equality of the graveyard'.[52] In essence, the minority did not properly deal with the acceptability of forcing all people to deteriorate on waiting lists at risk of adverse health consequences or death when it may be possible for some to escape these consequences by purchasing parallel private health insurance. The principal point here is that no one has an interest in equal access to inadequate care, because equal rights and opportunities to access

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[49] Monahan (note 45 above) 3-4. Being on a waiting list is not by itself unjustifiable. It only constitutes a denial of care when patients may die or suffer significant psychological or physical harm caused by untimely access to care. I do not understand Monahan to be arguing against the imposition of waiting lists for non-life threatening procedures when they are directed at the equitable management of the health system. See also S Hart & P Monahan 'The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians' (2002) 164 *C.D. Howe Institute Commentary – The Health Papers* <http://www.cdhowe.org/pdf/commentary_164.pdf> 1. The latter paper was published prior to the decision of the Supreme Court in *Chaoulli* but the arguments can be applied to counter the reasoning of the minority. For other opponents of the decision see A Davidson 'Under the Radar: Stealth Development of Two-Tier Healthcare in Canada' (2006) 2 *Healthcare Policy* 25 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585431/>.

[50] This indeed concerns one of the core functions of private health insurance, which is to supplement the public health system especially in cases when it cannot offer timely and quality treatment. Sometimes timeliness and quality of care are directly related to the probabilities of successful treatment, the alleviation of suffering and the deferment of death. See in this regard F Colombo & N Tapay (note 13 above) 19 para 40 but also see 20-1 paras 41-7.

[51] See See I Kant *Kant: Groundwork for the Metaphysics of Morals* ed M Gregor (Cambridge University Press; Cambridge UK, 1997) 43-6.

[52] For a thorough explanation of this concept see the introduction to this chapter and footnote 6. Colleen Flood and two other commentators who generally oppose the decision of the Supreme Court in *Chaoulli* also acknoweldge that 'equality in misery is not worthwhile'. See C Flood, M Stabile and S Kontic 'Finding Health Policy 'Arbitrary' The Evidence on Waiting, Dying and Two-Tier Systems' in C Flood, K Roach & L Sossin (eds) *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (2005) 297.

health care are meaningless to the dead and dying. It is not acceptable for government to inhibit people from using their resources to access adequate health care because some cannot afford it, and then refuse all of them cover for the needed service. This, according to Monahan and Hart, amounts to 'equality with a vengeance', in which the desire to bring about an equal outcome has the effect of denying *everyone* access to necessary and timely care.[53] In this view, wealthier people are prevented from accessing essential treatment because most people cannot afford it.

The reasoning of the minority is consistent with equality being an end in itself: the minority did not indicate if the legislative prohibitions on parallel private health insurance would be inconsistent with the Québec or Canadian Charters if the public sector reached a severe state of disintegration. In other words, for the minority in *Chaoulli*, regardless of the state of the public system, equality will always trump liberty. If such a state of disintegration of the public system exists, there may be equality but this would be of no consequence if the health system is unable to ensure reasonable health outcomes for many of its patients.

In contrast, it may be argued that some inequality is preferable in the cases of a deteriorating system, if health outcomes are, at least, better for some people. Some inequality does not necessarily mean that the poor are inevitably worse off. Moreover, insisting on absolute equality of access is unjustifiable if it prevents *everyone* from accessing reasonable services.[54] No health system should be made to adhere to principles of absolute equality that are abstracted from the context and state of the public health system.[55] Therefore, if the public health system fails to offer adequate treatment for all persons who require similar treatments, it should not be constitutionally objectionable to allow some people to opt out the system, even if the system cannot give everyone adequate services and treatment.

A similar argument related to the 'equality of the graveyard' objection is that the legislative prohibitions were blanket ones that did not differentiate between different categories of publicly funded care. Being *legislative* prohibitions as opposed to regulatory ones, they rendered *all* parallel private health insurance contracts void or ineffective, regardless of the quality of the service in the public sector and its ability to cope with patient demand for particular treatments. Indeed, the legislation forced all people to use publicly

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[53] See Hart & Monahan (note 49 above) 21-2.

[54] See Frankfurt (note 7 above) 30.

[55] Indeed public health systems generally do not follow absolute equality in all cases. For example, public health systems cannot place everyone on a renal dialysis programme or on the list for other expensive treatments and services. Despite this, no health system has a policy of not putting anyone on renal dialysis treatment because the programme cannot cater for the needs of everyone who requires it.

insured services regardless of the standard or type of service. It makes no sense to legislate a blanket prohibition on all parallel private health insurance without considering the standard of specific services in the public sector. Thus according to this criticism, a better approach would be to apply the legislative prohibition only to those services in the public sector that are not subject to denial of care as a result of intense need-based rationing or waiting lists.

In order to avoid the above objections, the minority should have held that the legislative prohibitions on parallel private health insurance could, in some cases of under-performance by the public sector, be inconsistent with the Canadian and Québec Charters. By not doing so, the minority implied that the state of the public health system is of no relevance to the issue of whether the impugned legislation is consistent with the Charter. In contrast, the majority adopted a contextual approach in which the provisions were inconsistent with the Charter *only* in cases where the public system failed to offer reasonable care. By not laying down principles that guide future constitutional challenges against similar provisions in cases of severe under-performance by the public health sector, the minority failed to account for the above objections in any meaningful way.

Ronald Dworkin makes a similar case against equality of the graveyard. However, in writing about whether the British government may abolish private medicine to achieve more equality, he argues that this may be done if the government is 'willing and able, concurrently, to improve the national health service in whatever dimension' it does not accord with the level of resources and services available under a justifiable distribution of resources.[56] Supposing that there is an unjustifiable distribution of health care resources in a particular country favouring the wealthy, levelling down 'privileged health' when the public health service is not improved to compensate for the loss of life-sustaining care in the private sector is problematic. In other words, replacing inequality of access with insubstantial access merely exchanges one problem for another. Dworkin's argument seems to imply that redistribution and other equality enhancing measures cannot result in the levelling down of access for less vulnerable persons to such an extent that the care accessed does not achieve the health outcomes that it should.

Contrasting the criticisms levelled at the majority and minority judgments illustrates the difficulty in reconciling the interests implicated in the equality-liberty debate as it pertains to health system design. The criticisms of the minority emphasise the importance of personal liberty when its existence is necessary to access needed health care. On the other

[56] Dworkin (note 3 above) 178.

hand, implicit in the arguments against the majority judgments is their failure to promote the interests of the poor above the interests of more privileged persons. The differing interests highlighted by liberty and equality are indeed difficult to resolve because some interests will have to yield in favour of others. Inevitably, the way in which this conflict is resolved will largely determine who will have access to needed care and who will not.[57]

## V. THE CONFLICT IN REAL-WORLD CASES

In the previous section I articulated arguments against both equality- and liberty-centred approaches to the right to health as implicitly recognised in *Chaoulli*. Underlying this conflict in health care is the intractable problem of how to distribute scarce resources amongst persons with legitimate competing claims. In this section, I consider two cases – *Soobramoney v Minister of Health, Kwazulu Natal*[58] ('*Soobramoney*') emanating from the South African Constitutional Court and *Stein v Québec (Tribunal administratif)*[59] ('*Stein*') from the Superior Court of Québec. These cases show how the academic arguments advanced above play out in real cases. In the former case, the applicant was denied access to renal dialysis in a public-sector hospital in South Africa. Whilst this seemed to be an ordinary case of a court refusing to order a health authority to supply health services, which is common is many jurisdictions,[60] the Constitutional Court was mindful of the context of inequality that characterised the South African health sector at the time. In the latter case, I show the importance of the individual autonomy to pursue alternative avenues for accessing health care when the public system fails to deliver necessary health care. *Stein* is an indictment against bureaucratic state-administered health authorities that apply rationing policies rigidly by denying beneficial and cost-effective treatment to patients. In the analysis that follows, I am not concerned with the legal reasoning of the respective courts.[61] Rather, the factual scenarios in these cases are used to illustrate the interests that are implicated by the libertarian and egalitarian approaches to access. This line of reasoning is used to

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[57] See W C Hsiao & Y Liu 'Health Care Financing: Assessing its Relationship to Health Equity' in T Evans, M Whitehead, F Diderichsen, A Bhuiya & M Wirth (eds) *Challenging Inequities in Health: From Ethics to Action* (2001) 261.

[58] *Soobramoney* (note 15 above).

[59] *Stein* (note 16 above).

[60] See for example *R v Cambridge Health Authority, ex parte B* [1995] 2 All ER 129 (CA).

[61] In Chapter 4, I deal more closely with the legal reasoning in *Soobramoney*. The legal reasoning in *Stein* was based on administrative law grounds, which is not relevant to this thesis.

demonstrate the need for a balanced approach in reconciling the conflict between liberty and equality.

The applicant in *Stein* was a 41-year-old man diagnosed with colon cancer. During an operation to remove part of his colon, the surgeons found cancerous liver lesions that required a later operation. Stein's doctors recommended that he have these lesions removed timeously because of the urgency of his condition. His surgery was scheduled and postponed three times within a four-month period on the grounds of hospital overcrowding and the elective nature of the surgery. Stein's doctors then proceeded to write a request to the relevant health authority to authorise his treatment in the United States of America ('America'). The authority denied the application for the following reasons: Firstly, the effectiveness of the procedure in question had not been proven, as survival rates had not demonstrably increased. Secondly, the health authority had a policy not to fund procedures in foreign countries when similar and adequate procedures were available in Canada. However, in the opinion of his doctors, the procedures that were available within Canada were not conducive for the proper treatment of his lesions.[62]

Stein persisted and travelled to America for two operations that were performed within a short period of time. Two years after the operations, he was given a clean prognosis. The surgery saved his life. Afterwards, Stein applied to be reimbursed for two treatments. The Authority refused his request for one of the procedures because it was supposedly available in Québec, and refused the other on the basis that it was experimental and was not performed in Canada. Stein appealed to an administrative tribunal who dismissed his appeal. He then took the decision on review to the Québec Superior Court, which upheld the review application. The Superior Court held that the refusal to reimburse Stein was unreasonable since the treatment was only obtained in America because he could not obtain timeous and adequate treatment in Montreal. Making Stein wait for the treatment while his condition deteriorated was unlawful and contrary to the stated purposes of the Québec health system, which was 'to make necessary treatment available to all Quebeckers.'[63]

Though Stein's argument was based on administrative law and not constitutional law, the facts of the case illustrate the potential disastrous consequences when public sector monopolies fail to deliver needed medical treatment because of bureaucracy and mal-

[62] The overview of the facts is sourced from Monahan & Hart (note 49 above) 5-8 and from the text of the decision itself at *Stein* (note 16 above) paras 5-13.

[63] Ibid para 16-32.

administration.[64] When this occurs and necessary access to health care is compromised, then permitting people to opt out allows them to escape the consequences of an inefficient bureaucratic system. Mr Stein, unlike many other people, was wealthy enough to secure finances for his treatment without having first been paid out for the treatment. It is unjust to require people to access health care in a public system that offers inadequate care and then to make it difficult for them to use their own resources to access treatment in the private sector in the name of equality. Forcing wealthier persons on to a health system that has poor health outcomes merely because the poor cannot access upper-tier care only entrenches an 'equality of the graveyard' – something that both egalitarians and libertarians are keen to avoid.

On the other side of the spectrum is *Soobramoney v Minister of Health, Kwazulu-Natal*[65] – a case that lays bare the injustice of inequality on the poor. Mr Soobramoney, the applicant, launched an urgent application in the Durban and Coast Local Division of the High Court attempting to compel a hospital to provide him with dialysis services for treating kidney failure.[66] The High Court, per Combrinck J, dismissed the application. The applicant then appealed the Constitutional Court, which then dismissed the appeal.

Mr Soobramoney was a 41-year-old unemployed man from a disadvantaged community. He suffered from various health conditions including diabetes, ischaemic heart disease and cerebro-vascular disease, the latter of which had caused him to suffer a stroke. He then started to suffer from chronic kidney failure, which had reached its final stages at the time he instituted proceedings. His life could be prolonged if he had access to dialysis treatment. He initially accessed renal dialysis in a private hospital but could no longer afford to do so and became reliant on the public sector to provide him with the treatment.[67]

A public hospital in Durban refused to give him access to renal dialysis. The hospital had a set policy, which stated that only those patients who were eligible for kidney transplants could be admitted to the renal dialysis programme. People like the applicant who suffered from irreversible chronic renal failure were not eligible for kidney transplants. This policy was in place to maximise benefit from a limited number of dialysis machines. If

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[64] Hart & Monahan (note 49 above) 7.

[65] *Soobramoney* (note 15 above).

[66] The case is reported at 1998 (1) SA 430 (D). The current name of the division is the Kwazulu-Natal High Court, Durban.

[67] *Soobramoney* (note 15 above) paras 1-5.

people in the applicant's position were given access to dialysis services at the hospital, the programme would collapse, resulting in no one benefitting from the programme.[68]

Nevertheless, the applicant argued that the hospital's refusal to admit him violated his constitutional right 'not to be refused emergency medical treatment' under section 27(3) as well as his right to life in section 11. However, the Constitutional Court dismissed his appeal on the ground that he did not have a constitutional right to the treatment in terms of section 27(1) read with section 27(2) of the Constitution.[69] Since resources were scarce, his right to have access to health care services did not include what the state could not afford to provide.

Madala J, in his minority judgment, considered the difficulties faced by poor persons in accessing health care. Although he acknowledged the role that the private sector plays in facilitating access to renal dialysis, he seemed to criticise it for not coming to the aid of persons like the applicant. Importantly, he pointed out that the private sector fulfils a complementary role by providing needed care in cases when the public sector is unable to do so. The private sector does so without having strict rationing conditions that make it difficult for people in advanced stages of kidney failure to access dialysis. However, Madala J pointed out that, in order to access private hospitals, patients must have access to funding in order to have treatment.[70] Here, Madala J implicitly points to the inequity between those who can afford private sector care and those who cannot.

*Soobramoney* is an indictment against the prevailing inequalities in the South African health system. In market-oriented health systems, there will always be many people like Mr Soobramoney who cannot alleviate the shortfalls of the public sector by purchasing private health insurance or otherwise accessing the private sector through out of pocket payments. There will always be an inherent unfairness: wealthier people in the same situation will be able to access renal dialysis in the private sector, whilst people like Mr Soobramoney, through no fault of their own, will not. Unfortunately, there are many people in comparable situations to Mr Soobramoney, who suffer from a number of terminal conditions and face similar agonising decisions. The number of people facing such decisions could be lessened

[68] Ibid paras 1-4; 25-6.

[69] Ibid paras 7, 14, 22-3. Sections 11, 27(1), 27(2) and 27(3) appear in Annexure A.

[70] Ibid para 48.

under a health system that had a more equitable distribution of human, technological and financial resources.[71]

The cases of *Stein* and *Soobramoney* illustrate that extremes of the libertarian and egalitarian approaches must be avoided in any equitable health system. On the one hand, it is unjust for privileged members of society to access health care that is of world-class standards whilst the poor are subjected to long waiting lists, intense degrees of need-based rationing and maladministration.[72] When this occurs, health policy reform is required to raise the level of access for poor people through redistributive and other measures in order to achieve equality and fairness within the health system. Sometimes this requires the 'levelling down'[73] of access to care for privileged persons in order to fairly distribute scarce resources. Indeed, individual claims to health resources by more privileged persons have no more priority than claims by poor persons. On the other hand, it should not be difficult for people to use their resources to facilitate access to health care. This is especially the case where the public system fails to offer reasonable health care necessary to prevent suffering or death. As a result, the egalitarian and libertarian approaches must be balanced in any equitable health system.[74] Rigid adherence to either approach will ultimately lead to unjustifiable outcomes: either equity will be diminished or health-related interests will be compromised by badly run health systems.

## VI. CONCLUSION: FINDING A BALANCE BETWEEN COMMUNITY AND THE INDIVIDUALS THAT FORM ITS COMPOSITION

This chapter illustrated the tensions between equality- and liberty-based approaches to a right to health. This was accomplished by analysing the *Chaoulli* decision of the Supreme Court of

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[71] Although Mr. Soobramoney might still have been unable to access renal dialysis in an egalitarian health system, the inequalities might be far less than in a divided system or one that is substantially market based.

[72] L Gostin, S Burris & Z Lazzarini 'The Law and the Public's Health: A Study of Infectious Disease Law in the United States' (1999) 99 1 *Columbia LR* 59, 68 where the authors state that a country in which a privileged sector of the population has access to world standard 'health conditions' but where the poor majority live below a decent norm is not a country with good public health. In such cases, the authors argue that there must be a redistribution of resources from the rich to the poor.

[73] Parfit (note 8 above) 211.

[74] See *Soobramoney* (note 15 above) para 54 where Sachs J writes of the importance of 'striking appropriate balances the equally valid entitlements of a multitude of claimants…'. Although, he writes this in the context of health rationing, the idea of balancing also has application in this context. This is so because the libertarian and egalitarian approaches to health rights adjudication each protect a class of persons who have valid entitlements to necessary treatment.

Canada from the perspective of each approach. Criticisms of the majority and minority judgments were considered. The real life cases of *Soobramoney* and *Stein* were then examined, where these criticisms were vindicated in some way by the respective judgments. This lead to a conclusion that there needs to be a proper balancing of the libertarian and egalitarian approaches in a way that neither undermines individual entitlements nor the equity of the health system. Sachs J appropriately addresses this in *Soobramoney*, where he stated that 'each claimant seeking access to public medical resources is entitled to individualised consideration' whilst also writing about the interdependent nature of health care rights.[75] These are two inseparable ideas that need to be considered in any future health system.

In achieving an appropriate balance between the two approaches, care must be taken to steer away from graveyard equality. It does not serve anyone if private sector health care is levelled down so all similarly situated persons have equal access to inadequate care. The levelling down of access to health care, whether through direct or indirect means, must be done responsibly without losing sight of fair individual entitlement and the equity of the health system as a whole:

> '[T]he course of a community as akin to that of a bicycle, forever teetering in one direction or another. That is, either towards the anarchy of extreme individualism and the denial of common good *or* towards the collectivism that views itself as morally superior to its individual members. Hence communities constantly need to be pulled toward the center course, where individual rights and social responsibilities are properly balanced.'[76]

[75] Ibid paras 53-4.

[76] A Etzioni *The Spirit of Community: Rights Responsibilities and the Communitarian Agenda* (1995) x.

# CHAPTER 3

# EQUALITY AND FREEDOM AS CONSTITUTIONAL VALUES AND RIGHTS: REDISTRIBUTION, POSITIVE LIBERTY, AND PERSONAL SECURITY

## I. INTRODUCTION

In chapter 2, I contrasted the characteristics of libertarian and egalitarian interpretations of latent constitutional rights to health as evident from diverging judicial opinions in an influential Canadian judgment. In this chapter, I consider the values of, and rights to equality and freedom in the Constitution of the Republic of South Africa as interpreted by the Constitutional Court and academic commentators.[1] Equality and freedom, together with human dignity, comprise the constitutional trilogy of values contained in section 7(1) of the Constitution, which underscore the interpretation of all rights in the Bill of Rights.[2] It will be evident from the argument presented here that the values of equality and freedom in constitutional jurisprudence do not conflict, but 'overlap, intersect and mutually reinforce each other'.[3] The interdependence of rights and values permeates the Constitutional Court's jurisprudence on socio-economic rights.[4] At their core, the values of human dignity, equality and freedom must be understood to reflect the transformative purpose of the Constitution, which is achieved through the implementation of equality enhancing programmes.[5]

In Part II of this chapter, I analyse the value of equality as espoused by the Constitutional Court and academic commentators. I join the chorus of judicial and academic authority in arguing for a substantive understanding of equality that is sensitive to the needs of vulnerable persons and others who have difficulty in accessing socio-economic resources and services. I point out that the Constitutional Court emphasises the need for people to be

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[1] Sections 9 and 12 of the Constitution. The value of equality appears in sections 7(1) and 36(1) of the Constitution. See Annexure A.

[2] See S Baer 'Dignity, Liberty and Equality: A Fundamental Rights Triangle of Constitutionalism' (2009) 59 *Univ of Toronto LJ* 417 who has referred to equality dignity and freedom as a rights triangle. In this chapter I do not deal with the value and right associated with human dignity.

[3] See *Sidumo v Rustenburg Platinum Mines* 2008 (2) SA 24 (CC) para 148. These words were not used in the context of equality and freedom.

[4] See for example *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) para 83.

[5] The Constitutional Court has indicated on many occasions that it would adopt purposive interpretations of law to further the transformative purpose of the Constitution. See for example: *S v Zuma* 1995 (2) SA 642 (CC) para 15; *S v Mhlungu* 1995 (3) SA 867 (CC) para 8; *S v Makwanyane* 1995 (3) SA 391 (CC) paras 9, 325; *Ferreira v Levine* 1996 (1) SA 984 (CC) paras 46 (Ackermann J), 172, 205 (Chaskalson P), 213 (O' Regan J).

treated according to the circumstances in which they find themselves, which may require the state to differentiate between people in disparate positions.

In Part III, I consider the test of fairness developed by the Constitutional Court as the main indicator of whether a measure unfairly discriminates against an individual or group. I argue that fairness emphasises the achievement of equality for those disadvantaged by past unfair discrimination. Distributive measures taken in pursuit of this objective are unlikely to be found unfair, merely because of an adverse impact on previously advantaged groups. However, I argue further that the state must avoid adverse effects on previously advantaged groups that override their interests in a way that denigrates their basic human dignity. I then consider instances in which aspects of NHI may nevertheless infringe upon the constitutional prohibition on unfair discrimination. In this respect, I then consider age and health status as grounds of unfair discrimination. In Part IV, I conclude the arguments made in this chapter in respect of equality and the Constitution.

In Part V of this Chapter, I discuss the concept of freedom in philosophical and constitutional discourse. In subpart (a), I summarise the literature on negative freedom and positive freedom. I argue that negative freedom views the absence of regulation and other forms of state-imposed constraints as defining freedom. In subpart (b), I consider the literature on positive freedom, which views individuals as being free when they have the resources necessary for achieving their potential. The state is charged with a significant role in realising this ideal. In subpart (c), I argue that positive freedom is the dominant conception of freedom in the Constitution. In line with this, I argue that the Constitution imposes a positive obligation on the state to enhance the freedom its residents.

In Part VI, I analyse the transformative aspect of the value of freedom in the Constitution. I argue that freedom as a value cannot be synonymous with a limited government that fails to implement redistributive measures that facilitate access to health resources for disadvantaged South Africans. In Part VII, I illustrate the interests protected by the rights under sections 12(1) and 12(2) of the Constitution. These are the rights to freedom and security of the person, and physical and psychological integrity. Most claims made under section 12 of the Constitution are likely to be made by individuals who are denied access to treatment, or who are adversely affected by a measured scaling down of access to health services. I consider the threshold that such persons would need to satisfy in order to be successful in a section 12 claim. Ultimately, freedom and equality as constitutional values and rights can exist in tandem with one another so that distributive equality is achieved.

Nevertheless, the need for distributive equity must still be balanced with individual interests implicated by section 12.

## II. THE VALUE OF EQUALITY – SUBSTANTIVE EQUALITY

Equality is described by Moseneke J as 'a core and foundational value' of the Constitution, as well as a 'justiciable right'.[6] In describing the relationship between the right to equality and the value of equality, Albertyn and Goldblatt argue that, as a value, equality expresses a constitutional vision of a more socially just and equal society. Thus, rights must be interpreted 'through the eyes' of equality in order to realise this vision. In this view, the rights to equality and not to be subjected to unfair discrimination become legal mechanisms for facilitating the realisation of that vision by entitling groups to equal concern and respect.[7]

Central to the understanding of equality as a constitutional value in South Africa is the notion of 'substantive equality'. Substantive equality, as opposed to formal equality, recognises that people have divergent needs necessitating differential treatment by the state.[8] In considering substantive equality in an adjudicative setting, regard must be given to the context of constitutional infringements and their association with systemic insubordination and disadvantage. Substantive equality is not blind to the unique history and context of different social groups in South Africa with differing levels of material inequality, deprivation and privilege. Indeed, it is attentive to systemic, structural and cyclical inequalities caused by past discrimination, and to the need to achieve a society based on social justice and equality.[9] This is appropriately encapsulated by Brodsky and Day, who argue that substantive equality recognises the entrenched inequality of certain groups who are denied basic rights and freedoms because of their poverty.[10] Through its emphasis on

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[6] *Minister of Finance v Van Heerden* 2004 (6) SA 121 (CC) ('*Van Heerden*') para 22.

[7] C Albertyn & B Goldblatt 'Facing the Challenge of Transformation: Difficulties in the Development of an indigenous jurisprudence of Equality' (1998) 14 *SAJHR* 248, 249; *Minister of Home Affairs v National Institute for Crime Prevention and the Reintegration of Offenders (NICRO)* 2005 (3) SA 280 (CC) para 21. See also the judgment of Sachs J in *Sidumo v Rustenburg Platinum Mines* (note 3 above) paras 148-50.

[8] For a useful explanation of substantive equality see the judgment of Sachs J in *Van Heerden* (note 3 above) paras 141-6. See also C Albertyn 'Substantive Equality and Transformation in South Africa' (2007) 23 *SAJHR* 253, 254-61.

[9] See also Albertyn & Goldblatt (note 7 above) 250; S Liebenberg & B Goldblatt 'The Interrelationship Between Equality and Socio Economic Rights under South Africa's Transformative Constitution' (2007) 23 *SAJHR* 335, 342.

[10] G Brodsky & S Day 'Denial of the Means of Subsistence as an Equality Violation' (2005) *Acta Juridica* 149, 161-2.

substantive equality, the Constitution promotes the transformation of society through the egalitarian sharing of resources and political influence. Indeed, this presupposes the eradication of material disadvantage based principally on race, gender and class.[11]

Substantive equality rejects the notion of individual merit that characterises formal equality. This is essential because not all persons are properly placed to reap the benefits of their rights to resources and services. Therefore, substantive equality, at its essence, entails a 'positive duty' on the state to provide those it governs with essential resources and services in a way that accords each citizen equal concern and respect.[12] It recognises that vulnerable persons are not culpable for their impoverishment and deprivation and that the state cannot adopt policies that assume their individual and collective ability to participate as equals in society. Failing to alleviate the burden faced by vulnerable persons perpetuates the cyclical nature of poverty and disease, and their association with not having access to essential resources and services.[13]

Substantive equality aims to achieve two types of equality: First, there is the attainment of 'equality of opportunity' and secondly, there is the realisation of 'equality of results'. Fredman explains that equality of opportunity requires positive measures to be taken so that all persons and groups have an equal chance to access socio-economic amenities. Equality of results is where people who have the same opportunities achieve similar or equal outcomes. Equality of results should follow from equality of opportunity, but is not guaranteed by it. In order to achieve this, measures must be adopted that are sensitive to the needs of dissimilarly situated people, instead of adopting a one-size-fits-all approach that fails to consider the differing ways in which disadvantage affects different people. In this respect, people suffer from different diseases, and face divergent obstacles that inhibit access to health care.[14]

Substantive equality is also premised on the idea of social solidarity, which views groups and individuals as bearing responsibility for the wellbeing of other groups and

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[11] Albertyn & Goldblatt (note 7 above) 249.

[12] S Fredman 'Providing Equality: Substantive Equality and the Positive Duty to Provide' (2005) 21 *SAJHR* 163, 167.

[13] On the cyclical nature of ill health and poverty see S Murray 'Poverty and Health' (2006) 174 *Canadian Medical Association J* 923; A Wagstaff 'Poverty and Health Sector Inequalities' (2002) 80 *Bulletin of the World Health Organization* 97; P Braveman & S Gruskin 'Poverty, Equity, Human Rights and Health' (2003) 81 *Bulletin of the World Health Organization* 539.

[14] Fredman (note 12 above) 167.

individuals in society.[15] This entails a duty to share resources fairly. In other words, groups and individuals cannot live in isolation from each other with some groups being flush with resources and others lacking basic necessities. The ability to maximise individual and group potential is directly related to the degree of interdependence on one another with cross subsidisation between the rich and poor being an essential element.[16] Individual autonomy thrives when an all-inclusive community contributes to its own wellbeing. In other words, the value of substantive equality suggests that the only way to maximise individual and group advantage is through an inclusive, cooperative and mutually responsible community.[17] The contribution of all sectors of society to the common good creates the conditions necessary for effectively maximising individual potential for all.

Ultimately, the maximising of individual potential can only be achieved when the deprivation of others is seen as our own.[18] Indeed, when privileged sectors of society have access to more than sufficient resources to enable the achievement of the good life and there are others who do not have even basic resources, then to those who are less vulnerable, there is unfairness and injustice.[19] This idea of 'mutual responsibility' underlies the redistributive call of substantive equality. It is only through redistributive policies that the harmful effect of social constructs of inequality, institutionalised deprivation, and poverty can be eradicated. Indeed, in South Africa, where privilege was previously defined on the basis of race, those who benefitted from apartheid and those who are economically privileged must allow for and contribute to the achievement of a more egalitarian distribution of resources.[20]

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[15] H Collins 'Discrimination, Equality and Social Inclusion' (2003) 66 *Modern LR* 16, 24. See also a lecture given by John Laws on social solidarity and interdependence in J Laws 'The Constitution: Morals and Rights' (1996) *Public Law* 622.

[16] See J Agatuba & J Azakili 'Health Care Financing in South Africa: Morving Towards Universal Coverage' (2010) 28 *Continuing Medical Education* 74, 76. This source deals with solidarity in universal health insurance markets and does not directly deal with potential and social solidarity. Social solidarity is central to the notion of social citizenship. On social citizenship in the European Union see C Newdick 'The European Court of Justice, Trans-national Health Care, and Social Citizenship – Accidental Death of a Concept? (2008-2009) 26 *Wisconsin Int LJ* 844 and C Newdick 'Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity' (2006) 6 *Common Market LR* 1645, 1646-53.

[17] See A Etzioni *The Spirit of Community* (1995) 8.

[18] This idea also pervades the interface between ubuntu and dignity. See D Cornell 'Is There a Difference Between Ubuntu and Dignity' (2010) 25 *SA Public Law* 382, 393-5; D Cornell 'A Call for a Nuanced Constitutional Jurisprudence: Ubuntu, Dignity and Reconciliation' (2004) 19 *SA Public Law* 666, 668.

[19] See J Sacks *To Heal a Fractured World – The Ethics of Responsibility* (2005) 5 where the author writes of a righteous person who would not light a fire in his own home if he knew that poor persons were suffering from the cold.

[20] See the judgments of Sachs J in *Van Heerden* (note 6 above) paras 137, 142-5 and *Pretoria City Council v Walker* 1998 (2) SA 363 (CC) para 109.

Flowing from this idea of responsibility is the positive obligation on government to implement measures that are designed to alleviate the effects of past discrimination, both in purpose and effect. This obligation has two interrelated aspects. First, social programmes must be focussed on distributing resources and offering a set of services that have particular benefit for those who are most vulnerable, especially those who were previously disadvantaged. Secondly, substantive equality requires differential treatment for dissimilarly placed persons: those who are less able to exercise their constitutional rights must be given adequate opportunities to do so.[21] Therefore, substantive equality requires some level of discrimination.[22] These requirements are not incompatible with the requirement to treat all persons with the same concern and respect and as having equal worth.[23] Some persons are better able to secure access to services and resources due to past and current economic privilege, and are thus less reliant on the goodwill of government. Others are totally dependent on provision by government, requiring programmes to be developed by it to respond more directly to their needs.

Similarly, in *Van Heerden*, Sachs J describes substantive equality as being 'relational rather than linear.' [24] It is relational because the value of equality is premised on the equal dignity and respect of *all* human beings regardless of group membership or personal characteristics.[25] At times, this may require individuals and groups within society to bear a proportional measure of sacrifice for the wellbeing of the 'other'. Such sacrifice is borne by the need for government to give priority to the needs of the most vulnerable.[26] In describing

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[21] Albertyn & Goldblatt (note 7 above), 253.

[22] S Cowen 'Can 'Dignity' Guide South Africa's Equality Jurisprudence' (2001) 17 *SAJHR* 34, 37.

[23] See the often quoted statement of Goldstone J in *President of the Republic of South Africa v Hugo* ('*Hugo*') 1997 (4) SA 1 (CC) para 41 where he states:

> 'We need, therefore, to develop a concept of unfair discrimination which recognises that, although a society which affords each human being equal treatment on the basis of equal worth and freedom is our goal, we cannot achieve that goal by insisting upon identical treatment in all circumstances before that goal is achieved. Each case, therefore, will require a careful and thorough understanding of the impact of the discriminatory action upon the particular people concerned to determine whether its overall impact is one which furthers the constitutional goal of equality or not. A classification which is unfair in one context may not necessarily be unfair in a different context.'

See also the judgment of O'Regan J in *Hugo* para 112 where she stated 'insisting upon equal treatment in circumstances of established inequality may well result in the entrenchment of that inequality' and the judgment of Sachs J in *Walker* (note 20 above) para 128 where he stated 'the right to equality means the right to be treated as equals, which does not always mean the right to receive equal treatment.

[24] *Van Heerden* (note 6 above) para 146.

[25] See also the statement of Goldstone J in *Hugo* (note 23 above) para 4.

[26] For a discussion on the notion of priority see D Parfit 'Equality and Priority' (1997) *Ratio* 202, 212-3; Collins (note 15 above) 23; R Norman 'Equality, Priority and Social Justice' (1999) *Ratio* 178.

the purpose of the equality guarantee in the Canadian Charter, Iacobucci J stated that 'the purpose of section 15 is ... to promote a society in which all persons enjoy equal recognition at law as human beings or as members of ... society, equally capable and equally deserving of concern, respect and consideration'.[27] In South Africa, such recognition can only come about when disadvantaged persons become equally capable of accessing the same health care services as socially advantaged persons.

The tools for achieving substantive equality are the rights to equality and not to be subjected to unfair discrimination in section 9 of the Constitution. These rights, as animated by section 9(2), protect measures designed to achieve equality from challenges likely to be brought by more advantaged persons on the basis of some adverse effect in the context of redistribution. This reinforces the commitment to substantive equality, as it evinces a burden on privileged persons to somehow contribute to the wellbeing of those less fortunate than them. Fulfilling this burden, restores their dignity because it promotes the enjoyment of rights for all people.[28] However, it also protects the interests of previously advantaged persons by limiting the effects that far-reaching restitutionary measures may have on their interests.

## III. FAIRNESS AND SECTIONS 9(2) AND 9(3) OF THE CONSTITUTION

The equality clause promotes equal concern and respect for all persons by outlawing all forms of unfair discrimination. It does this by guaranteeing 'everyone' equality before the law and equal protection and benefit of the law in terms of section 9(1). [29] It also prohibits unfair discrimination against 'anyone' on a specific ground or a non-specified ground under section 9(3) of the Constitution.[30] Section 9(2) allows for measures that are designed to promote the achievement of equality for disadvantaged persons even if they discriminate against previously advantaged persons. Section 9 signals a clear break from the apartheid era

[27] *Law v. Canada (Minister of Employment and Immigration)* [1999] 1 S.C.R. 497 para 51.

[28] See *Van Heerden* (note 6 above) para 145.

[29] In this section I do not analyse section 9(1) of the Constitution in any great detail. That section merely requires that a legislative or policy differenation is rationally related to a legitimate government purpose. See in this regard *Jooste v Score Supermarket Trading* 1999 (2) SA 1 (CC) paras 10-9; C Albertyn & B Goldblatt 'Equality' in S Woolman & M Bishop *Constitutional Law of South Africa* (2nd ed 2003) chapter 35, 17-22, as well as *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) para 18 where the Constitutional Court indicated that the rationality test may be dispensed with in a case of clear unfair discrimination.

[30] Section 9(3) also prohibits unfair discrimination on grounds not specified in that section. This is clear from the text of the section, which reads 'The state may not unfairly discriminate directly or indirectly against anyone on *one or more grounds, including* race, gender, sex…'

when the government expressly discriminated against non-white persons in a way that denied their human dignity.

However, it does not end with section 9 of the Constitution. The Legislature has enacted the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 ('PEPUDA'), which was enacted pursuant to section 9(4) of the Constitution. Section 6 of PEPUDA echoes the provisions of the Constitution and states that '[n]either the state nor any person may unfairly discriminate against any person.' In addition, sections 24 and 25 of PEPUDA impose an obligation on the state to 'promote and achieve equality' by taking 'measures to develop and implement programmes in order to promote equality' and to enact legislation to this effect. Section 8 of PEPUDA specifically prohibits limiting access to health care services and benefits by women. Section 3(b) of the schedule to PEPUDA prohibits the unfair denial and refusal of access to health care services to any person, or failing to make such health care facilities available to any person.[31]

### (a) Redressing disadvantage – The transformative aspect of section 9

In the case of *Harksen v Lane*,[32] the Constitutional Court, per Goldstone J, developed a test for considering whether a measure violates the equality clause of the Interim Constitution ('IC').[33] The enquiry for section 9 of the Final Constitution is substantially similar to the one laid down in *Harksen* for section 8 of the IC. In *Hoffmann*, Ngcobo J crystallised the enquiry developed in *Harksen* for determining whether a measure violates section 9 into a three-stage test:[34] Firstly it must be assessed whether the differentiation at issue is rationally connected to a legitimate government purpose. If the measure fails to pass this hurdle then it is irrational

[31] Section 3(c) of the schedule of PEPUDA substantially echoes section 27(3) of the Constitution by repeating its prohibition of refusing to deny anyone emergency medical treatment. Section 3(d) adds a further exhortation requiring the authorities to provide reasonable health care services to elderly persons. Section 5 of the schedule also contains detailed provisions prohibiting unfair discrimination in relation to insurance policies, which could be interpreted to apply to medical scheme options, health insurance products offered by short-term insurance companies as well as insurance type services provided by the state.

[32] See P De Vos '*Grootboom*, the Right of Access to Housing and Substantive Equality as Contextual Fairness' (2001) 17 *SAJHR* 258, 273-4 where he writes of the positive aspect of constitutional rights reflecting their transformative nature and the negative aspect reflecting their non-transformative nature. See *Harksen v Lane* 1998 (1) SA 300 (CC) ('*Harksen*') paras 40-53.

[33] Interim Constitution Act 200 of 1993, section 8. The Interim Constitution has been repealed. See also section 14 of PEPUDA, which amplifies in legislative form the test for an equality infringement.

[34] See *Hoffmann v South African Airways* 2001 (1) SA 1 (CC) para 24 and *Van Heerden* (note 6 above) paras 28-44. For an in-depth and expansive explanation of the formula for testing compliance with section 9 see Albertyn & Goldblatt (note 29 above) 17 onwards.

and violates section 9(1). If a measure is rational then one considers the fairness of the measure. If the measure is one that fits within the confines of section 9(2) in the sense that it is designed to promote the achievement of equality or to advance the position of disadvantaged persons, then the differentiation will be presumed fair and the enquiry ends there. If the differentiation is not one contemplated by section 9(2), then it must be assessed whether the differentiation implicates one of the grounds of discrimination under section 9(3) of the Constitution. If it does, then the measure is *presumed* to be unfair. If it does not implicate one of the section 9(3) grounds then it must be considered whether it implicates an analogous ground by violating the human dignity of the individual complainant or the complainant group.[35] If a measure is found to be unfair in terms of section 9 of the Constitution then one reaches the third aspect of the test, which is whether the discrimination can be justified under section 36 of the Constitution. I do not deal with section 36 in this chapter.

The overarching test of whether a measure is inconsistent with section 9 is whether the impugned group or individual on behalf of whom it is alleged that unconstitutional discrimination has occurred can show that the discrimination is *unfair*. In *President of the RSA v Hugo*, this test involved an assessment of the context of the alleged violation, its impact on those whom it adversely affected, the nature of the power through which the discrimination was effected and the nature of the interests implicated.[36] In *Harksen*, the Constitutional Court added that regard must be given to the standing of the complainants in society and whether they had been subjected to unfair discrimination in the past; the nature of the power and its purpose; whether the purpose of the measure was the achievement of a significant social objective and whether it was aimed at specifically impairing the interests of the affected group on a ground specified in section 9(3); and lastly whether the discriminatory measure has fundamentally impaired their human dignity.[37]

The question whether a legislative or policy measure is consistent with section 9 will depend on whether it unfairly discriminates against a specified group, having regard to the social context and the impact of the measure on the group concerned.[38] At times, socio-

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[35] See *Harksen* (note 32 above) para 51 point (c).

[36] See the judgment of Goldstone J in *Hugo* (note 23 above) paras 41-3.

[37] *Harksen* (note 32 above) para 51. See also the judgment of O' Regan J in *Hugo* (note 23 above) para 112.

[38] See *Khosa v Minister of Social Development* 2004 (6) SA 505 (CC) paras 49, 72. Although para 49 appears in the context of a reasonableness enquiry for socio-economic rights, the social and historical context of an individual or group, the reasonbleness test was also considered in the context of an equality violation. See

economic programmes will only benefit disadvantaged persons. At other times, advantaged groups might also have to endure negative repercussions from a transformative measure. This reflects a two-fold purpose of section 9 in general and section 9(2) in particular. The first is that government must take positive measures to enhance the achievement of equality for persons disadvantaged by unfair discrimination, such as black persons, women and the disabled. The second is that these measures must be devised and implemented despite there being adverse effects on previously advantaged groups. For example, a measure designed to benefit black persons or a class of persons that are mostly black is permitted to have an adverse effect on white persons.[39] Ordinarily, measures that directly or indirectly discriminate against persons on the basis of race and gender would attract a presumption of unfairness under section 9(3) of the Constitution. The effect of section 9(2) is to counter the presumption of unfairness for transformative measures that have an adverse impact on less vulnerable groups.

Moseneke J held on behalf of a majority in *van Heerden* that, for a measure to pass the hurdle of section 9(2) of the Constitution, it must be *aimed* at enhancing those subjected to unfair discrimination; it must also be designed to safeguard and improve the position of these persons; and must advance the achievement of equality. The first aspect of the test is clear. With regard to the second aspect, the measure 'must be *reasonably* capable of attaining the desired outcome', in the sense that the programme must be reasonably capable of achieving the purpose for which it was designed. The third aspect is satisfied if the measure promotes the achievement of equality in the long run, considering its effect in a broad societal context. However, if a measure is consistent with section 9(2), it does not amount to unfair discrimination.[40]

On a strict application of the test laid down by the majority in *Van Heerden*, it would be difficult to find that a *bona fide* redistributive measure predominantly benefitting previously disadvantaged groups would fall foul of the equality clause. Section 9(2) promotes the substantive equality character of the equality clause and the Constitution as a whole.[41] This is so because it imposes a positive obligation on government to devise and implement

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also P De Vos 'Substantive Equality after *Grootboom*: The Emergence of Social and Economic Context as a Guiding Value in Equality Jurisprudence' (2001) 52 *Acta Juridica* 52, 58-63.

[39] *Walker* (note 20 above) paras 110-111.

[40] *Van Heerden* (note 6 above) paras 37-44. Quote is at para 41.

[41] See Albertyn & Goldblatt (note 29 above) 30 where the authors call section 9(2) – 'a statement of substantive equality'.

programmes to advance the position of disadvantaged persons. This obligation is also derived from the injunction to 'promote all rights in the Bill of Rights' under section 7(2) of the Constitution. Government also has a negative obligation not to subject groups and individuals to unfair discrimination in terms of section 9 read with the obligation to respect existing rights in terms of section 7(2). It may be argued that these obligations apply not only to equality claims based on status, but also to resource-based claims. In other words, an unfair and inequitable distribution of resources can attract equality and unfair discrimination claims.[42]

This is evident from *Khosa v Minister of Social Development*[43] where several provisions of the Social Assistance Act 59 of 1992 were declared unconstitutional because they were inconsistent with rights to equality and to have access to social security.[44] There were two sets of applicants before the Court, all of whom were permanent residents. One set challenged the constitutionality of provisions in the Social Assistance Act for only affording social grants to aged South African citizens. The other set challenged the constitutional validity of provisions that reserved child-support and care-dependency grants for South African citizens only. The Constitutional Court held in favour of the applicants in both challenges. *Khosa* is an example of an equality claim based on the unfair and differential allocation of resources. Resource claims do in fact give rise to equality claims when the deprivation at issue is also one that arises from unfair discrimination.[45]

The intersection between equality and socio-economic rights shows that inequality and unfair discrimination can arise out of both distributive and status-based inequalities.[46] This shows that the state is obligated to implement ameliorative measures aimed at redressing socio-economic disadvantage as part of its obligations under section 9(2). Moreover, it gives force to the argument that poverty and socio-economic deprivation constitute analogous grounds that may give rise to unfair discrimination claims under section 9(4) of the Constitution.

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[42] In my view, to regard poverty as distinct from another traditional status-based claim is to fundamentally undermine a substantial purpose of the equality clause. For more on this topic see M Wesson '*Grootboom* and Beyond: Reassessing the Socio-Economic Jurisprudence of the South African Constitutional Court' (2004) 20 *SAJHR* 284, 293-4.

[43] *Khosa* (note 38 above).

[44] section 27(1)(c) of the Constitution. See Annexure A.

[45] See Wesson (note 42 above) 293.

[46] Se De Vos (note 38 above) 66.

The idea that poverty can give rise to unfair discrimination claims has attracted some academic support.[47] Brodsky and Day have forcefully argued in the context of the Canadian Charter that not implementing ameliorative measures would entrench the status-quo of group-based disadvantage. This, in turn, would violate the right to equality and not to be subjected to unlawful discrimination under section 15. According to them, if government denies the means of subsistence to various groups in society, then the goal of the equality right, which is the amelioration of group-based disadvantage, is impeded. This is so because poverty increases the inequality of those who are already disadvantaged and perpetuates it.[48] It does injustice to the scheme of the equality right if the degree of poverty experienced by distinct groups does not play a dominant role in assessing whether a measure falls within the ambit of section 9(2), and when otherwise considering the fairness of a measure. In the light of this, section 9(2) must also be read to allow for measures aimed at a redistribution of resources that benefit the poor.

*Khosa* bears this out. Whilst *Khosa* was decided primarily under section 9(3) of the Constitution, the determinative factor that weighed with the majority of the Court in assessing fairness was the impact these exclusionary measures had on the applicants. The majority pointed out that people in the position of the applicants were forced into relationships of dependency. In this regard, the majority stated 'the denial of the right is total and the consequences of the denial are grave.'[49] What made these persons deserving of constitutional protection was their poverty and the consequences this had on all aspects of their lives. Indeed, the negative impact of a discriminatory measure increases relative to the degree of poverty experienced by a person or vulnerable group. This causes the unfairness to be more explicit. Section 9(2) was not implicated in *Khosa*, because from the perspective of the applicants, the case was about a negative right not to be subjected to unfair discrimination

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[47] See J Mubangizi 'The Role of Human Rights Law in Community Development: A South African Perspective' (2004) 3 *Stellenbosch LR* 522, 527-8 where Mubangizi makes an argument connecting the purpose of the equality clause to alleveating the 'unequal distribution of resources'. See also S Liebenberg & M O'Sullivan 'South Africa's New Equality Legislation: A Tool for Advancing Women's Socio-Economic Equality?' (2001) *Acta Juridica* 70 for a useful analysis at 70-7 on women's socio-economic inequality and poverty in South Africa. See also 81 where the authors state in the context of the equality clause that 'Positive measures are essential to ensure that disadvantaged groups, such as poor women, enjoy equal access to resources, services and opportunities available in society.' See also P De Vos ibid 66-9 where the author discusses 'Disproportionate impact and socio-economic vulnerability as a suspect class'.

[48] Brodsky & Day (note 10 above) 162. See also L Sossin 'Towards a Two-Tier Constitution? The Poverty of Health Rights' in C Flood, K Roach & L Sossin (eds) *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (2005) 169 where Sossin writes of the inter-relatedness of poverty and health rights.

[49] *Khosa* (note 38 above) para 77.

instead of positive measures designed to enhance the position of disadvantaged persons. Nevertheless, the absence of such positive measures also implicates the fairness criterion. If measures are taken to enhance the position of people such as the applicants, these measures would be presumed to be fair primarily because of the extent of their disadvantage, which is primarily defined by their poverty. Therefore it is clear that poverty is and should be relevant to an assessment of fairness in a claim based on unfair discrimination.

Therefore, it is evident that the question of fairness is directly related to the 'position of the complainants in society', which requires an assessment of the poverty of vulnerable groups.[50] Indeed, if the targeted beneficiaries belong to a group that was subjected to past unfair discrimination, then the measure is likely to be regarded as fair, despite adverse effects on advantaged groups. Nevertheless, section 9 affords equal protection and benefit of the law to 'everyone' and also outlaws unfair discrimination against 'anyone', not just against previously disadvantaged groups. Less vulnerable groups may not be subjected to unfair discrimination because doing so would run counter to the scheme of the Constitution as a whole and also undermine transformative efforts undertaken by government designed to advance the position of the poor. It is to this topic that I now turn.

**(b) Adverse effect discrimination and preserving existing access for less vulnerable persons**

The purpose of section 9(2) of the Constitution is to ensure that previously advantaged members of society are prevented from quashing measures aimed at advancing equality.[51] It is evident from sections 9(3) and 9(4) of the Constitution that the state, natural persons and judicial persons may not unfairly discriminate against anyone, be it directly or indirectly, on any of the enumerated grounds or on an analogous ground. In terms of section 9(5) of the Constitution, if the discrimination is based on any of the listed grounds then a presumption of unfairness arises. For instance, if section 9(2) did not exist, then white persons would have a

[50] *Harksen* (note 32 above) para 51(a).

[51] The idea that the a constitution must not be used by better situated individuals to curtail legislation designed to enhance the position of disadvantaged persons was recognized by the Supreme Court of Canada per Dickson CJ in *R. v. Edwards Books and Art Ltd*., [1986] 2 S.C.R. 713, para 141 where the following is stated:

> 'In interpreting and applying the Charter I believe that the courts must be cautious to ensure that it does not simply become an instrument of better situated individuals to roll back legislation which has as its object the improvement of the condition of less advantaged persons.'

presumption of unfairness in their favour when challenging a measure aimed at enhancing the position of black persons because race is a listed ground under section 9(3). The same would apply to a situation in which males challenge a measure aimed at benefitting females.

The Constitutional Court has on numerous occasions said that, at times, transformative measures will adversely affect previously advantaged persons. For example, in *Bato Star Fishing v Minister of Environmental Affairs and Tourism*,[52] Ngcobo J stated:

> '[T]ransformation is a process. There are profound difficulties that will be confronted in giving effect to the constitutional commitment of achieving equality. We must not underestimate them. The measures that bring about transformation will inevitably affect some members of the society adversely, particularly those coming from the previously advantaged communities. It may well be that other considerations may have to yield in favour of achieving the goal we fashioned for ourselves in the Constitution. What is required, though, is that the process of transformation must be carried out in accordance with the Constitution.'

Sachs J also mentioned in *Van Heerden* that '[r]emedial action . . . destabilises the existing state of affairs often to the disadvantage of those who belong to the classes of society that have benefitted from past discrimination.'[53] From these passages, it is clear that adverse effects on advantaged groups in society are regarded as inevitable consequences of transformation. It is a sacrifice that must be borne by wealthier segments of society. If adverse effect discrimination trumped redistributive policy, it would be difficult for the state to implement programmes promoting the advancement of disadvantaged groups.

Nevertheless, the permissibility of adverse effect discrimination or indirect discrimination does not mean that all restitutionary measures will pass constitutional muster. In section 9, emphasis is placed on the vulnerability of affected parties. However, those who may allege unfair discrimination in the context of health redistribution programmes, such as NHI, might not always be previously disadvantaged persons. Some of these people have not been subjected to unfair discrimination in the past, and many of them still benefit from the systemic and structural privilege inherited from apartheid.[54] Despite this, these people can in certain instances be subjected to unconstitutional discrimination even if measures are designed to improve the position of disadvantaged persons. This could happen if

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[52] *Bato Star Fishing v Minister of Environmental Affairs and Tourism* 2004 (4) SA 490 (CC) para 76. See also para 106.

[53] *Van Heerden* (note 6 above) para 144.

[54] Moreover, an increasing number of non-white persons, despite coming from disadvantaged backgrounds, are economically privileged. Despite being black, the extent of their vulnerability is considerably less than those black persons who are poor. See judgment of O' Regan J in *Hugo* (note 23 above) para 112.

restitutionary measures fundamentally denigrate the interests of these individuals to such an extent that section 9(2) becomes inapplicable. This would then attract a presumption of unfairness in terms of section 9(3) read with section 9(5) of the Constitution.

In *Van Heerden*, Sachs J cautioned that when measures are taken pursuant to section 9(2), advantaged members of the community may not 'be treated in an abusive or oppressive way that offends their dignity and tells them and the world that they are of lesser worth than the disadvantaged.'[55] He stated further that a transformative measure may not

> '... be overbalanced in ignoring or trampling on the interests of members of the advantaged section of the community, and gratuitously and flagrantly imposes disproportionate burdens on them…'[56]

The impermissibility of disproportionate adverse effect discrimination is borne out by the three-pronged test adopted by the Constitutional Court in *Van Heerden* in assessing compliance with section 9(2), mentioned earlier in this chapter.[57] The three questions were first, whether the measure targets those who were previously disadvantaged by unfair discrimination; the second is whether the measure is designed to advance and protect the position of these persons; and the third is whether the achievement of equality is promoted by the measure under consideration.

Even if a measure passes the first hurdle under the *Van Heerden* test, it must still pass the second and third hurdles. In dealing with the second aspect of the test, Moseneke J stated that a measure must be 'reasonably capable of attaining the desired outcome… if the remedial measures are arbitrary, capricious or display naked preference they could hardly be said to be designed to achieve the constitutionally authorised end'. Furthermore he stated that, if the measures were unlikely to improve the position of the disadvantaged, then the measures would not be protected under section 9(2).[58] Therefore, it is evident that the second hurdle demands redistributive measures to have a reasonable likelihood of improving access to essential resources and services for disadvantaged persons. This requires that difficult social circumstances and hard realities affecting resource distribution in health care must be considered when assessing the constitutionality of a redistributive programme. Health policy must have the potential to effectuate an equitable redistribution of resources that puts

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[55] *Van Heerden* (note 6 above) para 151.

[56] Ibid para 152.

[57] Ibid paras 37-44. See above at 69 of this chapter.

[58] Ibid para 41.

disadvantaged persons into a better position without merely reducing access for less vulnerable persons.

An adverse effect unaccompanied by a reasonable probability of improvement in resource distribution and services to disadvantaged communities cannot fit within the scope of section 9(2). Even the term 'adverse effect' implies that there is a main purpose for which the measures are undertaken. If that purpose cannot be achieved, or if the desired purpose is not consistent with the values underlying the Constitution, then there can be no justification for any adverse effect. In such cases, measures would not be amongst those contemplated by section 9(2) because they would be 'arbitrary, capricious [and may] display naked preference'. Such measures would also be inconsistent with the exhortation of Sachs J in *Van Heerden* that 'a scheme that was so lacking in thought and organisation as seriously to threaten the very functioning and survival of the enterprise involved, would lack rationality, and could not be said to advance or be fair to anybody, let alone the disadvantaged.'[59]

The more direct caution against extreme adverse effects is evident from the third aspect of the *Van Heerden* test, which questions whether a measure will promote the achievement of equality. In this regard, Moseneke J stated 'whether a measure will in the long run promote the achievement of equality requires an appreciation of the *effect* of the measures in the context of our broader society' (my emphasis). Moseneke J accepted as a given that transformative measures will have adverse effects on previously advantaged persons. That is uncontroversial. However, he cautioned that the purpose of the Constitution is the achievement of a socially just society. If a measure frustrates this objective, then the adverse effects on previously advantaged groups would be considered unfair.[60]

Moseneke J held that if a measure amounted to an 'abuse of power' or caused 'substantial and undue harm' to those who do not benefit from a transformative scheme, then the measure would be inconsistent with section 9(2) of the Constitution. This is so because the Constitution's vision of a society in which all are treated with equal concern and respect is undermined. Indeed, if the impact of the redistributive measure is so invasive on the interests of the implicated group that even the gain to disadvantaged persons cannot justify it, then the measure would constitute unfair discrimination on specified grounds, such as race

[59] Ibid paras 41, 149.

[60] Ibid para 44.

and gender, under section 9(3) of the Constitution. These sorts of measures would, according to Moseneke J, threaten the 'long-term goal' of the Constitution.[61]

Moreover, in terms of *Harksen*, when assessing the fairness of a measure on a group, the test for unfair discrimination requires, in addition to other factors, an assessment of 'any other relevant factors, the extent to which the discrimination has affected the rights or interests of complainants and whether it has led to an impairment of their fundamental human dignity…'.[62] Therefore, despite its emphasis on ameliorating the plight of vulnerable groups, the test for unfair discrimination leaves room for an assessment of the impact of discrimination on the interests of more privileged sectors of society, albeit with the pendulum swinging in favour of disadvantaged persons. Therefore, it is clear that section 9 does not allow for measures that arbitrarily and disproportionately overrun the interests of an advantaged group in a way that undermines their human dignity. In such cases, not even the benefits to disadvantaged groups will justify such measures.

Moreover, the Constitution does not condone 'equality of the graveyard.'[63] Even if disadvantaged persons have inadequate access to health care services in public sector hospitals, section 9 does not allow the implementation of measures that merely reduce the benefits of advantaged persons to the same level of inadequacy. The text of section 9(2) bears this out. The first part states 'Equality includes the *full* and *equal* enjoyment of all rights and freedoms'. The juxtaposition of the words 'full' and 'equal' means that the equality envisioned by this section is defined by the extent of enjoyment of rights and freedoms, and not merely by equality of access to resources and services.

Consequently, measures that lead to 'equality of the graveyard' would not be presumed fair under section 9(2). Such measures are not reasonably capable of achieving the mandated purpose of increasing access to health care services if their only effect is to level down privileged access. Moreover, if the only purpose of a measure was to level down privileged access to health care services and not to enhance access for the disadvantaged, then this would constitute an 'abuse of power' and may cause 'substantial and undue harm'.[64] This could occur if health care services are either unreasonably withheld or become

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[61] Ibid.

[62] *Harksen* (note 32 above) para 51. This is in addition to a consideration of the 'position of the complainants in society' and 'the nature of the provision or power and the purpose sought to be achieved by it'.

[63] See chapter 2 of this thesis at footnote 6. *Minister of Home Affairs v Fourie* 2006 (1) SA 524 (CC) para 149; *National Coalition for Gay and Lesbian Equality v Minister of Home Affairs* 2000 (2) SA 1 (CC) para 77.

[64] *Van Heerden* (note 6 above) paras 41, 44.

unavailable as a result of health system reform. Indeed, if substantial and undue harm occurs for users of the health system then this has relevance to the impact inquiry in unfair discrimination claims. The probability of a finding of unfair discrimination succeeding increases as the impact of any adverse effect increases.[65]

It is clear then that when implementing redistributive measures, care must be taken not to unfairly discriminate against advantaged groups. That is not an excuse for entrenching the status quo, but a necessary precondition for transformative measures aimed at enhancing the position of those disadvantaged by past unfair discrimination. Otherwise, these measures will constantly be challenged in court and doubt regarding their constitutionality will hold back far-reaching and necessary redistributive programmes like NHI. However, even if a measure is consistent with section 9(2), this does not shield a redistributive programme from giving rise to unfair discrimination. In the following subsection, I deal with two examples of unfair discrimination that might arise under a future NHI.

### (c) Age and health status as examples of listed and unlisted grounds of discrimination – beyond the section 9(2) analysis

I explained above that redistributive measures, such as NHI, will generally be consistent with the right to equality in general, and section 9(2) in particular. This is because these measures will rarely be inconsistent with the *Van Heerden* test if their purpose is to facilitate the achievement of equality. But this does not mean that unfair discrimination will never result from redistributive measures like NHI. Sometimes, redistributive programmes, the main purpose of which are to ameliorate the position of the poor and disadvantaged, may cause resources to be allocated in ways that have an adverse impact on discrete groups of people. For example, the allocation of benefits under NHI or individual rationing decisions may give rise to discrimination on the basis of age and health status. Age is a ground listed under section 9(3) that gives rise to a presumption of unfair discrimination. Health status is an unlisted ground that has given rise to an unfair discrimination claim in the employment context, and may also be implicated in the context of health care.[66]

Unfair discrimination on the basis of age and health status may arise even if a redistributive programme is generally consistent with section 9(2). Section 9(2) does not

[65] *Hugo* (note 23 above) para 112

[66] See *Hoffmann v South African Airways* (note 34 above).

shield a measure from forms of discrimination unrelated to the achievement of equality for poor and disadvantaged persons. Consequently, unfair discrimination may still be established under section 9(3) for both listed and unlisted grounds. The test for compliance with section 9(2) in *Van Heerden* is arguably distinct from the assessment of whether a measure amounts to unfair discrimination under section 9(3).[67] In terms of *Harksen*, a measure amounts to discrimination if it differentiates between people on a listed ground or an unlisted ground. However, a measure will only be inconsistent with section 9 if the discrimination is unfair. If a listed ground is implicated, then unfairness will be presumed unless the contrary is shown. If there is discrimination on an unlisted ground, then it must be shown that a measure has an unfair impact on an individual or group. In considering whether this is the case, a court will consider the 'position of the complainants in society', the nature of the law or power giving rise to a decision and its relation to a sought after purpose ('rationality enquiry'), and any other relevant factors.[68]

When considering age and health status discrimination in the context of *Harksen*, the notion of 'capacity to benefit' must be taken into account. Expressed differently, the ability of a person to benefit from treatment must be considered.[69] This is important because the effectiveness of a health intervention depends on the medical condition of a person being presented for treatment. For example, the prognosis of an elderly person who undergoes an invasive surgical procedure might be lower than that of a younger person. Generally, elderly persons have feeble bodies, and therefore face greater risks when undergoing invasive treatment. Similarly, pre-existing health conditions might also reduce the capacity of a person to benefit from health care interventions. For example, the applicant in *Soobramoney v Minister of Health* was denied access to renal dialysis because he suffered from ischaemic heart disease and cerebro-vascular disease. He was also in final stage kidney failure and was not a candidate for a kidney transplant. For these reasons, the dialysis treatment was not deemed cost-effective, as the renal dialysis machines could be more advantageously devoted to people with a better prognosis.[70]

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[67] Daniel Pretorius criticises the Court for comparmentalising the tests for compliance with section 9(2) and the test for unfairness under section 9(3) of the Constitution. See D Pretorius 'Fairness in Transformation: A Critique of the Constitutional Court's Affirmative Action Jurisprudence' (2010) 26 *SAJHR* 536, 567-8. See also the judgment of Sachs J in *Van Heerden* (note 6 above) para 136.

[68] *Harksen* (note 32 above) paras 46-53.

[69] JG Evans 'Age Discrimination: Implications of the Ageing Process' in S Fredman & S Spencer (eds) *Age Equality as an Equality Issue – Legal and Policy Perspectives* (2003) 17.

[70] *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC). It should be borne in mind that this case was not decided on the basis of unfair discrimination.

The power invested in health authorities to make decisions concerning resource allocation and health rationing will sometimes adversely affect patients. Evidently, some of the decisions will discriminate between people on the basis of health status and age, as described above. Such discrimination is generally directed at using existing resources to the maximum advantage of those requiring them. Thus if the discrimination is based on sound clinical conditions of individual patients, then it is likely that the impact on an individual or group of persons will be fair in terms of the rationality enquiry in *Harksen*.[71]

However, if discrimination on the basis of age and health status are not based on sound clinical criteria or are used as arbitrary standards independent of the health prognosis of a particular patient, then the impact will likely be regarded as unfair.[72] This is so for at least two reasons: Firstly, arbitrary discrimination between people can never be related to a legitimate purpose in a rational way as required by *Harksen*.[73] Secondly, arbitrary discrimination denigrates the dignity of an individual or group because it fails to treat them with equal concern and respect. For example, a health authority may reason that elderly people beyond a certain age have had a 'fair innings' or have lived long enough and have no rightful claim to scarce health resources.[74] Similarly, administrators might have less regard for the experience of life of older people when compared to younger people, or sick people when compared to healthy people.[75] In other words, some may view the lives of the elderly and the sick as being of lesser worth because they are unable to do the same things as the young and healthy.

So there are clearly circumstances in which measures may be found to discriminate unfairly against particular groups. As the examples of age and health status illustrate, the implementation of NHI may in certain circumstances fall foul of the right to equality, notwithstanding its overall transformative aim.

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[71] *Harksen* (note 32 above) para 52.

[72] Similarly, any measure that views people as being part of a uniform class without consideration for the differences between them will also infringe patients' dignity. See in this regard K Syrett *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (2004) 91.

[73] *Harksen* (note 32 above) para 52.

[74] A Williams 'Intergenerational Equity: An Exploration of the Fair Innings Argument' (1997) 6 *Health Economics* 117, 119; S Fredman 'The Age of Equality' in S Fredman & S Spencer (eds) *Age Equality as an Equality Issue – Legal and Policy Perspectives* 47-8; See also N Daniels *Just Health* (2008) 171-3 where Daniels discusses 'normal life expectancy' and the 'Prudential Lifespan Account'.

[75] Evans (note 69 above) 17. For statements from philosophers on the importance of not expending health resources on the very sick see M Battin 'Age Rationing and the Just Distribution of Health Care: Is there a Duty to Die' (1987) 97 *Ethics* 317-8.

## IV. CONCLUSION ON CONSTITUTIONAL EQUALITY

In Parts II and III of this chapter, I have argued that substantive equality best encapsulates the value of equality in South African constitutional law. Since not all persons can equally exercise their constitutional rights, such as their right to have access to health care services, substantive equality puts redistribution at the centre of the transformation project. Owing to the fact that redistribution, by definition, means making more resources accessible to a greater number of people, the government must recognise the different ways in which people are prevented from accessing the health system. Differential treatment of wealthier people, who do not face significant obstacles preventing access to health care, might cause them adverse effects under a future health system. Nevertheless, the fairness of differentiating between people is generally inconsistent with the Constitution unless it amounts to unfair discrimination because the adverse effect is too great, impinges on the dignity of persons or amounts to an abuse of power.

## V. THE VALUE OF FREEDOM IN SOUTH AFRICAN CONSTITUTIONAL JURISPRUDENCE

The precise relationship between freedom and equality as values and rights depends on how freedom is interpreted in the Constitution. This will also inform the interpretation of section 12 of the Constitution.[76] Different interpretations of freedom can have diametrically opposing implications for NHI and the redistribution of health care resources in South Africa. For example, if freedom is interpreted as prohibiting state intervention in the economic liberty of individuals then redistribution becomes more difficult because the curtailment of such freedoms may be necessary for achieving distributive equity. Conversely, if freedom is interpreted as requiring the state to provide the necessary services and resources to enable people to achieve their individual and collective potential then redistribution facilitates the achievement of freedom.

[76] Section 12 of the Constitution. See Annexure A.

### (a) Negative freedom and its limits

There are competing understandings of the value of freedom in constitutional and philosophical literature.[77] One definition of freedom is based on the concept of classical liberalism. Woolman and Davis explain classical liberalism as requiring minimal state interference in the private affairs of individual people. According to them, a classical liberal definition of freedom denotes what is generally referred to as 'negative liberty'.[78] Isaiah Berlin famously explains that negative freedom "is involved in the answer to the question 'What is the are, within which the subject – a person or group of persons – is or should be left to do or be what he is able to do or be, without interference by other persons?'". In other words, negative liberty is infringed when one's freedom to act is obstructed by others including the state.[79]

John Stuart Mill also embraces a form of negative liberty rooted in the classical liberal tradition that is resistant to the idea of government interfering with the liberty of individuals. He argues that the only justification for doing so is 'self protection' and the prevention of harm committed against other people. In line with this view, Mill is against the use of legal sanction directed at controlling the life of an individual, unless it is necessary for the protection of other members of society. He warns against 'an increasing inclination to stretch unduly the powers of society over the individual, both by force of opinion and even that of legislation'.[80] In this way, Mill is sternly against using one's own liberty or the liberty of the state in a way that deprives other people of their personal liberty.[81] Mill only accepts

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[77] See JL Hill *The Five Faces of Freedom in American Political and Constitutional Thought* (2004) 45 *Boston College LR* 499.

[78] S Woolman & D Davis 'The Last Laugh: *Du Plessis v De Klerk, Classical Liberalism, Creole Liberalism, and the Application of Fundamental Rights Under the Interim and Final Constitutions*' (1996) 12 *SAJHR* 361, 382 -3.

[79] I Berlin 'Two Concepts of Liberty' in *Four Essays on Liberty*' (1969) 121-2. See also J Christman 'Liberalism and Indiviudal Positive Freedom' (1991) 101 *Ethics* 343 who explains negative liberty as 'the claim that the liberty of a person is strictly a function of the restraints that the agent faces in the carrying out of her decisions'. Thomas Hobbes explained negative liberty as '[T]he absence of external impediments'. See T Hobbes *The Leviathon* (1651) C.B. MacPherson Ed Penguin Books (1968) 189 as cited in Hill (note 77 above) 524.

[80] JS Mill *On Liberty* (1859/2002 ed: Dover Publications Inc.) 8-11.

[81] It is unclear whether Mill's argument can be applied in a scarcity context where redistribution and the infraction of some elements of individual liberty may be necessary in order to bring equity within the system. Though on the whole he does accept the moral justifiability of taxation – admittedly a redistributive mechanism and central to NHI policy – but only to the extent that the amount taxed is not 'positively injurious.' See Mill ibid 85. See also O Kurer 'John Stuart Mill and the Welfare State' (1991) 23 *History of Political Economy* 713.

infringements by the state on personal liberty if these are necessary for the state to fulfil its functions as a sovereign or to protect the liberty of other people.[82] Therefore, Mill supports the general principle that government should not interfere in the liberty of its subjects without cogent justification.

John Rawls, in a *Theory of Justice*, also adopts a negative understanding of freedom consistent with classical liberalism. He says '[p]ersons are at liberty to do something when they are free from certain constraints either to do it or not to do it and when their doing it or not doing it is protected from interference by other persons.' Nevertheless, unlike Berlin and Mill, Rawls proposes a wider view, acknowledging the distinction between equal political liberty exemplified by equal citizenship and the *worth* of equal political liberty for different people. Although all people are entitled freedoms that the state is required to respect and protect from improper invasion, not all persons are equally placed to benefit from such freedom. For example, some persons are poor and lack the resources and wealth necessary to participate in political life. In acknowledging this, he accepts that individuals in democratic societies can never all derive equal value from negative political freedoms. However, for Rawls, poverty or the material worth of liberty are concepts distinct from liberty itself and play no role in defining it as a political value.[83]

Negative freedom in its purer forms then does not concern itself with the ability of people to take advantage of political freedom by securing access to resources necessary to live a dignified life.[84] Therefore, as pointed out by Berlin, a person's inability to buy bread because of her poverty is not a violation of freedom.[85] Negative freedom plays no role in determining how health resources should be redistributed in cases of scarcity. Although political freedom is necessary for people to access essential resources for life and health, especially to individuals living in a vulnerable social context, it does not guarantee such access. It merely means that the state or third parties may not inhibit access. In this way, negative freedom does not impose any positive obligations on the state to ensure that people have access to essential health care resources or services.

Since negative liberty does not concern itself with the inequitable distribution of wealth or socio-economic resources in conditions of scarcity, it may frustrate redistributive

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[82] Mill ibid 93.

[83] J Rawls *A Theory of Justice* (1971, Original Edition, Harvard University Press) 202-5 (quote at 202).

[84] Hill explains negative liberty by saying "One is not 'unfree' by virtue of lack of capacity to perform an act." See Hill (note 77 above) 525.

[85] Berlin (note 79 above) 122.

efforts. Indeed, negative liberty may at times place too much emphasis on the negative rights and interests of the 'atomistic individual' without sufficient consideration of social context and the interdependence of human beings.[86] As a result, small infractions on individual liberty imposed or caused by government redistributive programmes, such as NHI, will inevitably not be considered in a social and historical context of past discrimination and poverty. Rather, what should occur, at least in cases of resource scarcity, is that losses in negative liberty should be balanced against the ideals of social upliftment and the enhancement of access to health care services and resources for the majority of the population.

Some authors argue that liberty is not intrinsically desirable, nor can its application be absolute. Ronald Dworkin, for example, argues that liberty is only valuable because it allows those who have it to live more enjoyable lives. To this end, Dworkin defines liberty on the basis of what distributive equality actually entails, which is the distribution of resources in a way that treats all citizens with equal concern and respect. However, because the value of liberty cannot exist in isolation of equality, some infractions of individual freedom are permissible if taken to affirm the equal dignity of each person. For Dworkin, the value of liberty is only of importance in specified contexts, presumably those enumerated in a bill of rights.[87] Liberty is not intrinsically valuable in and of itself. This was pointed out by the Supreme Court of Canada in *R v Big Drug Mart*, where it was stated that liberty must be 'understood… in the light of the interests it was meant to protect'.[88] Thus, understood in the South African context, liberty is meant to entrench distributional equality.

Central to Dworkin's argument is that liberty is inherently limited so that other people can enjoy the same liberties. As argued by Baer, '[a]s long as there is more than one human being present, the liberty of each is inherently limited by the presence of the others'. Thus, not all liberty interests deserve protection. For Baer and Dworkin, absolute liberty fails to give due consideration to the costs of one's actions on other people.[89] By extension, the untrammelled usage of scarce resources undermines competing claims to those resources by others who are equally deserving of them. These commentators would reject defining

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[86] See J Nedelsky 'Reconceiving Autonomy: Sources, Thoughts and Possibilities' (1989) 1 *Yale J of Law and Feminism* 7, 8.

[87] R Dworkin *Sovereign Virtue* (2001) 121-2, 127.

[88] *R v Big Drug Mart* [1985] 1 S.C.R. 295 para 116.

[89] See Baer (note 2 above) 449; Dworkin (note 87 above) 122-3.

freedom solely on the basis of negative liberty, because it fails to have regard for the liberty interests of other people.

Consequently, any defensible definition of constitutional equality cannot allow the free market to dictate how and to whom scarce health resources are to be distributed. Such a definition must account for unequal power relations between different groups. More privileged groups are often better situated to seize control of scarce health resources than the poor and marginalised. This occurs because wealthier people often control the institutions that finance and provide health care, either through membership, shareholding or management. If liberty is given to wealthier people to dictate how resources should be distributed, then inevitably selfish interests will override those of the community, resulting in access to more than their fair share of scarce resources.

The above-mentioned drawbacks do not mean that negative freedom plays no role at all in distributive quandaries regarding scarce health care resources. Rather, negative conceptions of liberty must not be the sole guiding principle of constitutional freedom in a distributive context. Nor should it be over-emphasised. The negative aspect of freedom may play a role where redistributive programmes fail to have regard for egalitarian purposes, and treat sectors of society as being devoid of self worth. Indeed, sometimes the invasion of a negative freedom can be so profound and foundational that it ought to be protected under the law. Isaiah Berlin states in this regard:

> '[T]here ought to exist a certain minimum area of personal freedom which must on no account be violated; for if it is overstepped, the individual will find himself in an area too narrow for even that minimum development of his natural faculties which alone makes it possible to pursue, and even to conceive, the various ends which men hold good or right or sacred. It follows that a frontier must be drawn between the area of private life and that of public authority. Where it is to be drawn indeed is a matter of argument, indeed of haggling.'[90]

Berlin is saying here that there is some undefined minimum of negative liberty essential for meaningful human existence beyond which the state or another party may not transgress. Similarly, in the distributive context, a rejection of negative liberty is not tacit permission to trample the rights and interests of persons who already have access to health resources and services. Indeed, negative freedom may have some relevance to constitutional freedom if the government *overreaches* beyond its redistributive mandate or implements an irrational or

[90] Berlin (note 79 above) 124.

unreasonable policy that overrides the constitutionally protected interests of groups in an unjustifiable manner.

**(b) Positive freedom and state intervention**

In my view, the dominant conception of freedom in the South African Constitution is positive freedom.[91] Isaiah Berlin explains positive freedom as answering the question 'What, or who is the source of control or interference that can determine someone to do or be, this rather than that?'[92] The question implies that freedom is the desire of individual people to be the master of their own fate by making their own decisions about how to live their lives.[93] Interpreted in this way, positive freedom is something more akin to individual and collective empowerment to achieve the measure of one's inherent capabilities. Social conditions, like poverty and lack of access to essential resources necessary to sustain dignified life, indicate a lack of freedom. Systematic deprivation and cyclical poverty are antithetical to the cause of positive freedom because they diminish a person's ability to achieve their version of 'the good life'.

The idea of positive freedom strongly corresponds to Amartya Sen's capability theory. He describes his theory in the following terms:

> '[I]ndividual advantage is judged in the capability approach by a person's capability to do or things he or she has a reason to value. A person's advantage in terms of opportunities is judged to be lower than that of another if she has less capability – less real opportunity – to achieve those things that she has reason to value. The focus here is on the freedom that a person actually has to do this or that – things that he or she may value doing or being. Obviously, the things we value most are particularly important for us to be able to achieve. But the idea of freedom also respects our being free to determine what we want, what we value and ultimately what we decide to choose.'[94]

In short, freedom as capability is a freedom of self-determination, where people have the capacity and capability to make and act upon decisions concerning how to live the

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[91] See S Liebenberg 'The Value of Freedom in Interpreting Socio-Economic Rights' (2008) *Acta Juridica* 149, 158-63.

[92] Berlin (note 79 above) 122.

[93] See G Taylor & H Hawley 'Health Promotion and the Freedom of the Individual' (2006) 14 *Health Care Analysis*, 15, 19-20.

[94] A Sen *The Idea of Justice* (2009) 231-2.

subjective good life.[95] This idea is further expounded upon by Martha Nussbaum, who argues that human capability is defined by the ability 'to do and to be' and hence being able to live a life that can be worthy of being called human. If a person is impoverished and lacks access to resources such that she is unable to act upon her own human capabilities to even a limited extent, then she is bereft of human dignity and autonomy.[96] Fundamentally, the ability to act upon one's capability is made possible by central human functions amongst which are life and bodily health. These functions presuppose access to resources so that people are *free* to reach their potential. Such a presupposition is contrary to any assumption that all persons are equally capable of accessing basic resources. This assumption undermines the attainment of freedom because it ignores the fact that human beings may exist within a social context of poverty and unequal power relations.[97]

In achieving human dignity and autonomy in the positive sense, Nussbaum advocates a central role for the state directed by constitutional law: the state should ensure that citizens can attain a basic 'threshold level of capabilit[y]'. This can only be achieved if people have access to essential resources necessary for human functioning.[98] If the state is to play the role of facilitating individual capability, then constitutional freedom must not be defined exclusively by classical liberalism. Likewise, it must not be defined by negative freedom, which emphasises protecting the freedom of individuals from state intrusion. Rather, as Fredman argues, state intervention and regulation directed toward resource redistribution must be a component of constitutional freedom.[99] Such actions are indispensible because access to resources is essential for human development and the enhancement of capability.[100] Fundamental to this is the recognition that 'only the state can supply what is needed for an individual to fully enjoy her human rights.'[101] Therefore, state programmes that limit

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[95] Liebenberg (note 91 above) 158.

[96] M Nussbaum *Women and Human Development: The Capabilities Approach* (2000) 5, 12.

[97] See ibid 78 at (1) and (2) where Nussbaum defines 'life' as 'Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living.' She then defines 'bodily health' as 'Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.' See also 81-2 where Nussbaum writes of 'differences in starting point[s] that are caused by natural endowment or power'.

[98] See ibid 5-6, 12, 90-2 (Quote at 12).

[99] S Fredman 'Human Rights Values Refashioned: Liberty, Equality and Solidarity' in *Human Rights Transformed, Positive Rights and Positive Duties* (2008) 9.

[100] Liebenberg (note 91 above) 162.

[101] Fredman (note 99 above) 9-10

individual freedoms must be understood within the context of increasing the freedom of all persons to achieve their potential.

### (c) Freedom as a value in constitutional jurisprudence

Unlike the equality cases considered above, the Constitutional Court's jurisprudence on freedom as a value and a right is burdened by contestation and lack of precise definition over freedom's meaning and purpose. Despite this, I argue that a positive view of freedom in the context of the inequitable distribution of scarce resources in South Africa best reflects the Constitutional Court's jurisprudence to date. Nevertheless, negative freedom plays a residual role in curbing excesses of state power when such excesses unjustifiably diminish the ability of persons to access health care outside a deteriorating state health system.

The most substantial discussion by the Constitutional Court on the nature of freedom as a right and value is found in *Ferreira v Levin*. Here, Ackermann J, writing in the minority, held that the constitutional value of freedom was to be interpreted in line with Isaiah Berlin's doctrine of negative liberty. Like Rawls, Ackermann J held that liberty or freedom is distinct from the 'conditions of its exercise', and thus viewed poverty as being a separate issue from freedom. He also attempted to ground his view of freedom within a paradigm of human dignity. For him, freedom is the guarantee of self-determination such that each individual is able to develop their own unique potential. Although the latter aspect of his analysis is more consistent with positive freedom, Ackermann J still defines freedom as being negative in character.[102]

The difficulty for Ackermann J was how to reconcile a negative definition of freedom with the need for state intervention. He answered this by emphasising the need for the state to regulate the liberty of all people so that the liberty of some does not impinge on the liberty of others. Despite this, Ackermann J would have required all infractions of negative liberty designed to promote equality to be justified by the limitations clause of the Interim Constitution.[103] If accepted by the majority, this construction of the value and right to freedom may have had negative consequences for redistributive programmes, such as NHI,

[102] *Ferreira v Levin* (note 5 above) paras 47-52A-D.

[103] Ibid paras 52, 59; Interim Constitution Act 200 of 1993, section 33. As further authority for his position that negative freedom is definitive of constitutional freedom see para 54. There he does not adopt a resource based conception of freedom. See judgment of Chaskalson P para 174.

because every minor limitation of liberty would have to be justified under the limitations clause.

However, the majority, per Chaskalson P, was not persuaded by Ackermann J's definition of the value and right to freedom as being characterised by negative liberty. Nor did the majority accept Ackermann J's reconciliation between the restrictive effects of negative freedom and the need for state intervention and redistribution. In this regard, the majority stated 'If freedom were to be given the wide meaning suggested by Ackermann J, all regulatory laws, which are a feature in any modern Constitution, would have to be justified as being *necessary*' (emphasis in original) under the limitations clause of section 33 of the Interim Constitution.[104] Nevertheless the majority ascribed some meaning to section 11 by holding that it protected the physical integrity of a person.[105] Nevertheless, the majority emphasised that the protection of physical integrity was not the only interest protected by section 11. As such, there might be scope for the residual application of the freedom and security right beyond the enumerated freedom rights in the Bill of Rights, but that it was necessarily very limited and undefined.

The majority's reasoning for rejecting Ackermann J's interpretation of freedom is open to both wide and narrow interpretations. The wide interpretation is that the majority left the door open for a court to ascribe negative content to the value of freedom underpinning the freedom and security right but only on a case-by-case basis. In doing so, courts must recognise that the right to freedom is not of a residuary nature to be applied when other specific freedom rights and interests are not implicated. Nonetheless, the majority's rejection of negative liberty as the sole defining aspect of freedom can be ascribed to the stunting effects that a wide interpretation may have on redistribution and equality enhancing programmes.[106] Taken further, such an interpretation suggests that the majority recognised the idea that freedom is predicated on each person having access to resources essential for living with human dignity.

The narrow interpretation of the majority is that it viewed the right to freedom to be a right to physical integrity. The implication of this position is that the right to freedom only applies in those cases where the state deprives people of their physical liberty, such as in cases of unlawful arrest and detention. In other words, constitutional freedom is directed

[104] Ibid paras 169-74 (Quote in para 174).

[105] Parenthetically, the majority held that it was not necessary to consider the contents of the right so broadly as did Ackermann J. See ibid paras 169, 184-5.

[106] Ibid para 180.

against protecting people from anarchy of the state and its functionaries as well as governmental dictatorship. If this is the case, then freedom has almost no application to a distributive context, and the lack of freedom cannot be defined by the absence of resources necessary for survival.

In a separate judgment, Sachs J held that freedom cannot simply refer to 'the right to be left alone'. He further held that the *rechsstaat* is not only concerned with protecting people from government encroachment, but is also concerned with creating the conditions in which people can pursue their aspirations and be free from danger. In Sachs J's view, such a society can only exist when there is recognition of human interdependence where the state takes on a positive role in enhancing capability, even if this requires regulations that limit the freedom of others. Although not explicitly stated, Sachs J's judgment is compatible with the notion of positive freedom that envisions a role for the state to facilitate freedom by redistributing resources and providing services. This must be so, because if freedom is concerned with 'maximising effective personal choice', it must be predicated upon individuals having the necessary resources to sustain dignified living.[107]

O' Regan J in *Bernstein v Bester* supported this notion of positive freedom. She rejected any notion of freedom being interpreted as a licence to do whatever one wishes. In stating this, she recognised that a breach of a person's liberties does not, by that fact alone, amount to an infringement of constitutional freedom. If this were the case, then it would deny the interdependent nature of democratic society where the positive acts and negative liberties of some people impact on other people. In her view, liberty entails the '*ability*' of persons to 'exercise and enjoy their rights and freedoms', and not merely political freedom conferred by equal citizenship. She envisioned a positive role for the state in enhancing this freedom. In other words, according to O' Regan J, freedom is not just about the state refraining from interfering in individual lives but is also about the state playing a positive role in creating conditions within which people can flourish.[108]

In a different context, the Constitutional Court recognised that sometimes the Constitution requires positive state action to protect the right to freedom and security of the person. In *Carmichele v Minister of Safety and Security*, the Court held that the state had breached its positive duty to provide effective law enforcement. In this case, a woman sued the Minister of Safety and Security for damages arising out of a sexual assault committed

[107] Ibid paras 250-1.

[108] *Bernstein v Bester* 1996 (2) SA 751 (CC) paras 149-51. At para 151 of *Bernstein v Bester*, O'Regan J cites Sachs J in *Ferreira* (note 5 above) para 251.

against her after the offender was released on bail.[109] Similarly, the Constitutional Court held in *Rail Commuters Action Group v Transnet* that, in the appropriate context, the Constitution imposes 'correlative obligations' on the state to take positive action to protect the physical integrity of its subjects.[110] In this case, the Constitutional Court held that Transnet, a parastatal company, and the South African Rail Commuters Corporation had a positive obligation to enact reasonable measures to provide security for railway passengers in order to protect their rights, including their right to freedom and security of the person. In reaching this conclusion, the Court mentioned in passing that socio-economic rights in the Constitution, including the right to health care services, impose corresponding obligations on the state to fulfil these rights.[111]

The Constitutional Court has explicitly recognised the importance that access to essential resources plays in advancing dignity, equality and freedom. It also recognised the role the state plays in advancing that access. In *Grootboom*, the Court stated '[t]here can be no doubt that human dignity, freedom and equality, the foundational values of our society, are denied to those who have no food, clothing or shelter'. The Court also noted a positive state obligation to assist those living in extreme poverty. The state is obliged to enact reasonable measures within available resources to enhance access to health care services in section 27 of the Constitution. Indeed, without 'the basic necessities of life' people will not have the capability to achieve their potential.[112]

## VI. FREEDOM AND SECTION 12 OF THE CONSTITUTION IN THE CONTEXT OF NHI

Section 12 of the Constitution provides for the 'right to freedom and security of the person' and the right to 'bodily and psychological integrity' ('general rights'). These general rights

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[109] *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC) para 44.

[110] *Rail Commuters Action Group and Others v Transnet* 2005 (2) SA 359 (CC) para 69. The Constitutional Court stated the following at para 78: 'The principle of accountability, therefore, may not always give rise to a legal duty whether in private or public law. In determining whether a legal duty exists whether in private or public law, careful analysis of the relevant constitutional provisions, any relevant statutory duties and the relevant context will be required. It will be necessary too to take account of other constitutional norms, important and relevant ones being the principle of effectiveness and the need to be responsive to people's needs.'

[111] Ibid paras 111(4) & 71 citing *Carmichele* (note 109 above) para 44. See also para 69 for the statement on socio-economic rights.

[112] *Grootboom* (note 4 above) paras 23-4, 44 (quotes at paras 23 and 44). See also *Soobramoney* (note 70 above) para 8.

are partially defined by various specific rights that are directed towards protecting the physical freedom of the person and integrity of the body and mind ('enumerated rights').[113] These rights are closely associated with the value of freedom. They are thus likely to be implicated in constitutional challenges to policies, such as NHI, that might cause the scaling down of access to care in the private sector.[114]

Unlike many other Constitutions, the South African Constitution contains a specific right to have access to health care services in section 27. The ensuing obligations imposed on the state must be viewed within a framework that considers the reasonableness of any measures to be undertaken by the state, the availability of resources, and the requirement of progressive realisation. As a result, courts are unlikely to read aspects of a health care right within the meaning of section 12 as the Canadian Supreme Court did in *Chaoulli*.[115] This does not mean that health related interests will not be implicated by section 12. In the following sections, I examine the types of instances in which section 12 may be violated by redistributive programmes like NHI, despite a specific right to have access to health care services in section 27 of the Constitution.

The jurisprudence of the Constitutional Court has arguably settled that section 12(1) consists of two rights: the right to freedom and the right to security.[116] The precise nature of the interests protected under section 12(1) beyond the already enumerated rights is unclear.

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[113] The plain meaning of the word 'including' in the context of section 12(1) implies that the enumerated rights are not the exclusive content of the general rights.

[114] For these reasons, my analysis is not a general one but rather focuses on matters pertaining to the topic of the thesis. I do not deal with those aspects of section 12 that are more plainly relevant to arrest and detention and other issues not directly associated with NHI.

[115] *Chaoulli v Quebec* [2005] 1 S.C.R. 791; 2005 SCC 35, 254 D.L.R. (4th). Indeed in *Soobramoney* (note 70 above), the applicant, who attempted to compel a public hospital in Durban to admit him to the renal dialysis treatment programme, relied unsuccessfully on the right not to be refused emergency medical treatment under section 27(3) and the right to life under section 11 to support his case (para 7). In this regard Chaskalson P held on behalf of the majority that 'the right to medical treatment does not have to be inferred from the nature of the State established by the Constitution or from the right to life which it guarantees. It is dealt with directly in section 27.' (para 19)

[116] In *Coetzee v Government of the Republic of South Africa* 1995 (4) SA 631 (CC) para 35, Sachs J explicitly pointed to the possibilities of interpreting section 12 to freedom and security disjunctively or conjunctively. He left the question open. The majority judgment in *Coetzee*, per Kriegler J, held that to put someone in prison is a limitation of that person's right to *freedom* and made no mention of security of the person. In *Ferreira* (note 5 above) para 46, Ackermann J indicated that he would interpret the right to freedom disjunctively from the right security of the person. However the majority in *Ferreira* at para 170 adopted a conjunctive reading by interpreting the right to 'freedom and security of the person' as a composite right to physical integrity. However, in later cases, differing stances appear to come out the Constitutional Court. In *Malachi v Cape Dance Academy International (Pty) Ltd* 2010 (6) SA 1 (CC) para 25, in the context of section 12(1), Mogoeng J stated the following: '[t]he protection of the right to *freedom of the person* in terms of section 12(1)(a) has both a substantive and a procedural dimension'. (my emphasis). Indeed this seems to support the disjunctive reading. Also in *Law Society* ibid paras 57-67, Moseneke DCJ refers specifically to a right to 'security of the person'.

Analysing the constitutional text of section 12(1), it appears that the right 'not to be deprived of freedom arbitrarily or without just cause' and the right 'not be detained without trial' are aspects of the right to freedom. Interpreted thus, the right to freedom denotes a right to 'physical freedom' and the absence of physical constraint, covering activities like unlawful imprisonment and arrest.[117] The enumerated rights under section 12(1) are not exhaustive. As such, the right to freedom may have some residual meaning beyond physical restraint and confinement.[118] In some instances, the right to freedom under section 12(1) may be interpreted to include legislative and regulatory prohibitions and standards that limit the freedom of a person to engage in economic transactions such as the purchasing of health care.

The interests implied by the term 'security of the person' are implicated when law or conduct threatens threaten a person's physical survival or wellbeing. The right to be 'free from all forms of violence from either public or private sources', not to be tortured and not to be subjected to 'cruel, inhuman or degrading' treatment or punishment are all aspects of the right to security of the person. In *Law Society*, Moseneke DCJ accepted that the right to security of the person is implicated whenever "there is an 'immediate threat to life or physical security' deriving from any source."[119] This means that whenever a person's life, physical health or security are in danger in some significant way, section 12(1) is implicated. This can in appropriate circumstances include health-related interests. In such cases, the violation would have to be justified in terms of section 36 of the Constitution in order to pass constitutional muster.[120]

Section 12(2) provides for the right to bodily and psychological integrity, which also includes the right to make decisions concerning reproduction and the right to security and

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[117] See I Currie & J De Waal *Bill of Rights Handbook* (2009) 294-5.

[118] Section 12(1) states 'Everyone has the right to freedom and security of the person, which *includes* the right…'. The *Oxford Dictionary of English* Version (2005-2011) 2.2.1. (156) defines 'include' as 'comprise or contain as part of a whole'. The implication is that the enumerated rights of section 12(1) are not exhaustive of the meaning of freedom and security of the person. The majority in *Ferreira* did accept that there may be some residual content to section 11 of the Interim Constitution.

[119] See *Law Society v Minister for Transport* 2011 (1) SA 400 (CC) para 58 referring to M Bishop & S Woolman 'Freedom and Security of the Person' in S Woolman & M Bishop (eds) *Constitutional Law of South Africa* (2nd ed 2006) chapter 40, 9. This is consistent with Chaskalson P's interpretation of section 11 of the interim Constitution as protecting 'physical integrity'. See *Ferreira* (note 3 above) para 170.

[120] Section 12(1) can be infringed procedurally and substantively. O'Regan J explained in *Bernstein v Bester* (note 108 above) para 145 that the substantive aspect of the freedom and security right is violated when the grounds justifying the deprivation of freedom are inconsistent with the Constitution. She explained further that the procedural aspect is violated when the procedures followed in pursuance of the deprivation are not consistent with the dictates of procedural fairness. For my purposes, I focus primarily on the substantive aspect.

control over one's body.[121] The right to bodily and psychological integrity did not appear in the Interim Constitution. Currie and De Waal point out that much of what the Constitutional Court read into section 11 of the Interim Constitution is now specifically formulated in section 12(2) of the Final Constitution.[122] Except, section 12(2) also contains a right to psychological integrity, recognising that injurious activity does not relate solely to bodily infliction but also emotional suffering. Currie and De Waal explain further that the general right of section 12(2) protects 'aspects of bodily self-determination', or the protection of the body and mind from improper interference by the state and third parties.[123] Woolman explains section 12(2) as according each '*physical body*' with equal worth.[124]

Some infractions of freedom and security interests will not attract constitutional sanction under section 12. Sachs J stated in *Ferreira*, in the context of section 11 of the Interim Constitution, that the right is violated whenever there is a 'real or substantial invasion of freedom, and not a mere regulatory act.' Chaskalson P on behalf of a majority in *Ferreira* required a breach of section 11 to be 'fundamental'.[125] O'Regan J in *Bernstein v Bester* seemed to accept that a breach of a residual freedom and security right had to be 'substantial' in order for the right to be violated.[126] The Constitutional Court has arguably rejected a liberal interpretation of freedom and security that would cover almost any infraction of individual freedom by legislative or regulatory actions, or conduct.[127] Therefore, the jurisprudence thus far suggests that section 12 is violated when breaches of residual freedoms

[121] These rights together with the right to have access to reproductive health care under section 27(1) have been relied upon in the past by the High Court to dismiss claims against the constitutionality of the Choice on Termination of Pregnancy Act 92 of 1996. See *Christian Lawyers Association of SA v Minister of Health* 1998 (4) SA 1113 (T) (*Christian Lawyers 1*) 1121 I-J, 1122 G-H and *Christian Lawyers Association v Minister of Health* 2005 (1) SA 509 (T) - (*Christian Lawyers 2*) 518. This Act regulates the circumstances in which a woman may legally terminate her pregnancy. In addition, section 3(a) and 3(c) of the National Health Act provides that public health establishments must provide free health care services to pregnant and lactating women and free abortion services.

[122] See Currie & De Waal (note 117 above) 308.

[123] Ibid 293, 308 (quotes at 308).

[124] Woolman & Bishop (note 119 above) 77.

[125] *Ferreira* (note 5 above) paras 184 , 257 (Sachs J).

[126] See *Bernstein v Bester* (note 108 above) paras 139, 140, 151.

[127] This is clear from the majority's clear rejection of Ackermann J's generous interpretation of section 11 of the Interim Constitution in *Ferreira* (note 5 above). See paras 169, 173-4. Ackermann J's interpretation is at paras 51, 52, 57-60.

are 'substantial' and 'fundamental'. This being the case, there is room to interpret section 12 as protecting health related interests.[128]

The severity of freedom and security infringements can be assessed by whether there is a violation of a freedom interest that implicates a security interest and vice-versa. For example, if the state legislated a comprehensive ban on abortion such that women who were raped or others who require abortion for therapeutic purposes could not obtain access to termination of pregnancy services. In both instances, not only will these women be deprived of freedom to access abortion services but will also suffer severe psychological stress and anxiety. Women requiring abortions for therapeutic services will also suffer harmful physical effects. Furthermore, the right of a woman to have control over her body and make decisions concerning her pregnancy is fundamental in liberal democratic societies. As can be seen through this example, the *extent* of the breach of the security right may in appropriate cases reinforce an allegation of the infringement of the right to freedom. 'Minor' curtailments of liberty are not *per se* constitutionally objectionable without something more substantial. However, the higher the degree of the infringement of a security interest, the more compelling the reason for the limitation of a residual freedom must be.[129]

Thus far there are no South African Constitutional Court cases on residual health interests adjudicated under section 12.[130] However, certain cases from the Supreme Court of Canada support the argument that the impairment of health related interests may implicate a residual freedom right, but will only do so when the infringement of health related interests are substantial. Whether this will occur depends on the impact on the individual or group concerned and whether the deprivation of a residual freedom is at odds with freedoms fundamental to liberal democratic society.[131] These cases also indicate the types of residual interests implicated in freedom and security rights adjudication. Significantly, as

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[128] For the most part, health-related interests implicated under section 12 will fit under the rubric of the general rights of 'freedom and security of the person' and 'bodily and psychological intgerity.' Section 12(1)(a), which is the right 'not to be deprived of freedom arbitrarily or without just cause' applies to physical freedom from unlawful detention or confinement. Health-related interests may be inferred from the 'right not to be treated or punished in a cruel, inhuman or degrading way' (section 12(1)(e)); the right to 'make decisions concerning reproduction' (section 12(2)(a)); the right 'to security in and control over [the] body' (section 12(2)(b)).

[129] This sort of reasoning was used by O'Regan J in *Hugo* (note 23 above) para 112 in the context of a claim for unfair discrimination.

[130] See M Pieterse 'The Interdependence of Rights to Health and Autonomy in South Africa' (2008) 125 *SALJ* 553, 562-3 for a discussion of various High Court decisions on autonomy interests in the context of health.

[131] *Ferreira v Levin* (note 5 above) para 174. See section 36 of the Constitution. See also section 1 and 7 of the Canadian Charter of Rights and Freedoms.

demonstrated in the cases cited below, physical and psychological impact, adverse effects on the integrity of the human body and its wellbeing, and 'bodily self-determination'[132] feature prominently in substantiating a claim under section 7 of the Canadian Charter, which is similar to section 12 of the South African Constitution.

In *R v Morgentaler*, three medical practitioners were charged for conspiring to perform illegal abortions. At the time, pregnant women who required therapeutic abortions in Canada faced difficulties in securing approval for the procedure in the public sector. These medical professionals asserted that these women had a right to a therapeutic abortion in cases where the state failed to facilitate access in the public system.[133] The Supreme Court of Canada held that the delays in procuring a therapeutic abortion violated the 'right to life, liberty and security of the person' protected under section 7 of the Canadian Charter. In coming to this conclusion Dickson CJ held that the phrase 'security of the person' meant that the '*human body* ought to be protected from interference by others' and also provided for 'respect for physical integrity.' He held further that 'interference with bodily integrity and serious state-imposed psychological stress' or significant 'emotional stress' breached the security of the person. The psychological stress was occasioned by the long waiting times endured by women who require therapeutic abortions before the state granted them certificates allowing the procedure. In *Morgentaler*, Beetz J emphasised this by stating:

> "'Security of the person' within the meaning of s. 7 of the Charter must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction. If an act of Parliament forces a pregnant woman whose life or health is in danger to choose between, on the one hand, the commission of a crime to obtain effective and timely medical treatment and, on the other hand, inadequate treatment or no treatment at all, her right to security of the person has been violated."[134]

In *Chaoulli v Québec,* the applicants successfully challenged the constitutionality of legislative provisions prohibiting private health insurance for services available in the public sector.[135] The applicants asserted that these provisions violated the freedom and security rights under section 7 of the Canadian Charter and section 1 of the Québec Charter when patients encountered waiting lists in the public sector for medically necessary services.

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[132] Currie & De Waal (note 117 above) 293.

[133] [1998] 1 S.C.R. 30 para 5.

[134] Ibid paras 5, 14, 20, 22, 68 (large quote at para 68).

[135] See Annexure B for the text of the section 15 of the Health Insurance Act R.S.Q., c. A-29 and section 11 of the Hospital Insurance Act R.S.Q., c. A-28.

Waiting lists may have adverse effects on patients when timely treatment is necessary to ensure successful outcomes. The majority judgment of the Supreme Court held that the impugned provisions violated section 1 of the Québec Charter. The concurring judgment held that these provisions were also inconsistent with section 7 of the Canadian Charter. Although the minority held that the prohibitions were not inconsistent with either the Canadian Charter or the Québec Charter, it accepted that waiting lists having an adverse effect on the health of Canadians implicated freedom and security interests.[136]

The Canadian decisions of *Morgentaler* and *Chaoulli* show that health-related interests beyond physical freedom might implicate rights to freedom and security as well as rights to physical and psychological integrity. The cases illustrate four points about the potential reach of section 12 rights. First, these rights protect residual interests beyond physical freedom, violence and torture, which may in appropriate circumstances include health interests. Secondly, in order to infringe these rights, actions by the state must have some significant impact on the physical and psychological integrity of individual persons, or otherwise infringe on their personal security in some fundamental way. Thirdly, the state must avoid equality enhancing prohibitions such as bans on *all* parallel private health insurance or other legal devices that unduly restrict the liberty of persons to access care outside of the public sector, in circumstances where it offers inadequate care. Fourthly, the curtailment of the freedom to abort a foetus is so intrinsic to the autonomy of women in democratic societies that making it difficult for women to access reproductive health services is a substantial and fundamental violation of the right to bodily and psychological integrity. This may be applied to other contexts as well, like birth control interventions, HIV/AIDS treatment, and interventions made necessary because of rape, sexual abuse and physical abuse.

In the light of the above, it is difficult to argue that the section 12 rights of private hospital users would be infringed under an NHI system merely because such persons must endure increased health care rationing than is currently the case in the private system. If such persons are subjected to an increase in waiting times, or if criteria for access to expensive tertiary treatments become more limited than is currently the case, this can hardly be described as substantial. Many people using public health systems in constitutional democracies inevitably come to a point where the system can no longer afford to give them

[136] *Chaoulli v Québec* [2005] 1 S.C.R. 791; 2005 SCC 35; 254 D.L.R. (4th) 577 paras 37-45, 109-28, 199.

access to all medically beneficial health care. However, this is generally subject to the criterion that the state may not block access to alternative treatments or access routes to such treatments. Indeed, it would be impermissible for the state to prohibit all forms of parallel private health insurance and private health care without considering the state of specific public sector health services.

Considering that substantial or foundational violations of freedom and security interests of the kind mentioned here may breach section 12 of the Constitution, it is unlikely that NHI will do so. This means that an increase in regulatory measures that inhibit a person's liberty to access health care services will, for the most part, not infringe section 12. Even if such measures do in fact do so, these may be justified under section 36 of the Constitution, which I deal with in the following chapter in the context of limiting the negative content of the health right.[137] Such an approach to section 12 rights is sensitive to the need for redistributive measures, and is also sensitive to the importance that the Constitution places on respecting the enjoyment of existing rights. Ultimately, the state will have the leeway to implement a constitutionally compliant NHI without being impeded by an over-extensive right to freedom and security that frustrates the achievement of positive liberty.

## VII. CONCLUSION

In chapter two, I demonstrated in reference to *Chaoulli v Quebec* that over-emphasising either equality or freedom in isolation does not satisfactorily deal with measures that limit access to private health care.[138] An over-emphasis on liberty fails to recognise that the liberty of some people is limited by the liberty of others.[139] If law and policy dictate that free market principles apply to health care, wealthier persons will have almost unfettered liberty to access health care, which will impinge on the ability of poor people to do so. In the same vein, an over-emphasis on equality may lead to equality of the graveyard where all people have access to inadequate health care. Nevertheless, in South Africa, freedom and equality as values and rights will rarely give rise to such tensions, given that the emphasis is

[137] It suffices to say at this point that these measures will pass constitutional muster if they are 'reasonable and justifiable in an open and democratic society based on equality, dignity and freedom.' In terms of this analysis the measure must amongst other things minimally impair the enjoyment of the right. See section 36(1)(c) and (e).

[138] *Chaoulli* (note 136 above).

[139] Baer (note 2 above) 449.

on substantive equality and positive freedom. Both of these require redistribution, yet neither would condone free market health care systems or inadequate access to health care systems. If redistribution amounts to an abuse of power or is not reasonably capable of enhancing access for the poor, or otherwise fails to promote the achievement of equality, redistributive measures will be inconsistent with the Constitution. This may be the case if there is excessive malperforance in the overall health system and few people are in a position to access quality care.[140]

[140] *Van Heerden* (note 6 above) paras 38-44.

# CHAPTER 4

## BALANCING THE POSITIVE AND NEGATIVE RIGHTS TO HAVE ACCESS TO HEALTH CARE SERVICES

### I. INTRODUCTION

This chapter analyses section 27 of the Constitution, which bestows the right to have access to health care services on 'everyone'. This right has two components. The first component is positive and transformative, in that it entails an obligation on the state to 'promote and fulfil'[1] the right in terms of sections 27(2) read with section 7(2) of the Constitution. Section 27(2) defines the extent of the obligation by stating that the measures to be taken in fulfilment of the right must be reasonable and are subject to the criteria of resource availability and progressive realisation. The second component is negative and non-transformative because it is aimed at preserving existing access to health care. This aspect is derived from the state's obligation to 'respect' the existing enjoyment of the right under section 27(1)(a) read with section 7(2) of the Constitution.[2] These two aspects of the health right are frequently pitted against each other in the context of NHI, in the light of competing claims to scarce resources.

In potential litigation arising out of NHI, the government, other state actors and civil society groups will likely rely on the positive aspect of section 27 in attempting to defend a redistributive NHI. In contrast, private sector actors will most likely rely on the negative

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[1] Section 7(2) of the Constitution. In this chapter I do not deal with the obligations to protect in any great detail as it deals with the obligations on the state to protect those it governs from the unconstitutional infringements by third parties. I am more concerned in chapter with the direct relationship between the state and the people it governs. I also do not deal with the obligation to 'promote' socio-economic rights because it is a dimension of the obligation to fulfil. The obligation to 'promote' is more concerned with awareness and educational programmes relevant to socio economic rights. See S Liebenberg 'The Interpretation of Socio-Economic Rights' in S Woolman & M Bishop (eds) *Constitutional Law of South Africa* (2nd ed. 2003) Chapter 33, 6. The idea of that the state must respect, protect and fulfil rights was first articulated substantially in this form by Henry Shue in H Shue *Basic rights: Subsistence, affluence and US foreign policy* (1980) 1-248 cited in S Liebenberg '*Grootboom* and the seduction of the negative/positive duties dichotomy' (2011) 26 *SA Public Law* 37. It was further elaborated upon and entrenched in international law by the UN Committee on Economic, Social and Cultural Rights, General Comment No 14 *The Rights to the Highest Attainable Standard of Health* UN Doc E/C 12/2000/4 (2000), para 33 and the *Masstricht Guidelines on Violations of Economic, Social and Cultural Rights reprinted in (1998) Human Rights Quarterly* para 6.

[2] The distinction between the positive and negative aspects of socio economic rights is usefully discussed by Pierre De Vos in P De Vos '*Grootboom*, the Right of Access to Housing and Substantive Equality as Contextual Fairness' (2001) 17 *SAJHR* 259, 273-4. He also describes the positive aspect as 'transformative' and the negative aspect as 'non-transformative'. This idea was stated somewhat similarly by Holmes & Sunstein who put it thus 'Negative rights typically protect liberty; positive rights typically promote equality.' See S Holmes & C Sunstein *The Cost of Rights: Why Liberty Depends on Taxes* (1999) 40.

aspect of the right in order to preserve the role that the private sector currently plays in facilitating access to health care services. I argue that section 27 imposes a positive obligation on government to increase access to health care services through redistributive measures that enhance access. In fulfilling this obligation, the direct or indirect causation of adverse effects on privileged sectors of society would generally not fall foul of the state's duty to respect existing access. In most cases, adverse effects will not be of such a nature that they would infringe the state's negative obligations under section 27(1)(a). In other cases, when the infringement is caused by a law of general application, the limitation will pass constitutional muster if it is 'reasonable and justifiable in an open and democratic society' in terms of section 36.[3] However, there can be cases where the impact on adversely affected persons could is so significant, that the state may be found to be in unjustifiable breach of its negative obligations in terms of section 27(1)(a).

In Part II, I consider the positive aspect of the right to have access to health care services under section 27(1)(a). In doing so, I state the position adopted by the Constitutional Court on the relationship between sections 27(1) and (2) of the Constitution. This analysis is positioned within the context of the academic debate on this topic. Under subpart (a) of Part II, I consider the meaning of the word 'everyone' in section 27(1). In subpart (b), I explain the meaning of the word 'access' under section 27(1), relying primarily on the Constitutional Court's decision in *Grootboom*.[4]

In Part III subpart (a), I consider the meaning ascribed to 'health care services' under section 27(1)(a). I argue that the term comprises all clinically proven and effective health care services. However, I point out that just because a treatment is clinically proven does not mean that everyone has an immediate entitlement to that treatment. Much will depend on whether the treatment is medically indicated and whether there are available resources. In subpart (b), I consider the import of emergency medical treatment, reproductive health care, and the right of children to *basic health care* as special categories of 'health care services' under section 27(1)(a).

In Part IV, I deal with the positive obligations of the state to take reasonable measures to enhance access to health care services. I also consider the criteria of 'available resources' and 'progressive realisation' under section 27(2) of the Constitution. In subpart (a), I deal with the reasonableness paradigm considered in *Grootboom*. In subpart (b), I consider the

[3] Section 36 of the Constitution will only apply operate when the limitation is a result of a law of general application. See in this regard *Hoffmann v South African Airways* 2001 (1) SA 1 (CC) paras 24, 41.

[4] *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) ('*Grootboom*').

meaning of 'available resources' with regard to the Constitutional Court's jurisprudence and the opinions of academic commentators. I deal with the question of whether 'available resources' should be interpreted to mean those resources allocated by the state for a specific purpose, or whether a broader interpretation is warranted. In subpart (c), I offer an interpretation of 'progressive realisation'. I place my discussion within the context of the academic criticism that the Court's interpretation has generated. I do not deal with the limitations clause at all in this section because a measure that is unreasonable under section 27(2) will unlikely be found to be justifiable under section 36.[5]

In Part V, I consider the negative dimensions of the health right, which are likely to be relied on by private sector actors in future litigation. I explain that section 27(2) is irrelevant to a negative rights violation enquiry. Once a service or treatment becomes effectively unavailable for a particular group of people then a violation of section 27 occurs, requiring justification under section 36 of the Constitution. I explain that negative rights violation must have a proportional relationship between the adverse effect it creates and its overall purpose in order to pass constitutional muster. If the adverse effects are severe then the measure may be unjustifiable.

## II. THE POSITIVE DIMENSIONS OF THE RIGHT OF ACCESS TO HEALTH CARE SERVICES – ITS TRANSFORMATIVE ASPECT

In its most prominent socio-economic rights judgments, the Constitutional Court has consistently reviewed government policy in relation to the state's obligations under section 27(2), and has generally refrained from ascribing much substantive content to section 27(1).[6]

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[5] This view was clearly expressed by Sandra Liebenberg in S Liebenberg 'The Interpretation of Socio-Economic Rights' (note 1 above) 55. The isssue was considered by the majority in *Khosa v Minister of Social Development* 2004 (6) SA 505 (CC) ('*Khosa*') paras 83-4 where Mokgoro J decided to leave the question open of whether the reasonableness analysis of section 27(2) was different to that under section 36. She concluded even if section 36 consisted of a different standard of reasonableness to section 27(2), the exclusion of permanent residents from receiving social security payments was unreasonable in terms of both sections. Ngcobo J writing for the minority at paras 105-140 held that section 36 of the Constitution still plays a useful role in cases of violations of section 27(2). See also I Currie & J De Waal *The Bill of Rights Handbook* (2009), 595; M 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, 43, 46-7. See also K Iles 'Limiting Socio Economic Rights: Beyond the Internal Limitations Clauses' (2004) 20 *SAJHR* 448.

[6] The major socio economic rights attest to this, see *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC) ('*Soobramoney*'); *Government of the Republic of South Africa v Grootboom* (note 4 above); *Minister of Health v Treatment Action Campaign* (No 2) 2002 (5) SA 721 (CC) ('*TAC*'); *Khosa v Minister of Social Development* (note 5 above); *Jaftha v Schoeman* 2005 (2) SA 140 (CC) ('*Jaftha'*); and *Mazibuko v City of Johannesburg* 2010 (4) SA 1 (CC) ('*Mazibuko*'); *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties* 2012 (2) SA 104 (CC) ('*Blue Moonlight*'). See also the Supreme

In these cases, the Court expressly adopted a conflated reading of sections 27(1) and 27(2)[7] and then proceeded to evaluate state action against the reasonableness review standard under section 27(2).[8] Frank Michelman, in response to *Soobramoney v Minister of Health, Kwazulu-Natal*, warned against interpreting the conflated reading of the two subsections in a way that limits the ambit of one's rights under section 27(1) to the extent of the state's obligations under section 27(2).[9] David Bilchitz offers a slightly different reading of sections 27(1) and 27(2). He says that the realisation of socio-economic rights is conditional on the availability of resources and at times cannot be fulfilled for all persons. This interpretation assumes that the right to have access to health care services has independent content beyond the scope of the government's obligations. Although there are dicta in *Soobramoney* indicating this position,[10] commentators view the Court as reading the positive aspect of section 27(1) as being comprised of a right to the fulfilment of government's obligations in terms of section 27(2), at least in the context of the vertical application of positive rights.[11]

The Court's reading suggests that it has adopted an obligations-centred approach to adjudicating socio-economic rights. In *Soobramoney*, the majority adopted a conflated reading of the two subsections, and then held that it had not been shown that the state failed to comply with its *obligations* under section 27.[12] In *Grootboom*, despite adopting a more rigorous standard of review, the Court mainly assessed government action with reference to

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Court of Appeal judgment in *Blue Moonlight* which is cited as *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39* 2011 (4) SA 337 (SCA).

[7] The conflated reading is evident from various dicta of the Constitutional Court. See in this regard: *Soobramoney* ibid para 11, *Grootboom* ibid para 34, *TAC* ibid para 39, *Khosa* ibid para 43, *Mazibuko* ibid para 50.

[8] In *Soobramoney*, the Court adopted a deferential low scrutiny rationality review. See para 29 of the judgment.

[9] F Michelman 'The Constitution, Social Rights and Reason: A Tribute to Etienne Mureinik' (1998) 14 *SAJHR* 499, 503-5. See also M Pieterse 'Resuscitating Socio-Economic Rights: Constitutional Entitlements to Health Care Services' (2006) 12 *SAJHR* 473, 481.

[10] See *Soobramoney* (note 6 above) paras 11, 43.

[11] D Bilchitz *Poverty and Fundamental Rights*: *The Justification and Enforcement of Socio-Economic Rights* (2008) 215-20. Evidently Bilchitz's argument is predicated on a preference for the minimum core approach to the interpretation of socio-economic rights. The essence of the minimum core approach is that section 27(1)/26(1) contains an immediately enforceable entitlement to a basic minimum of resources and services forming the substance of the right. The Court in *Grootboom* (note 4 above) paras 26-33 and *TAC* (note 6 above) paras 26-39 expressly rejected the minimum core approach to socio-economic rights. Bilchitz argues that the Court should have endorsed an interpretation, which regarded the minimum core as comprising an unconditional obligation on the government to provide basic necessities for dignified existence even if the full ambit of government's obligation could not be realised immediately. See also S Liebenberg *Socio Economic Rights Adjudication under a Transformative Constitution* (2010), 139.

[12] *Soobramoney* (note 6 above) para 36.

its obligations except in relation to the meaning of 'access'.[13] Academic commentators have criticised the Court's failure to set any substantive benchmarks arising from section 27(1) for reviewing state socio economic policy. Danie Brand, for one, has criticised the Court for not giving substantive content to the *right* of access to health care services. In his view, the Court has adopted a means-end test, which assesses whether state action is reasonably capable of achieving the fulfilment of the right without describing the end goal in any meaningful way.[14] As implied by Brand's criticisms, the Court's approach may not allow for directly enforceable entitlements in appropriate circumstances.[15]

Whenever the health right gives rise to an entitlement to tangible health benefits, these are to be understood as being derived from a joint reading of section 27(1) and (2).[16] Section 27(2) defines the extent to which section 27(1)(a) gives rise to tangible individual and collective entitlements. In the light of this, the text of section 27(1)(a) is of cardinal importance in assessing the meaning of the health right. The composite reading also suggests that none of the various parts of section 27(1)(a) are to be understood as absolute requirements irrespective of section 27(2).

In the next two subsections, I analyse the meaning of the words 'everyone' and 'access'. Assessing the proper meaning of the terms of section 27(1)(a) as interpreted by the Constitutional Court is necessary for evaluating the constitutionality of health policy interventions such as NHI.

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[13] *Grootboom* (note 4 above) paras 35-7 (access) and para 38-46 (obligation of state).

[14] See D Brand 'The Proceduralisation of Socio-Economic Rights Jurisprudence, or What are Socio-Economic Rights For?' in H Botha, A van der Walt & J van Der Walt (eds) *Rights and Democracy in a Transformative Constitution* (2003) 33, 40-6; J Klaaren 'An Institutional Interpretation of Socio-Economic Rights and Judicial Remedies after *TAC*' in H Botha, A van der Walt & J van der Walt *Rights and Democracy in a Transformative Constitution* (2003) 105; Bilchitz (note 11 above) 215-6; D Bilchitz 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations For future Socio-Economic Rights Jurisprudence' (2003) 19 *SAJHR* 1, 5-7; Liebenberg (note 11 above) 131; M Pieterse (note 9 above) 481.

[15] Though, in several cases, section 27 has been successfully relied upon by prisoners to secure access to HIV/AIDS drugs and other health care services. See for example *Van Biljon v Minister of Correctional Services* 1997 (4) SA 441 (C); *N v Government of Republic of South Africa* (No 1) 2006 (6) SA 543 (D). For further cases see M Pieterse 'The Potential of Socio-Economic Rights Litigation for the Achievement of Social Justice: Considering the Example of Access to Medical Care in South African Prisons' (2006) 50 *J of African Law* 118, 123-8.

[16] See Pieterse (note 9 above) 480, 492; see also J Klaaren (note 14 above) 109-110.

### (a) The right of 'everyone' to have access to health care services

Implicit in the word 'everyone' in section 27(1) of the Constitution is the requirement that all persons must be treated equally in relation to these rights and not be subjected to differential treatment, which amounts to unfair discrimination. It is here that equality rights provided for in section 9 intersect with the health right and other socio-economic rights more generally.[17] Marius Pieterse interprets the word 'everyone' as firstly prohibiting any unfair distinctions between groups of persons; secondly, as outlawing the unfair and arbitrary exclusion of persons or groups from being entitled to health services and associated benefits; and thirdly, as disallowing the inequitable provision of health care services.[18]

The first and second of Pieterse's explanations of the egalitarian character inherent in section 27 were expressly recognised in *Khosa v Minister of Social Development*. Mokgoro J, on behalf of a majority of the Constitutional Court, held that legislative provisions, which granted an entitlement to citizens to receive social security grants to the exclusion of permanent residents, were inconsistent with the right to have access to social security in section 27(1)(c) of the Constitution, and the right not to be subjected to unfair discrimination in terms of section 9(3). In commenting on the intersection between the two rights, Mokgoro J stated that 'Equality in respect of access to socio-economic rights is implicit in the reference to 'everyone' being entitled to have access to such rights in section 27.'[19] Murray Wesson regards the Court's reading of 'everyone' in section 27 as effectively transplanting the equality clause within the scope of socio-economic rights.[20] Whilst most socio-economic rights cases do not necessarily involve an equality enquiry, it is clear that, when devising and implementing distributive policies, the state is required to ensure that individuals and groups, especially vulnerable persons, are not excluded from an entitlement to benefit from such programmes.

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[17] See M Pieterse ibid 492; S Liebenberg & B Goldblatt 'The Interrelationship between Equality and Socio-Economic Rights under South Africa's Transformative Constitution' (2007) 23 *SAJHR* 335; P De Vos (note 2 above) 264 onwards.

[18] M Pieterse 'Indirect Horizontal Application and the Right to have Access to Health Care Services' (2007) 23 *SAJHR*157, 165 footnote 23.

[19] *Khosa* (note 5 above) para 42.

[20] M Wesson 'Chronic Illness and the Right of Access to Health Care Services' in M Du Plessis & S Pete (eds) *Constitutional Democracy in South Africa 1994-2004: Essays in Honour of the Howard College School of Law* (2004), 104; see also M Wesson '*Grootboom* and Beyond: Reassessing the Socio-economic Jurisprudence of the South African Constitutional Court' (2004) 20 *SAJHR* 284, 293; see also S Liebenberg & B Goldblatt 'The Interrelationship between Equality and Socio-Economic Rights Under South Africa's Transformative Constitution' (2007) 23 *SAJHR* 335, 345; P De Vos (note 2 above) 264-7.

This position is further buttressed by the Constitutional Court's finding in *City of Johannesburg v Blue Moonlight Properties*. In this case, a private landowner obtained an eviction order against unlawful occupiers of a dangerous building in inner city Johannesburg. The City of Johannesburg was joined to the proceedings. It was submitted on behalf of the occupiers that the City was constitutionally obliged to provide them with emergency temporary housing. If the City did not do so, the occupiers would be rendered homeless upon execution of the eviction order. It was argued on behalf of the occupiers that the City's policy of only providing emergency temporary accommodation for those persons evicted by the City, as opposed to private landowners, is inconsistent with the Constitution. It was argued further that the distinction between these two classes of evictees unfairly discriminated against them in terms of section 9 of the Constitution and was also inconsistent with section 26 of the Constitution.[21]

Although the Court introduced its analysis as encompassing a section 9 and section 26 enquiry, it focussed mainly on the reasonableness of the distinction as required by section 26(2) of the Constitution. The Court found that the distinction between those evicted by private landowners and those evicted by the City was unreasonable because it precluded the City from assessing the individual circumstances of people falling within the former category. The Court was keenly aware of the dire circumstances of the occupiers, and that it was manifestly arbitrary and unfair for the City not to set aside some portion of the municipal budget for those evicted from dangerous buildings by private landowners.[22] This case, like *Khosa*, demonstrates that it is not consistent with the dictates of the Constitution for the government to unreasonably exclude a class of persons from benefitting from a socio-economic programme. The unreasonableness is compounded when the excluded group is vulnerable in the sense that their basic human and survival interests are threatened due to a lack of access to essential resources and services.

The third aspect of 'everyone' mentioned by Pieterse is inequitable access to health services. In cases where inequitable access stems from legislative exclusion, the remedy is to bestow an entitlement. However, in most socio-economic rights cases, there is no clear intersection with the right to equality because there is no legal exclusion of the impugned group, nor any conduct triggering the application of the equality clause. For example, in *Grootboom*, the applicants argued that the government was obliged to provide them with

[21] *Blue Moonlight* (note 6 above).

[22] See ibid paras 72-4, 87-92.

shelter or temporary housing pending the grant of a permanent house. There was no equality claim. Although the Court declined to make an order granting them that substantive relief, it declared that the state was obliged in terms of section 26(2) to implement a programme within its available resources aimed at progressively realising the right to adequate housing.[23] It is clear from here that, although distributive inequalities do not necessarily give rise to equality claims, the fulfilment of the right to have access to health care services and other socio economic rights involves *more people* gaining access to health care services over a period of time.

**(b) 'Access'**

Equality of entitlement does not guarantee that in practice out-groups and other vulnerable people will actually receive the benefits to which they are entitled. For this to occur, barriers that hinder access must be eliminated. From an international law perspective, article 12 of the International Covenant of Economic Social and Cultural Rights ('ICESCR') provides for the enjoyment of the highest attainable standard of physical and mental health. The content of the right ascribed to it by the Committee on Economic Social and Cultural Rights ('Committee') is instructive on the meaning of 'access' under section 27(1)(a) of the Constitution.

Paragraph 12(b) of General Comment 14 drafted by the Committee on article 12 of the ICESCR, defines accessibility in terms of four components. First, there must be no unfair discrimination in the provision of health care services Secondly, services must be physically accessible to everyone. Particular attention must be paid to the circumstances of individuals and groups who have physical difficulty in accessing services such as elderly persons, disabled persons and children. Thirdly, services must be affordable in the sense of being 'economically accessible'. Fourth, there must be information accessibility, which entails the right to 'seek, receive and impart information and ideas concerning health issues'.[24] These categories indicate which barriers may prevent meaningful access to health care services, which the state is obliged to remove over a period of time.

A number of cases have recognised these components of access. For example, in *Affordable Medicines Trust v Minister of Health*, the Constitutional Court recognised the importance of legislation and regulations aimed at ensuring that medicines dispensed by

[23] *Grootboom* (note 4 above) paras 13, 45,95 and 99.

[24] UN Committee on Economic, Social and Cultural Rights General Comment No 14 (note 1 above) para 12.

health professionals, as opposed to pharmacies, are safe. Pursuant to this objective, the Court accepted the legitimacy of regulations requiring health professionals to obtain dispensing licenses from the Department of Health. This allowed the Department to rid the health system of bad dispensing practices that might harm the health of patients.[25] In *Pharmaceutical Society of South Africa v Tshabalala-Msimang*, the Supreme Court of Appeal considered the constitutionality of laws aimed at reducing the prices that pharmacies may charge for medicines. The Court, per Harms JA, held that high medicine prices violate the right to access health care services. However, the Department of Health has to balance affordability with the need to keep pharmacies in business, as otherwise medicines would become unavailable.[26] On appeal to the Constitutional Court, these sentiments were repeated. Moseneke J and Ngcobo J held that implicit within section 27 is a right to have access to affordable medicines. However, the need for medicines to be affordable had to be balanced against the need for the pharmacies to make enough profit to remain in business, as well as ensuring that medicines are of good quality.[27]

The cases above focussed on the importance of safety and affordability in relation to access. However, all barriers preventing access to care must be eliminated. It is insufficient for the state to concentrate on making health care more affordable by removing financial barriers to access, through programmes like NHI, if hospitals and clinics are not located in areas where people live. In *New Clicks*, the Constitutional Court held that measures enacted to make medicines more affordable may not cause *rural* pharmacies to go out of business since these pharmacies are necessary for dispensing medicines to poor persons in rural areas. Similarly, people who are ill or disabled must be able to access health care through home services and *courier* pharmacies.[28] In *Law Society v Minister for Transport*, the Constitutional Court noted the importance of home visits by psychologists, psychiatrists and physiotherapists for paraplegics and quadriplegics. These home visits are sometimes

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[25] *Affordable Medicines Trust v Minister of Health* 2006 (3) SA 247 (CC). See also M Pieterse 'A Benefit-Focused Analysis of Contitutional Health Rights' unpublished PhD thesis (University of the Witwatersrand 2005) 182 n 22.

[26] *Pharmaceutical Society of South Africa v Tshabalala-Msimang* 2005 (3) SA 238 (SCA).

[27] *Minister of Health v New Clicks* 2006 (2) SA 311 (CC) paras 517-27, 531, 704-6. See however *Hospital Association of SA v Minister of Health* (2010) 10 BCLR 1047 (GNP) 1084 where the North Gauteng High Court, per Ebersohn AJ, held that the Director General of the Department of Health had to have regard to the financial needs of private hospitals when issuing a national health reference price list dealing with the costs of health services.

[28] *Minister of Health v New Clicks* ibid paras 19, 179, 380, 388-404, 555-63, 653-5, 767-72, 779-81.

necessary for survival.[29] Equally, people are generally not in a position to choose which language they speak. Therefore, health practitioners must be able to communicate with patients in order to properly diagnose their conditions.[30] For these reasons, positive measures taken to fulfil the right of *access* to health services must be comprehensive and respond to the circumstances of all people.

'Access' to health care services has a much broader scope than simply eliminating barriers preventing access to health care. In *Grootboom*, Yacoob J explained that the right to access adequate housing depends on 'more than bricks and mortar': it also depends on 'available land, appropriate services such as the provision of water and the removal of sewage and the financing of all these, including the building of the house itself.' He stated further that to exercise the right of access to adequate housing, 'there must be land, there must be services [and] there must be a dwelling'. Regarding the distinction between those in different economic circumstances, Yacoob J explained that the state's obligation to upper income earners 'lies in unlocking the system, providing access to housing stock and a legislative framework to facilitate self-built houses through planning laws and access to finance', while poor persons must be accorded special attention in policy initiatives associated with socio economic rights.[31] Moreover, in the specific context of health care services in *New Clicks*, the Court emphasised the importance of keeping pharmacies in business so that medicines can be dispensed to the public. Indeed, without pharmacies or a supply of medicines, the right to have access to health care would be meaningless.[32]

These findings show that the state must create the legislative, regulatory, and physical conditions that allow for access to health services by facilitating the creation of institutions and the enactment of the laws that enable people themselves to access health care.[33] In my view, then, 'access' denotes the existence of all the legal and physical structures and systems

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[29] *Law Society v Minister for Transport* 2011 (1) SA 400 (CC) para 92.

[30] See *Eldridge v British Columbia (Attorney General)* [1997] 3 S.C.R. 624 where the Supreme Court of Canada held that the failure of the authorities in British Columbia to provide sign language interpreters for deaf patients when consulting with physicians was inconsistent with section 15 of the Canadian Charter, which is the Canadian equality clause.

[31] *Grootboom* (note 4 above) paras 35-6. See also Liebenberg 'The Interpretation of Socio-Economic Rights' (note 1 above) 22.

[32] See for example *Minister of Health v New Clicks* (note 27 above) paras 517-27.

[33] See *TAC* (note 6 above) para 70 where the Constitutional Court stated in relation to accessing HIV/AIDS drugs that government was obliged to consider the differences between those who can afford to pay for them and poor persons who are unable to do so. See also M Pieterse 'Relational Socio-Economic Rights' (2009) 25 *SAJHR* 198, 201, 205 onwards, where Pieterse explains the different ways in which people overcome barriers of access to health care.

and the human resources that make access to health care services possible. Thus, 'access' presupposes the existence of the essential elements of a health system, such as a legal framework regulating the system and the presence of physical, technological, financial and human resources essential for its operation. By ensuring the existence of these prerequisites, people become individually empowered to access services without major interventions from the state or private parties.

## III. THE AMBIT OF 'HEALTH CARE SERVICES'

### (a) The meaning of health care services under section 27(1)(a) of the Constitution

In this section, I argue that the term 'health care services' in section 27(1)(a) includes *all* treatments and services that are clinically proven to treat conditions for which they were developed.[34] Marius Pieterse argues that the health right confers 'on everyone an entitlement to the availability, accessibility, and acceptability of preventive, diagnostic, and curative health care services of adequate quality on primary, secondary and tertiary levels.'[35] Whilst the word 'entitlement' conveys the beneficial potential of socio-economic rights too strongly because of the Court's conjunctive reading of sections 27(1) and 27(2), the all-encompassing description of 'health care services' given by Pieterse is indeed consistent with the Constitutional Court's jurisprudence on the health right. In this subsection, I consider the cases of *Soobramoney v Minister of Health*, *Minister of Health v Treatment Action Campaign*, and *Law Society of South Africa v Minister for Transport*, which, in my view, support such an interpretation.

In *Soobramoney*, the applicant, a middle-aged unemployed man, sought to obtain renal dialysis treatment at a public hospital in Durban. He had reached final stage kidney failure, and dialysis treatment was the only realistic way to prolong his life. Unfortunately, he also suffered from ischemic heart disease and cerebro-vascular disease. These conditions disqualified him from the dialysis programme. Owing to the few dialysis machines available

[34] I accept that the term 'medically necessary' is subject to contestation depending on which principles of distributive justice are used in defining the term. I accept further that there would be disagreement amongst medical professionals regarding the efficacy of some treatments for specific patients. For these reasons I do not offer an expansive explanation for the term. It suffices to say for the purposes of this thesis that a treatment would be medically necessary if its efficacy has been proven and is likely to benefit patients who suffer from a condition that the treatment was designed to remedy.

[35] Pieterse (note 9 above) 480.

and the high demand for services, the hospital had a bona fide rationing policy designed to derive maximum benefit from limited resources. The hospital administrators were of the view that the benefit to be gained by the applicant did not justify the cost of the dialysis.[36]

In this case, the applicant applied to court to compel the hospital to admit him to the renal dialysis programme. He based his claim on the right not to be refused emergency medical treatment in terms of section 27(3), and the right to life in section 11 of the Constitution. The majority found that these rights did not have application to the case at hand, and then proceeded to consider the case under sections 27(1) and (2) of the Constitution.[37] In finding that sections 27(1) and 27(2) did not entitle the applicant to be admitted to the renal dialysis programme, the Court held that the scarcity of renal dialysis services in the public sector and an overall stretched health budget effectively meant that resources had to be rationed so that there could be 'maximum advantage [to] the maximum number of patients.'[38]

In *TAC*, the constitutionality of the state's anti-retroviral treatment programme for 'prevention of mother-to-child transmission' of HIV/AIDS ('PMTCT') was challenged on the basis that PMTCT was limited to a fixed number of pilot sites instead of being available throughout the public sector. The applicants were successful in the High Court, which ordered the government respondents to make Nevirapine available to pregnant women and their children in all parts of the public sector.[39] On appeal to the Constitutional Court, it was held that government's PMTCT programme was unreasonable in the sense of being 'inflexible', because it denied mothers and their newly born babies access to a single dose of Nevirapine, which had the potential to save the lives of newly born babies. Having come to this finding, it followed that the programme aimed at prevention of mother-to-child transmission of HIV/AIDS was not consistent with government's obligations under section 27(2). The Court classified the government programme, as it existed at the start of the proceedings, as being 'rigid'. Notably, the Court only found the government's policy inconsistent with the Constitution to the extent that it did not enable all public sector doctors to prescribe Nevirapine when this was medically indicated.[40]

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[36] *Soobramoney* (note 6 above) paras 1-4.

[37] Ibid paras 14-22.

[38] *R v Cambridge Health Authority ex parte B* 1995 (2) All ER 129 (CA) 137d-f quoted by the majority in *Soobramoney* ibid para 30.

[39] See *TAC* (note 6 above) para 8.

[40] Ibid paras 69, 80.

In *Law Society*, the applicants challenged the constitutionality of a regulation that obliged the Road Accident Fund ('RAF') to honour claims for medical treatment of road accident victims on the basis of what is known as the 'Uniform Patient Fee Schedule' ('UPFS'). This is an extremely low payment standard reflecting the costs of treatment in public health facilities. The public sector was unable to provide essential rehabilitative treatment for those who became paraplegics or quadriplegics as a result of a road accident. Such treatments included home-based nursing and physiotherapy, which are especially important for poor persons in rural areas. Adequate treatment was only available in the private sector, which many people could not access at the UPFS rate. Moseneke DCJ held that the regulation providing for compensation at the UPFS rate breached section 27 of the Constitution because patients who accessed public sector services could possibly die as a result of not receiving proper treatments.[41]

The three cases of *Soobramoney*, *TAC,* and *Law Society* show that the Constitutional Court has a broad view of the term 'health care services' in section 27(1)(a) of the Constitution. It was assumed that the treatments considered in the above cases fell within the definitional content of the term subject to the criteria developed in *TAC* and *Law Society*. The rationing decision in *Soobramoney* was not simply based on the type of treatment the applicant sought, but rather on his clinical condition. The applicant was *not* denied access to renal dialysis because renal dialysis fell beyond the definitional content of 'health care services' under section 27(1) of the Constitution. It was simply not cost-effective to provide him with renal dialysis given his pre-existing health condition and the minimal benefit that would be derived from the service. There were many other people not before the Court in *Soobramoney*, who *were* entitled to receive renal dialysis and for whom section 27 bestowed tangible benefits.[42] The only proviso was that they qualified for admission to the treatment programme. It would seem that Sachs J endorsed this position, when he stated in *Soobramoney*:

> 'When 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 section 36), but as defining the circumstances in which the rights may most fairly and effectively be enjoyed.'[43]

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[41] See *Law Society* (note 29 above) paras 87-101, 135.

[42] See Wesson 'Chronic Illness and the Right of Access to Health Care Services' (note 20 above) 107.

[43] *Soobramoney* (note 8 above) para 54.

The Court in *TAC* qualified the general approach that was implicit in *Soobramoney*: If a treatment or drug is unsafe or is not effective in achieving a therapeutic purpose then the administration of the drug or treatment does not fall within the scope of 'health care services' in section 27. For a treatment to fall within the scope of the right, it has to be medically indicated. The Court made this qualification in response to the government respondents who specifically challenged the safety and efficacy of administering Nevirapine to mothers and their children at birth.[44] Put simply, treatments not prescribed by a registered health care professional would, in most contexts, fall beyond the scope of the health right. Prescriptions indicate a specific patient's reasonable clinical need for particular treatments. Doctors also take into account the efficacy and safety of treatments when prescribing them.[45] No one has a right to health care interventions that are harmful to one's health or are unlikely to achieve a therapeutic purpose.

In *Law Society*, the Court had to determine, based on expert evidence, the clinical adequacy of public sector care for paraplegic and quadriplegic road accident victims. Public sector care was not of a good standard and did not achieve reasonable health outcomes. As a result, the regulation providing for compensation according to the UPFS tariff rate was inconsistent with section 27. It is evident from this that a treatment will only fall within the definitional ambit of section 27 if it is likely to achieve reasonable and adequate health outcomes. *At times*, this may even impose an obligation on the state to provide private health care services when the public sector fails to offer sufficient care. However, this does not mean that section 27 bestows a right to private sector health care in all circumstances.[46] It

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[44] *TAC* (note 6 above) paras 50, 57-65, 69, 73 and 135. See also *Van Biljon v Minister of Correctional Services* (note 15 above) para 34 where Brand J refused to order a declarator that required medical doctors to prescribe anti-viral treatment to HIV positive prisoners. He said this would amount to dictating to medical doctors 'when they must prescribe anti-viral treatment.' Brand J at para 65(a) ordered the respondents supply 'anti-viral treatment, *which has been prescribed for them*… for as long as this medication is prescribed to them on medical grounds.' (my emphasis).

[45] However *TAC* should not be interpreted as making the operation of the right contingent on the prescription of medication in all cases because for many people in South Africa, accessing a medical practitioner is impossible at some given time. Prescription of medication or the direction by a medical practitioner to undergo a medical procedure is only indicative of 'clinical need'. If a person is unable to access the services of a medical practitioner but indications are that an appropriately qualified doctor would/may prescribe a certain treatment then the health right would have application to that person.

[46] Nonetheless I would caution against a reading of *Law Society* that said that one has a right to private health care services. As long as the service is received and the state has the resources to ensure that the service is accessible, the nature of the health care provider is somewhat irrelevant. If public hospitals do not offer an adequate service for a particular condition, then one is entitled to access in the private sector subject to available resources. That is a far cry from a right to private health care. See also *Van Biljon* (note 15 above) para 49 where Brand J discusses the implications of 'adequacy' in relation to providing prisoners with adequate medical

only does so when the private sector is solely capable of offering access to adequate or reasonable care to the exclusion of the public sector. In such cases, the care offered in the public sector would not fit within the definitional ambit of 'health care services' under section 27(1)(a).

### (b) The right not to be refused emergency medical treatment, the right to reproductive health care and the right of children to basic health care

I argued above that the term 'health care services' must be given a generous definition subject to the limitation that services should be clinically effective, medically indicated, and adequate. However, the Constitution assigns some level of significance to emergency medical care, reproductive health care, and basic health care for children. The significance is borne from the fact that specific constitutional rights protect and promote access to these categories of health care services. Section 27(3) states that no person 'may be refused emergency medical treatment'. Section 27(1)(a) states that 'Everyone has the right to have access to health care services, including *reproductive health care*'. Section 28(1)(c) affords children the right to basic health care. The significance of these categories of health care is related to the vulnerability experienced by pregnant women, infants and young children, and those who suddenly face an unpredictable health emergency. In most cases, these persons depend on others for their survival and wellbeing, and may be unable to take care of themselves. These persons may also be at increased risk for life threatening complications.

#### *(i) Emergency health care*

Section 27(3) is a negative right not to be refused emergency medical care. However, emergency medical treatment has significance from a positive rights perspective as well. To explain this, it is necessary to return to the judgment of the majority in *Soobramoney*. In determining that section 27(3) did not have application to the facts of the case, the majority in

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treatment. For further discussion of the concept of adequacy in relation to medical care in prisons see M Pieterse 'The Potential of Socio-Economic Rights Litigation for the Achievement of Social Justice: Considering the Example of Access to Medical Care in South African Prisons' (note 21 above) 122-5. There, Pieterse considers cost effectiveness and the benefit to be gained as relevant indicators of adequacy. See also E Elhauge 'Allocating Health Care Morally' (1994) 82 *California LR* 1449, 1465-72. See 1467 where Elhauge discusses the problems associated with defining necessity in health care. See also N Daniels *Just Health* (2008) 26 onwards where he discusses the idea of adequacy as being defined by a 'normal species functioning standard'. For a discussion of the standard of adequacy, albeit in relation to the minimum core approach see D Bilchitz (note 11 above) 191-3.

reference to the Indian Supreme Court case of *Paschim Banga Khet Mazdoor Samity v State of West Bengal*,[47] held that the right not to be refused medical treatment applies where the following conditions occur: there is a sudden need for treatment; the patient has no way of making prior arrangements to receive the service; the obtainment of the treatment is urgently needed to stabilise the patient; and lastly, the right applies only if emergency health care services are available. The majority held that section 27(3) is a negative right whose purpose is to ensure that available emergency treatment is not denied to a person in sudden need because of 'bureaucratic or other formalities'.[48]

Scott and Alston point out that the majority viewed section 27(3) of the Constitution as only imposing negative duties on the state to refrain from refusing access to already existing emergency treatment. They argue that the Constitutional Court should have interpreted section 27(3) as imposing a positive duty on the state to ensure that emergency medical treatment, as a matter of priority, is made accessible to more people.[49] This line of criticism was followed in subsequent literature. For example, Marius Pieterse argues that the Court should have inferred a positive obligation to ensure the accessibility of proper emergency care in terms of section 27(3), which would have give emergency care some priority in allocation decisions.[50] Currently, as Liebenberg points out, section 27(3) prohibits existing health care centres from refusing to give emergency treatment but does not entail an obligation to expand the number of emergency health care centres.[51]

The majority's take on section 27(3) and the academic criticism it has attracted indicate that there is a positive obligation to provide emergency medical treatment. This obligation falls under section 27(1)(a), and is subject to the limitations of section 27(2), as are other forms of health care. Yet, it may be argued that the right not to be refused emergency

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[47] 1996 AIR SC 2426.

[48] *Soobramoney* (note 6 above) paras 18-20. The negative aspect of the right not to be refused emergency medical treatment was endorsed in *Law Society* (note 29 above) para 65 where Moseneke DCJ stated on behalf of a unanimous Court that:

> 'Although the right is written in negative terms, *at the very least*, victims of motor accidents would be entitled not to be denied emergency healthcare by a health care provider, health worker or health establishment.' (my emphasis)

The words 'at the very least' in this dictum may imply that that the right not to be refused emergency medical treatment may have more content than mere negative obligations.

[49] C Scott & P Alston 'Adjudicating Constitutional Priorities in a Transnational Context: A Comment on *Soobramoney*'s Legacy and *Grootboom*'s Promise' (2000) 16 *SAJHR*, 206 245-9.

[50] M Pieterse 'Enforcing the Right not to be Refused Emergency Medical Treatment: Towards Appropriate Relief' (2007) 1 *Stell LR* 75, 84.

[51] Liebenberg (note 11 above) 138.

medical treatment, interpreted with the right to have access to health care services, still have positive implications for state health policy. If the state fails to create the conditions in which health care institutions are able to deliver emergency health care, it would violate section 27(3) as well as section 27(1)(a). This can occur if the state fails to provide financial cover for emergency care so that health care centres recover their costs. By not providing adequate financial cover, or otherwise failing to create the conditions in which emergency health care can be effectively provided, the state would fall foul of its positive obligations.

*(ii) Reproductive health care*

The right to reproductive health care is the only classification of health care specifically mentioned in section 27(1)(a). It is also alluded to in section 12(2)(a) and (b) of the Constitution. The types of health care covered within the scope of this right would include termination of pregnancy services, primary health care during pregnancy to ensure the health of the mother and foetus, birthing services, and services needed after birth. Sections 4(3)(a) and (c) of the National Health Act ('NHA') gives expression to this right by providing that state-run and funded health care facilities must provide pregnant and lactating women with health care services and free abortion services. In addition, Parliament has enacted the Choice on Termination on Pregnancy Act ('Choice Act') to regulate abortions in South Africa.[52] Despite the fact that the right to reproductive health care is circumscribed by section 27(2), the NHA and the Choice Act have essentially bestowed an immediately enforceable entitlement to receive abortion services and reproductive health care services. Thus, it would be impermissible for a state-run health care centre to refuse an abortion to a woman on the basis of resource scarcity if the expertise exists within the facility and the woman qualifies for an abortion. A state-run health care centre with the necessary expertise would also be obliged to give regular check-ups to a pregnant woman and deliver her baby once she reaches term. This can only be possible if the state allocates sufficient financial and technological resources to public clinics to enable to the delivery of these services.

[52] The constitutionality of the Choice Act has been tested in two cases: and held to be consistent with the Constitution. See *Christian Lawyers Association of SA v Minister of Health* 1998 (4) SA 1113 (T) and *Christian Lawyers Association v Minister of Health* 2005 (1) SA (T).

### *(iii) The right of children to basic health care*

Section 28(1)(c) of the Constitution bestows on every child the right to basic health care services. Despite this right being textually independent from the limitations of section 27(2), the Constitutional Court in *Grootboom* held that section 28(1)(c) can only be interpreted in the context of those limitations.[53] In addition, the Court held that children's rights under section 28 only operate against the state when children are removed from their family environments. But the state still does have an obligation to ensure families have access to basic health care and must also 'provide legal and administrative infrastructure necessary to ensure that children are afforded the protection contemplated by section 28.'[54]

Commentators have lamented the Court's conjunctive reading of sections 26 and 27 with section 28. For example Ann Skelton has criticised the Court for mostly basing its decisions on children's socio-economic rights on sections 26 and 27 as opposed to section 28.[55] Nevertheless, in *TAC*, the Constitutional Court relied on both section 28(1)(c) and section 27 to hold that the state bears a constitutional obligation to administer a single dose of Nevirapine to children requiring it. The Court pointed out that most children requiring Nevirapine in public hospitals are usually born to poor mothers who are unable to access private care, and are thus totally dependent on the state for health care services.[56] Therefore, it appears that children's health rights under section 28(1)(c) do in fact serve to highlight the plight of poor and vulnerable children who require the state to provide them with essential health care services.

The constitutional importance of health care services for children, just like reproductive health care, is reflected in the legislative obligation on state-run health care facilities in terms of section 4(3)(a) to provide children under six-years of age with free health care services. It is evident then that the state bears a constitutional and legislative obligation to provide children with treatment for illnesses that commonly affect them such as

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[53] Marius Pieterse argued that section 28(1)(c) could be read as part of the core of section 27(1)(a) if these sections are to be read together. See M Pieterse 'Reconstructing the private/public dischotomy? The enforcement of children's social rights and care entitlements' (2003) 1 *TSAR* 1, 5.

[54] *Grootboom* (note 4 above) para 174-8 (quote at para 178).

[55] A Skelton 'Girl's Socio-Economic Rights in South Africa' (2010) 26 *SAJHR* 141, 146-7.

[56] *TAC* (note 6 above) paras 74-9.

HIV/AIDS, diarrhoea, lower respiratory infections, sepsis, meningitis and pneumonia.[57] Two examples of treatments that the state would be obliged to administer to children are the pneumococcal vaccination, and nevirapine for children born to HIV positive mothers. However, the state's obligation to administer these treatments remain subject to the criteria governing the state's obligations in section 27(2).

## IV. THE POSITIVE OBLIGATIONS ON THE STATE IN TERMS OF SECTION 27(2)

In light of the Constitutional Court's conflated reading of sections 27(1) and 27(2) of the Constitution, courts will focus much of their attention on the requirements of the latter section. Section 27(2) expressly binds the state and so indisputably applies to vertical relationships between the state and the people it governs.[58] The purpose of section 27(2) is to limit the extent to which individuals are entitled to have their socio-economic needs fulfilled by the state as an immediately enforceable entitlement.[59] Despite the goal of section 27(1)(a) being the realisation of the right of all people to have access to health care services to the fullest extent possible, section 27(2) grounds this vision within the realistic limitations of the state. People only have an entitlement to resources and services that the state can afford to provide at a specific time.[60]

Section 27(2) defines the state's positive obligation to fulfil the health rights of the people it governs.[61] This section requires the state to implement measures aimed at achieving

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[57] D Sanders & D Bradshaw 'The status of child health in South Africa' (2009/2010) *SA Child Gauge* <http://www.ci.org.za/depts/ci/pubs/pdf/general/gauge2009-10/sa_child_gauge09-10_status_child_health.pdf> 31-2.

[58] See Pieterse (note 18 above) 163 where Pieterse accepts that section 27(2) applies to the state because of its expressive wording of 'The state must…'. However he argues that section 27 still has room for application toward private entities otherwise known as horizontal application. However, the horizontal application of socio-economic rights falls beyond the scope of the thesis.

[59] See *Grootboom* (note 4 above) para 46 where Yacoob J stated regarding the term 'available resources' in section 26(2): 'The third defining aspect of the obligation to take the requisite measures is that the obligation does not require the State to do more than its available resources permit. This means that *both the content of the obligation in relation to the rate at which it is achieved* as well as the reasonableness of the measures employed to achieve the result are governed by the availability of resources.'

[60] See Pieterse (note 9 above) 480; Liebenberg (note 11 above) 139-42; and Bilchitz (note 11 above) 215-35.

[61] In the case of *Jaftha v Schoeman* (note 6 above) para 31, the Constitutional Court held in effect that section 26(2) of the Constitution does not have application for the negative content of socio economic rights. However, Murray Wesson has argued that the requirement of 'progressive realisation' implicitly disempowers the state from deliberately implementing retrogressive measures that cause the 'withdrawal' of existing health

access to health care services for those who do not have access at all, and increasing the degree of existing access for those who only have minimal access. The overarching test in evaluating compliance by the state with its positive obligations is whether the measures adopted by the state are 'reasonable' in the sense that they are reasonably 'capable of facilitating the realisation of the right'.[62] If there is no such capability, then the measure or policy cannot be reasonable. In what follows, I analyse the Constitutional Court's interpretation of section 27(2). I supplement the analysis with opinions of academic commentators.

### (a) Reasonable legislative and other measures

The content of the reasonableness standard was first developed and applied by the Constitutional Court in *Government of the Republic of South Africa v Grootboom*, in the context of a challenge against the housing policy in the Cape Metropolitan area, which implicated the right of access to adequate housing in section 26 of the Constitution.[63] Since then, the reasonableness standard has been applied in numerous other cases to evaluate the constitutionality of several state socio-economic programmes.[64] Reasonableness is a low level standard of judicial review for assessing the constitutionality of measures aimed at facilitating the progressive realisation of socio-economic rights. It does not demand that each person immediately receive a socio-economic service or resource, and gives the state a margin of discretion in choosing how to achieve its aims.[65] Nonetheless, the Constitutional Court has on numerous occasions held that government socio-economic programmes fall short of the reasonableness standard. In this section, I analyse the criteria comprising the reasonableness paradigm that pertain to the first essential point of this thesis, namely that the state must take steps to bring about better access to health care services through redistributive measures like NHI.

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care services. See Wesson 'Chronic Illness and the Right of Access to Health Care Services' (note 20 above) 99-100.

[62] *Grootboom* (note 4 above) 41. See also Brand (note 14 above) 39-40 where Brand places emphasis on the means-end idea as being the central part of the reasonableness paradigm.

[63] *Grootboom* (note 4 above).

[64] Most notably in *TAC*; *Khosa*; *Mazibuko*; and *Blue Moonlight* (notes 5-6 above).

[65] See *Grootboom* (note 4 above) paras 39-45; *Mazibuko* (note 6 above) para 50. Bilchitz (note 11 above) 142 referring to C Hoexter 'The Future of Judicial Review in South African Administrative law' (2000) 117 *SALJ* 484, 509-15. See also C Sunstein 'Social and Economic Rights: Lessons from South Africa' (1999-2001) 11 *Constitutional Forum* 123, 130-1.

When evaluating the reasonableness of health care programmes, courts consider the following factors: First, whether 'the appropriate financial and human resources are available'. Secondly, the measures 'must be reasonable in their conception and their implementation'. Thirdly, consideration must be given to the 'capacity of institutions responsible for implementing the programme. Fourthly, the programme must be 'balanced and flexible'. Fifthly, a measure must cater for crises situations and respond to 'short, medium and long term needs'. Sixthly, the programme may not 'exclude a significant segment of society'. Subsumed into this last factor is the need to consider the position of those who are most vulnerable and in desperate situations because of their lack of access to health care services. However, courts will not apply an optimal threshold in assessing the reasonableness of the programme. All these criteria are part of a contextual approach to socio economic rights adjudication that looks at the position of claimants in society and their particular social and historical context.[66]

Central to these factors is the assessment of the means adopted by the state to achieve the progressive fulfilment of the right to have access to health care services. Danie Brand refers to this as a 'means-end justificatory model' where the court asks if the measures adopted by the state are reasonably 'capable of facilitating the realisation of the right' of access to health care services.[67] If, considered objectively, the measures cannot facilitate the realisation of the right of access to health care, then they cannot be reasonable.[68] Similarly, Hoexter explains, albeit in an administrative law context, that '[a] reasonable decision must have reasonable *effects* as well as a rational *structure*' (emphasis in original).[69] From a socio-economic rights perspective, policies must have at least the objective likelihood of achieving constitutionally mandated ends. In other words, policies must have real-world potential of enhancing access to health care services.[70]

Since the notion of 'progressive realisation' is fluid and not subject to rigid classification, it follows that constitutionally authorised ends lack precise definition. This is the case despite the fact that the reasonableness of a programme is assessed in relation to the

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[66] See *Grootboom* ibid paras 19; 21-2, 25, 36-44. See *Khosa* (note 5 above) para 49. See also De Vos (note 2 above) 266, 275.

[67] Brand (note 14 above) 39-40; *Grootboom* ibid para 41. See also Liebenberg (note 11 above) 140 where she adopts the 'means-end justificatory model' idea of Danie Brand.

[68] See D Bilchitz (note 11 above) 142. See also C Steinberg 'Can Reasonableness Protect the Poor? A Review of South Africa's Socio-Economic Rights Jurisprudence' (2006) 123 *SALJ* 264, 265-7.

[69] Hoexter (note 65 above) 511. See D Bilchitz ibid.

[70] Brand (note 14 above) 42.

ends that the measures should be designed to achieve when compared with actual successes and failures of the current policy. The fluidity of 'ends' is evident from Danie Brand's criticism of the Court in *Grootboom* for not obliging the state to provide substantive relief. Indeed, he indicates that courts will adopt a contextual approach in determining the 'constitutionally prescribed end' required by the Constitution in any given case.[71]

As a result, in the absence of clear unreasonableness or irrationality, courts will be wary of declaring policies inconsistent with the Constitution. Policies will not be subjected to a heightened standard of review where courts ask if better ones could have been devised.[72] The fluidity of 'ends' means that when assessing the constitutionality of a programme like NHI, a court will not apply an absolute standard whereby anything less than the optimal use of available resources will be inconsistent with the Constitution. Moreover, the state is not required to achieve specific results, but rather a range of ends.[73] Consequently, the government is not required to devise the 'best' programme before it does anything at all to progressively fulfil the right to have access to health care services.[74] Indeed, the Constitution calls upon the state to implement reasonable programmes, which should become better over time.

Despite 'ends' not being defined, the Court in *Grootboom* differentiates between 'short, medium and long term needs'.[75] Short term needs are those, which, if not attended to on an immediate basis, are likely to have grave consequences within a short period of time. Long-term needs are closely associated with human resources, infrastructure and technological investment. Attending to these needs puts the state in a better position to respond to health needs in the future. However, the lines between the various categories can sometimes be blurred. For example, improving the capacity of health care institutions to cope with demand takes time even if the consequences are presently dire. Whatever the

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[71] Ibid.

[72] *Grootboom* (note 4 above) para 41-2; *TAC* (note 6 above) para 68.

[73] See *Glenister v President of the Republic of South Africa* 2009 (1) SA 287 (CC) where the Constitutional Court held that it did not have the power to declare draft legislation that had not been enacted inconsistent with the Constitution. The Court held that the separation of powers doctrine prevented it from interfering with the work of Parliament. Similarly, it is unlikely that a court will interdict the enactment of policy initiatives proffered by the executive before such policies are implemented or are otherwise at a point of finality. In a later case, a majority of the Constitutional Court declared the impugned legislation inconsistent with the Constitution in *Glenister v President of the Republic of South Africa* 2011 (3) SA 347 (CC).

[74] See *TAC* (note 6 above) para 68.

[75] See *Grootboom* (note 4 above) para 43.

categorisation of need, the state must respond to all of them within available resources without inappropriately prioritising some needs over others.

The issue of capacity is central to the reasonableness standard.[76] If health care institutions cannot cope with current or increased demand, then government policy may be incapable of achieving constitutionally required outcomes. Therefore, the reasonableness paradigm requires the existence of well-functioning clinics. The state cannot 'promise the world', and then fail to deliver because there is insufficient capacity. Nevertheless, courts will not require the government to deliver beyond what available resources allow. But the capacity criterion also works in reverse – government policy will be unreasonable if it does not take into account the ways in which institutions involved in delivery can benefit a greater number of people. If the state under-utilises existing capacity in some significant way, then the measures implemented by the government may be insufficient to fulfil its constitutional obligations.

The reasonableness standard also requires measures to be 'balanced and flexible'. Even if a policy is rational and is designed to achieve greater access to health care services, it is possible that it may not have this effect at a given time. In such cases, the state would be required to develop the policy so that it becomes reasonably capable of achieving its intended purpose. Not allowing policy to evolve in such cases would be retrogressive because of its inflexibility, and therefore inconsistent with the state's constitutional obligations. Government policy that is stagnant and does not respond to changing realities cannot be reasonable. The Constitutional Court recognised this in *Grootboom* where it stated that '[c]onditions do not remain static and therefore the programme will require continuous review.'[77]

Sometimes socio-economic policy is plainly incapable of achieving constitutionally mandated ends, and may even subvert those ends. If government obstinately abides by such policies and in doing so fails to bring about progressive realisation of access to health care services, then the policy will be unreasonable. In *TAC*, the Constitutional Court held that the

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[76] Ibid. In *TAC* (note 6 above) paras 65-73, the Court held that that the government's policy on PMTCT is unreasonable only to the extent that it prevents Nevirapine from being administered where the capacity to do so exists.

[77] *Grootboom* (note 4 above) para 43. See also *Mazibuko* (note 6 above) paras 67, 162. In *Mazibuko* (note 6 above) para 162, O' Regan J states: 'A policy that is set in stone and never revisited is unlikely to be a policy that will result in the progressive realisation of rights consistently with the obligations imposed by the social and economic rights in our Constitution.' Although this dictum of O'Regan J is stated in the context of 'progressive realisation', it is improper to divorce the reasonableness enquiry from progressive realisation analysis because by doing so one removes the benchmark for testing reasonableness.

government policy of restricting the availability of Nevirapine to pilot sites was 'inflexible' because it rendered a simply administered treatment inaccessible to the majority of mothers and infants who required them.[78] As a result, the Court held that the overall policy programme was 'rigid' and did not comply with the Constitution.[79]

It may be argued further that the AIDS policy in *TAC* also fell short of the reasonableness paradigm because it was not reasonable in its 'conception'[80] because it failed to address the avoidable plight of newly born children susceptible to contracting HIV. In this regard, a policy that is unreasonable in its conception will always be unreasonable in its implementation. Similarly, for government to fulfil its constitutional obligations, it must ensure that its policies are not unduly restrictive due to the stubborn adherence to false premises informing those policies.[81] Policies must be flexible, and adapt as new information becomes available and circumstances change. In this sense, the state's socio-economic policies must also be sufficiently adaptable to respond to the plight of vulnerable persons, and are attentive to their differing circumstances and their constantly changing needs.[82]

The measures adopted by the state are further circumscribed by the need for the state to place special emphasis on the interests of vulnerable persons. Indeed, when devising and implementing socio-economic programmes, the state may not 'exclude a significant segment of society' from benefitting or being entitled to benefit from state programmes. *Grootboom* also requires that consideration be given to '[t]hose whose needs are the most urgent and whose ability to enjoy all rights is most in peril.'[83]Although these criteria may not be

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[78] *TAC* (note 6 above) paras 67-73, 80-1 (quotation from para 80).

[79] Ibid paras 93-5. See also *Grootboom* (note 4 above) paras 52, 56 (quoted in *Blue Moonlight* (note 6 above) para 55). See *Blue Moonlight* paras 84, 92 where the Constitutional Court upheld the finding of unconstitutionality by the Supreme Court of Appeal that a policy adopted by the City of Johannesburg which excluded those persons evicted from dangerous buildings by private landowners (as opposed to the City itself) from being considered for temporary emergency housing if eviction would result in homelessness. The Constitutional Court held that the policy 'inflexibly and therefore irrationally excluded from temporary emergency accommodation those who are evicted by private landowners.' (para 84 of *Blue Moonlight*). The fact that the City had revised its water policy during the *Mazibuko* litigation was partly why the Constitutional Court found its water policy to be reasonable.

[80] *Gootboom* (note 4 above) para 42.

[81] This was arguably the case in *TAC*, where government policy was likely influeced by AIDS denialism. See E Cameron *Witness to AIDS* (2005) 103-22; See also E Cameron 'AIDS Denial and Holocaust Denial: AIDS, Justice and the Courts in South Africa' (2003) 120 *SALJ* 525 (Lecture given at Harvard Law School).

[82] *Grootboom* (note 4 above) paras 42-4.

[83] Ibid.

determinative of the outcome of any case, these criteria have been central to the Court's findings of unconstitutionality in most of its socio-economic rights judgments.[84]

However, it was made clear in *Grootboom*, as well as in subsequent cases and literature, that the reasonableness standard does not require the state to provide everyone with the substance of the right immediately.[85] Nevertheless, the greater the vulnerability of the impugned group, the more likely it is that the state's policies will be found to be inconsistent with the Constitution if it does not meet their needs.[86] Indeed, when considering the reasonableness of the measures taken by the state to fulfil socio-economic rights, courts will and do assess the impact of current government policy on the human interests of claimant groups and others in society.[87] In this regard, the extent of deprivation of a group or person will be considered and whether the measures are capable of alleviating the plight of

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[84] I bring three examples here: In *Grootboom*, the Court declared the housing policy in the area of the Cape Metropolitan Council inconsistent with the Constitution because it failed to make provision for those in desperate need without 'access to land' or otherwise live in 'intolerable conditions or crisis situations.' (See subparagraph 2(c) of the order in *Grootboom* ibid paras 99, and also paras 52, 66)

In *Khosa* (note 5 above) the Court declared the legislative exclusion of certain categories of permanent residents from being entitled to receive social security payments to be inconsistent with section 9 and section 27(1)(c) of the Constitution. Whether a measure amounts to unfair discrimination is clearly central to the reasonableness enquiry when the equality right intersects with a socio-economic right. Although the Court did not refer to these criteria explicitly, when evaluating the impact of the exclusion on permanent residents as part of its unfair discrimination enquiry, the Court recognised the devastating impact of not having access to social security (see para 77). In the words of Mokgoro J writing for the majority 'They are relegated to the margins of society and are deprived of what may be essential to enable them to enjoy other rights vested in them under the Constitution.' (para 77) This indicates that the vulnerability of the persons claiming a rights violation and the impact of a measure on them is central to the question of whether measures are reasonable.

In *Blue Moonlight Properties* (note 6 above), a housing policy in terms of which the City only provided temporary accommodation to poor persons evicted from dangerous buildings at the instance of the City but not by private landowners who evicted them in terms of the Prevention of Illegal Eviction from Unlawful Occupation of Land Act 19 of 1998 was found to be inconsistent with the Constitution. In coming to its conclusion the Court referred to its holding in *Grootboom* (*Grootboom* para 44) that a 'reasonable housing programme cannot disregard those who are most in need.' (*Blue Moonlight* para 90) The Court found that it was unreasonable for the City to exclude an entire category of persons, namely those who are evicted by private persons, from being considered for emergency housing because amongst other things, it precluded an enquiry into the individual circumstances of those to be evicted. In the light of their desperate poverty, the impact that an eviction would have on them was very much determinative in the finding that the policy was unconstitutional. One notable exception is *Mazibuko* where the City of Johannesburg's water policy in a particular area was found to be reasonable.

[85] *Grootboom* (note 4 above) paras 44-5, 68. For the literature (which deals mainly with the idea that one does not have an immediately enforceable claim to a minimum core level of the right) see Bilchitz (note 11 above) 155-6, 194; Liebenberg (note 11 above) 150; Sunstein (note 65 above) 129-131; T Roux 'Response to Cass Sunstein' (2001-2003) 12 *Constitutional Forum.* 41, 46-7; Pieterse (note 9 above) 480; 485-6, 494; De Vos (note 2 above) 267, 271.

[86] In the context of unfair discrimination see *President of the Republic of South Africa v Hugo ('Hugo')* 1997 (4) SA 1 (CC) para 112.

[87] See *Khosa* (note 5 above) paras 76-8. See also De Vos (note 2 above) 267.

vulnerable persons. A policy will only be capable of doing so if the historical, economic, and social context of individuals and groups is considered.

**(b) Within the state's available resources**

The second express criterion for assessing the reasonableness of measures undertaken by the state to fulfil the health right is whether the measures are devised and implemented 'within its available resources'. In this section, I explain the Constitutional Court's interpretation of this term as well as responses by various academic commentators. I consider the question of what is considered available to the state for the purpose of fulfilling its constitutional obligation to promote access to health care services.[88] Section 27(2) may be interpreted broadly as applying to all resources currently under the control of the state, or resources that can be brought under its control through taxation and expropriation, or those resources it has budgeted for a specific purpose.[89]

David Bilchitz has argued forcefully for a broad construction of 'available resources.' He supports the argument that resources should be considered 'available' if the state can put them under its effective control by way of loans, legal expropriation, or other methods. In this regard, resources owned by private persons or non-state actors can also be considered 'available' for the purposes of section 27(2), at least in cases where the method of redistribution is consistent with constitutional norms. On this point, Bilchitz argues that private property rights are equal in status to other rights and in cases of conflict, courts would need to make a determination of preference between 'the suspension of property rights or the abrogation of subsistence rights.'[90] Bilchitz rejects the notion that courts can simply accept state budgetary allocations as trumps to 'conditional rights.' The mere fact that the state has organised the budget in a certain way and provided for some things and not for others does not by itself provide sufficient justification for existing budgetary allocations. Budgets are generally a coordinated and purposeful allocation of resources to be distributed toward a range of ends. However, budgetary allocations can still be considered arbitrary.[91]

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[88] See Bilchitz (note 11 above) 227.

[89] D Moellendorf 'Reasoning About Resources: *Soobramoney* and the Future of Socio-Economic Rights Claims' (1998) 14 *SAJHR* 327, 330.

[90] Bilchitz (note 11 above) 228-30.

[91] Ibid 238. Bilchitz explains the notion of conditional rights as referring to rights whose fulfilment is contingent on the availability of resources and other criteria in section 27(2). In other words, the fulfilment of

The Constitutional Court has arguably moved from a more restricted interpretation of available resources to a wider one. In *Soobramoney*, the first socio-economic rights case considered by the Constitutional Court, the Court implied that the availability of resources criterion only refers to those resources budgeted for a specific purpose. This followed from the fact that the Court gave deference to already existing allocations within the Department of Health's budget.[92] In *Grootboom*, the Court did not appear to reverse the findings in *Soobramoney* on the reach of the availability of resources criterion. However, it stated there that the availability of resources qualified the content of the state's obligation and the speed at which these obligations are fulfilled, as well as the reasonableness of the measures to be undertaken.[93]

This approach was qualified in *City of Johannesburg v Blue Moonlight*. The City argued before the Constitutional Court that '[r]esources not budgeted for are not available'. In other words, the City argued that the state has an almost exclusive prerogative on how to set its budget, and if funds have not been allocated to provide emergency temporary housing for those evicted by private parties then those funds or resources are, in constitutional terms, not 'available'.[94] Van der Westhuizen J on behalf of a unanimous Court rejected this argument, in the following terms:

> 'The City provided information relating specifically to its housing budget, but did not provide information relating to its budget situation in general. We do not know exactly what the City's overall financial position is. This Court's determination of the reasonableness of measures within available resources cannot be restricted by budgetary and other decisions that may well have resulted from a mistaken understanding of constitutional or statutory obligations. In other words, it is not good enough for the City to state that it has not budgeted for something, if it should indeed have planned and budgeted for it in the fulfilment of its obligations.'

The Court indicated in this dictum that existing budgetary allocations do not necessarily trump the fulfilment of constitutional rights.[95] In doing so, the court implicitly acknowledged

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those rights beyond the 'minimum core' is dependent on the existence of resources and other factors in section 27(2).

[92] *Soobramoney* (note 6 above) para 22-36.

[93] *Grootboom* (note 4 above) para 46.

[94] *Blue Moonlight* (note 6 above) para 72.

[95] However, it is noteworthy that the Court went even further than it did in previous socio-economic rights cases, and actually ordered the state organ, in this case the City of Johannesburg, to provide the occupiers with temporary accommodation upon the execution of the eviction order. (See order at para 104(e)(iv). Recall that in *Grootboom*, the Court declared the housing policy that applied in the Cape Metropolitan to be

that some reordering of budgetary priorities may need to occur within already existing resources at the state's disposal. No statement was made in *Blue Moonlight* on whether the state's available resources may extend beyond the resources within the possession of the state.

Therefore, it is evident that 'available resources' in section 27(2) of the Constitution may in some cases mean more than merely what is reflected in the state's budget. It also seems that the Constitutional Court is not wholly committed to its deferential approach in *Soobramoney* where it effectively interpreted 'available resources' as applying only to those resources allocated to a specific department and for a specific government programme such as the provision of kidney dialysis. It must be noted, however, that the Court has not yet excluded Moellendorf's wider reading of 'available resources' as sometimes including resources owned and controlled by companies, private persons or other entities outside the executive arm of government and its functionaries.[96] In summary, the implementation of a redistributive programme such as NHI requires budgeting for the provision of specific health care services. Courts will likely defer to the choices of administrators and policy-makers when confronted with challenges against these decisions. However, the deference given will not be unlimited, especially in cases where constitutional requirements are not respected.

### (c) Progressive realisation

Health reform policies implemented by the state must be reasonably capable of achieving the 'progressive realisation' of the right to have access to health care services.[97] According to the Court in *Grootboom*, the criterion of progressive realisation requires that health care services

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unconstitutional but did not order the provision of housing to the respondents in that case (*Grootboom* note 8 above at para 99). In *TAC*, the Court went further and declared the government policy that limited the provision of Nevirapine to mothers and their newly born children to be inconsistent with the Constitution. However, the Court also ordered to the government respondents to 'permit and facilitate' the use of Nevirapine and 'remove the restrictions' governing its use but did not order the government to provide the treatment to a specific class of persons (see order in *TAC* note 8 above at para 135). The court order in *Blue Moonlight* shows that the Court is developing an open mind towards the provision of tangible relief to an identifiable class of persons albeit without telling the state in specific terms how much to allocate towards the specific policy programme. Therefore, policy makers should be aware that health policy initiatives must be responsive to the needs of its intended beneficiaries without arbitrary distinctions between classes of persons or the unreasonable refusal to provide adequate health care.

[96] An argument may be made that an intersecting reading of government's obligation to implement measures designed to enhance the position of disadvantaged persons in terms of section 9(2) of the Constitution with its obligation to progressively realise access to health care services in terms section 27(2) may give rise to a wider understanding of available resources. However this is beyond the scope of this thesis.

[97] *Mazibuko* (note 6 above) para 50.

be made available to an increasing number of people as time passes. It is within this context that the Court has interpreted progressive realisation as a concession that rights to resources and services like health care cannot be 'realised immediately.' However, as emphasised by the Court, this is not an excuse to do nothing. Rather, it is a positive obligation imposed on the state to progressively reduce barriers preventing access.[98] Progressive realisation also entails an obligation to review socio-economic policies so that these goals can be achieved.[99]

Academic commentators have reacted to the Court's interpretation of progressive realisation with caution.[100] David Bilchitz takes issue with the Court's endorsement of an approach to progressive realisation that sees it as mandating an increase in the number of people who have access to socio-economic resources. In other words, according to Bilchitz's interpretation of the Court's jurisprudence, the words 'progressive realisation' essentially qualify the word 'everyone'. This means that everyone in theory should be able to exercise their right to have access to health services or housing. However, in reality, only some people will actually exercise that right. Therefore, the Constitution requires that the state should increase the number of people who have access over a period of time. This is reflected in the following dictum: – 'Housing [or health care services] must be made more accessible not only to a larger number of people but to a wider range of people as time progresses.'[101]

In contrast, Bilchitz argues:

> '[P]rogressive realisation means the movement from the realisation of the minimal interest in housing to the realisation of the maximal interest. Progressive realisation involves an improvement in the adequacy of housing for the meeting of human interests. It does not mean

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[98] *Grootboom* (note 4 above) para 45.

[99] See *Mazibuko* (note 6 above) para 40 where the Court states: 'The concept of progressive realisation recognises that policies formulated by the state will need to be reviewed and revised to ensure that the realisation of social and economic rights is progressively achieved.'

The Court in *Grootboom* quoted with approval from Article 2 of the UN Committee on Economic, Social and Cultural Rights General Comment No 3 *The Nature of States Parties' Obligations (Art 2, para 1 of the Covenant)* (1990) UN Doc HRI/GEN/1/Rev1 (1994). There the Committee states that the intent of the progressive realisation concept of the ICESCR is to impose 'an obligation on the state to move as expeditiously and effectively as possible' towards 'the full realization of the rights in question.' To this end, the Committee has effectively prohibited what it calls 'deliberately retrogressive measures.'

[100] For example Marius Pieterse has warned that the Court's interpretation carries the risk of curtailing the meaningful enforcement of rights guarantees by conflating sections 27(1) and (2), which makes the latter subsection exhaustive of the state's obligations and thus making it difficult to enforce claims for specified things or services from the state. See Pieterse (note 9 above) 481 referring to Liebenberg 'The Interpretation of Socio-Economic Rights' (note 1 above) 25 where she states that 'no 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.' See also Michelman (note 9 above) 504-5 and Scott & Alston (note 49 above) 249.

[101] *Grootboom* (note 4 above) para 45.

> that some receive housing now and others later; rather it means that each is entitled as a matter of priority to basic housing provision, which the government is required to improve gradually over time.'

In other words, Bilchitz argues for an interpretation of progressive realisation that is predicated on an approach that says everyone has a right to a minimum core of the resource or service in question on an immediate basis.[102] The level of access should then be progressively increased over time. Although the Court has only endorsed minimum core to the extent that it informs what may be reasonable, it has not specifically ruled out an interpretation of progressive realisation that would make it apply not just to the word 'everyone' but also to the substance of the right such as 'health care services'.[103] If so, progressive realisation can also be interpreted to mean that the level of resources and services that are made available to those who already have some minimum level of access should be increased over time. Thus, even once there is partial access to health care, the state bears a constitutional obligation to increase the range of health services accessible to the public.

The obligation on the state to progressively realise access to health care services requires that measures are not 'deliberately retrogressive'.[104] If a measure does not satisfy the requirement of progressive realisation it is considered 'retrogressive'. Unfortunately the Constitutional Court has not ascribed any meaning to retrogression in a socio-economic rights context.[105] The Maastricht Guidelines on Violations on Economic Social and Cultural Rights, a non-binding interpretive instrument for the ICESCR, specifically refers to the prohibition of retrogression in the context of acts of commission by a state. The Guidelines state that retrogression occurs when a state adopts measures reducing the extent of the enjoyment of a right.[106] For example, this would occur if the state reduced the level of access

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[102] The concept that the state is obligated to provide everyone with the minimum core standard of a right is provided for in international law in General Comment 3 article 2 para 1 of the ICESCR para 10 . The Constitutional Court has held in *Grootboom* (note 4 above) paras 29-33 that the minimum core standard may have relevance to the question of reasonableness under section 26(2) of the Constitution. The minimum core standard, if accepted, would have required the state to provide everyone with a minimum standard of resources and services provided for by socio-economic rights in the Constitution.

[103] For the Court's discussion on mimimum core see *Grootboom* ibid paras 29-33; *TAC* (note 6 above) paras 26-39; *Mazibuko* (note 6 above) paras 46-68.

[104] *Grootboom* (note 4 above) para 45 quoting General Comment 3 on Article 2 of the ICESCR para 9.

[105] This is confirmed in S Woolman, C Sprague & V Black 'Why State Policies that Undermine HIV Lay Counsellors Constitute Retrogressive Measures that Violate the Right of Access to Health Care for Pregnant Women and Infants' (2009) 25 *SAJHR* 102, 110.

[106] See *Maastricht Guidelines on Violations of Economic Social and Cultural Rights* (note 2 above) paras 14.

to health care for those who already have adequate access or made access more difficult for those who do not.

Academic commentators have not shied away from attempting to ascribe content to the concept of retrogression. Woolman et. al. refer approvingly to Fons Coomans who has written that retrogression occurs if the state adopts 'any deliberately retrogressive measure that reduces the extent to which the right is guaranteed … [or if there is a] calculated obstruction of, or halt to, the progressive realisation of the right.'[107] In a similar vein, Murray Wesson argues that retrogression occurs in cases where there is a withdrawal of pre-existing services. He therefore defines the retrogression as substantially amounting to a negative right not to reduce or withdraw existing services.[108] In this sense, the state is only empowered in terms of section 27(2) to devise and implement *progressive* measures. When it fails to do so, the state is acting inconsistently with its constitutional mandate.

Liebenberg points out that, the question of whether a measure is capable of achieving progressive realisation largely depends on whether the yardstick for the assessment is based on individuals and groups or the population as a whole. If the benchmark for progressive realisation is defined in relation to individuals then even the scaling back of treatment, which has severe consequences for some people but benefits the general population, is susceptible to being declared inconsistent with the Constitution. Similarly, Liebenberg argues that the exact opposite would apply if progressive realisation and retrogression are defined in terms of communitarian outcomes. This means that despite the severity of the consequences for individuals and groups, ameliorative measures, such as NHI, aimed at increasing access to health care services for a large proportion of society are less likely to being declared retrogressive and inconsistent with the Constitution.[109]

The issue of progressive realisation forms part of a holistic enquiry into the reasonableness of policy measures such as NHI. A court is unlikely to find that NHI or any similar measure is unconstitutional on the basis of being retrogressive, without reference to any other factors. To determine whether NHI is unconstitutional because of the adverse effects it will have on less vulnerable groups, the overall positive and negative effects of the

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[107] See F Coomans 'In Search of the Core Content of the Right to Education' in A Chapman & Sage Russel (eds) *Core Obligations: Building a Framework Economic, Social and Cultural Rights* (2002) 217, 239 quoted by Woolman, Sprague & Black (note 105 above) 110. See also C Scott & P Macklem 'Constitutional Ropes of Sand or Justiciable Guarantees? Social Rights in a New South African Constitution' (1992) 141 *Univ of Pennsylvania LR* 1, 26 (also quoted by Woolman et al at footnote 31 in their text).

[108] Wesson 'Chronic Illness and the Right of Access to Health Care Services' (note 20 above) 99-100.

[109] Liebenberg (note 11 above) 189-90. She refers there to the case of *Five Pensioners' v Peru* Inter-Am. Ct. H.R. (Ser. C) No 98.

policy will be weighed against each other. In doing so, a court will likely consider whether the positive aspect of the right is being realised for the general population, and measure this against the potential impact of the policy on less vulnerable groups. If the state scales back access to health care services for more advantaged South Africans, this will not in and of itself be regarded as retrogressive if access to health care is increased more generally. Merely equalising access to inadequate care by forcing wealthier persons to access the same inadequate health care as the poor will however be retrogressive, because the state is not simultaneously increasing access for poor people.

## V. THE NEGATIVE CONTENT OF THE RIGHT TO HAVE ACCESS TO HEALTH CARE SERVICES

The negative aspect of the health right requires all actors, whether public or private, to abstain from obstructing and reducing existing access to health care services.[110] It is derived from the state's constitutional obligation to 'respect' existing access to health care services in terms of section 27(1)(a) read with section 7(2) of the Constitution. The negative aspect is aimed at preserving the status quo for those who already have sufficient access.[111] In the light of its emphasis on preserving existing access, this obligation will likely form the backbone of any constitutional argument advanced by private sector actors for keeping current mechanisms of achieving access to care. The Constitutional Court has affirmed the existence of negative aspects to the health right and other socio-economic rights on more than one occasion.[112] For the most part, academic commentators also accept the existence of the

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[110] See Liebenberg '*Grootboom* and the seduction of the negative/positive duties dichotomy' (note 1 above) 38.

[111] De Vos (note 2 above) 273-4.

[112] In *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) ('first certification judgment') para 78, the Constitutional Court stated in response to an argument objecting to the inclusion of socio economic rights in the Constitution that 'At the very minimum, socio-economic rights can be negatively protected from improper invasion.' In *Grootboom* (note 4 above) para 20, on behalf of a unanimous Court, Yacoob J held in relation to the right to have access to adequate housing that 'there is, at the very least, a negative obligation placed upon the State and all other entities and persons to desist from preventing or impairing the right of access to adequate housing'. The Court in *TAC* (note 6 above) para 46 expressly applied the above dictum in *Grootboom* to the health right in section 27. Mokgoro J, on behalf of the Court, in *Jaftha* (note 6 above) paras 31-4 held that the right to have access to adequate housing comprised of a negative obligation that the state may not 'prevent or impair existing access to adequate housing.' In *Mazibuko* (note 6 above) O' Regan J stated in reference to the *Jaftha* case that 'The State bears a duty to refrain from interfering with social and economic rights just as it does with civil and political rights.'

negative component of these rights.[113]

A negative violation of the health right takes place when the state substantially 'impairs' existing access to health services or 'prevents' people from accessing them.[114] The state does so if one of its agencies or organs enacts laws or engages in conduct that deprives a person or group of persons from an existing entitlement or means of access to health services. Importantly, not all reductions in health care entitlements or the levelling down of access to care will automatically violate the negative content of the health right. Only substantial reductions of health care will do so. For example, in *Law Society*, the extent of liability by the Road Accident Fund for the medical expenses of paraplegics and quadriplegics was insufficient to cover necessary medical services in the private sector.[115] Public sector services were clearly insufficient for ensuring the survival of these people. As such, the Constitutional Court recognised that the tariff had to be higher to allow for access to the private sector. If prior to NHI, paraplegics and quadriplegics already had access to private sector services, and then these services became inaccessible once NHI was introduced, then a possible violation of the negative content of the health right may have occurred. Importantly, a court considering a negative violation of the health right will not consider the standards in section 27(2) such as reasonableness, the availability of resources and progressive realisation.[116]

A substantive violation of the negative content of section 27(1) will be unconstitutional unless it can be justified under section 36 of the Constitution. Section 36 provides that a right may only be limited in terms of 'law of general application' and the extent of the limitation must be 'reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom'. In deciding whether the latter test has been satisfied, a court will consider 'all relevant factors', including a list of factors directed at establishing the proportionality of the limitation in relation to its purpose

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[113] See for example De Vos (note 2 above) 274-5; Liebenberg 'The Interpretation of Socio-Economic Rights' (note 1 above) at 33-17 – 33-19; Liebenberg (note 11 above) 214-20; Liebenberg 'Needs, Rights and Transformation: Adjudicating Social Rights' (2006) 1 *Stellenbosch LR* 25-9. However, recently Sandra Liebenberg has questioned the usefulness of the distinction between negative and positive rights. See Liebenberg '*Grootboom* and the seduction of the negative/positive duties dichotomy' (note 1 above) 37.

[114] For more on negative rights in the socio-economic sphere and the obligation to desist from 'impairing' and 'preventing' the enjoyment of rights in the South African context see E Christiansen 'Adjudicating Non-Justiciable Rights: Socio-Economic Rights and the South African Constitutional Court' (2007) 38 *Columbia Human Rights LR* 321, 344-8, 365-6, and 372. For foreign commentaries on the issue see C Soohoo & J Goldberg 'The Full Realization of our Rights: The Right to Health in State Constitutions' (2010) 60 *Case Western Reserve LR* 997, 1015-8; B Jessie Hill 'Reproductive Rights as Health Care Rights' (2009) 18 *Columbia J of Gender and Law* 501, 521, 527, 531-7.

[115] *Law Society* (note 29 above) para 93.

[116] *Jaftha* (note 6 above) paras 31-4.

I now consider the first aspect of the limitations enquiry, which is that rights may only be limited 'in terms of law of general application'.[117] Currie and De Waal explain in reference to the judgment of Mokgoro J in *Hugo*[118] that the 'law' requirement in the phrase 'law of general application' includes 'rules of legislation, delegated legislation and common law, and exercises of executive rule-making authorised by the Constitution.'[119] Indeed, NHI will be comprised of general framework legislation, which will also delegate regulatory power to the Minister of Health. The Act and the regulations will give the Minister and the Department of Health the power to make rules on how benefits are to be distributed to the population. These rules will include guidelines for the day-to-day management of the health system including the rationing of health care. These laws, rules and guidelines as well as any decisions made in terms thereof can be challenged as being inconsistent with the Constitution.[120] Any policy or conduct, including that of an organ of state, which violates the negative content of section 27 but does not arise out of a law of general application, will be inconsistent with the Constitution.[121]

The second aspect of the limitations test is whether the limitation is reasonable. Here, a court might consider how courts in other democratic jurisdictions have dealt with similar quandaries.[122] A court will also consider 'all relevant factors' to assess the reasonableness of the limitation. This requires an assessment into the 'importance of the purpose of the limitation'; an examination of the 'nature and extent of the limitation'; whether there are 'less restrictive means to achieve the purpose'; and the relationship if any between the 'limitation and its purpose'.[123] Briefly summarised, the limitation must be proportional in relation to the sought after objective and must be rationally related to it. This involves a balancing exercise between the impact of the limitation on those persons adversely affected by it, and the benefit to be gained by the general population. The Constitutional Court held in *S v Manamela* that

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[117] Currie & De Waal explain further that a law of *general* application means that 'the law must be sufficiently clear, accessible and precise that those who are affected by it can ascertain the extent of their rights and obligations.' They explain further that the law must apply impersonally and not to particular people or groups'. See Currie & De Waal (note 5 above) 169-170.

[118] *Hugo* (note 86 above).

[119] Currie & De Waal (note 5 above) 172. See ibid para 103.

[120] Some of these decisions may in some circumstances be challenged under Promotion of Administrative Justice Act 3 of 2000 and section 33 of the Constitution. However, these sorts of challenges fall beyond the scope of this thesis.

[121] See *Hoffmann* (note 3 above) para 41. See also Currie & De Waal (note 5 above) 169.

[122] S Woolman & H Botha 'Limitations' in S Woolman & M Bishop *Constitutional Law of SA* (2006) 2nd ed. chapter 34, 68.

[123] Section 36 (1) (a-e) of the Constitution.

'[a]s a general rule, the more serious the impact of the measure on the right, the more persuasive or compelling the justification must be.'[124] Indeed, if the same objective can be achieved without unduly impacting the constitutional rights of those adversely affected by the limitation, then this would be preferred. However, sometimes, a sought after objective is so important that in order for a limitation to be unjustifiable, the impact must be especially significant.

Measures that prevent or impair existing access limit the negative content of the right to have access to health care services.[125] The objective of the limitation is, ordinarily, the progressive realisation of access to health care for the general population. Indeed, the importance of this purpose cannot be gainsaid. However, a negative violation of the health right can have a severe impact on those affected. For example, if one considers the hypothetical example based on *Law Society v Minister for Transport* surmised earlier, a reduction of access to services for paraplegic and quadriplegic patients in the private sector might cause the death of such patients.[126] Indeed, the availability and accessibility of many services might mean the difference between life and death or health and suffering. Longer waiting lists and queues at emergency wards can have similar adverse consequences for current private sector beneficiaries. In terms of section 36, the impact of any reduction of access to health care will be central to the analysis as well as whether other less obstructive measures might be used.[127]

There be must always be a nexus between the negative rights violation and the progressive realisation of access to health care services if the limitation and impact is to be justified. The limitation must also be reasonably capable of achieving greater access. Indeed, if the levelling down policy is ineffective, then it is arbitrary and inconsistent with the requirement that there be a 'relation between the limitation and its purpose' under section 36(1)(d) of the Constitution. Moreover, if the negative rights violation is directed at achieving a purpose inconsistent with constitutional norms then it does not matter that the measure is rational. For example, if the limitation equalises access to inadequate care or merely collapses the private sector without improving the public health system then the limitation may not be justifiable.

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[124] See *S v Manamela* (2000) 3 SA 1 (CC) para 32.

[125] See *Jaftha* (note 6 above) para 31.

[126] See *Law Society* (note 29 above) para 92.

[127] See Constitution, section 36(a-c) and (d). *Jaftha* (note 6 above) para 42.

## VI. CONCLUSION

In this chapter, I interpreted the right to have access to health care services, and the state's obligation to implement reasonable measures designed to progressively realise this right within available resources. Like other socio-economic rights, the health care right has positive and negative dimensions largely mirroring the conflict between liberty and equality. Implied in the positive right of access to health care services and the obligation to enact measures to fulfil it under section 27(2) is the need for redistribution of health care resources. This is necessary to progressively realise access to health care services. Sometimes, redistributive processes like NHI will compromise interests underlying the negative conception of the health right. When these are adjudged to be negative violations of section 27, these will be justifiable as long as they are reasonable and proportionate in relation to the purpose of progressively realising access to health care services for the general population. If the impact of any negative violations of the health right is too severe in relation the state's intended purpose then these might be constitutionally unjustifiable.

It is evident therefore, that as with the reconciliation between the values and rights of equality and freedom discussed in chapters 2 and 3 above, the negative and positive conceptions of health right protect libertarian and egalitarian interests, respectively. These can be reconciled and balanced so as to allow for redistribution, whilst still protecting the interests of middle-income earners.

# CHAPTER 5

# CONSTITUTIONAL IMPLICATIONS OF NATIONAL HEALTH INSURANCE

## I. INTRODUCTION

The purpose of this thesis is to provide a framework within which constitutional litigation between proponents and opponents of NHI can be understood. Up to now, I have illustrated the tensions between competing claims to scarce resources from broadly construed egalitarian and libertarian perspectives on health rights in chapter 2. I then analysed the essential content of constitutional values and rights implicated by the introduction of NHI in chapters 3 and 4. In this concluding chapter I apply the paradigm developed in the previous chapters to a specific policy context, namely the National Health Insurance ('NHI') policy as contained in the 'Green Paper' entitled 'National Health Insurance in South Africa – Policy Paper' published by the Department of Health.[1]

The constitutional paradigm developed in this thesis departs from the premise that the state is constitutionally obliged to redistribute health care resources in order to enhance equality within the health system and to reduce difficulties faced by vulnerable groups in accessing services. As a general rule, despite adverse effects caused to previously advantaged groups and other less vulnerable groups, redistribution does not, by itself, undermine the constitutionality of a socio-economic policy, such as NHI. Ngcobo J alluded to the permissibility of adverse effects in *Bato Star v Minister of Environmental Affairs and Tourism* where he stated that transformative measures sometimes come at a cost to 'some members of society'. In this vein, if the achievement of equality is to be advanced, then adverse effects cannot trump the process of transformation.[2] In this chapter, I argue that the central features of NHI are, for the most part, consistent with this paradigm.

However, not all adverse effects will pass constitutional muster. Sometimes the adverse impact will be so egregious for affected persons, that it undermines their human dignity and is not consistent with government's obligations to redress disadvantage. In such cases, where there is a lack of proportionality between the nature, extent and purpose of the limitation, the infringement will not be justifiable. In other cases, NHI may infringe

[1] 'National Health Insurance in South Africa – Policy Paper' published 12 August 2011 <http://www.info.gov.za/view/DownloadFileAction?id=148470> ('Green Paper').

[2] *Bato Star Fishing v Minister of Environmental Affairs and Tourism* 2004 (4) SA 490 (CC) para 76.

constitutional rights but these limitations will likely be justifiable because of the overall increase in access to health care for society as a whole.

In Part II of this chapter, I summarise the essential features of NHI that form the bases of my analysis in the remainder of the chapter. I do not attempt to summarise the Green Paper comprehensively. I only consider those parts which are likely to give rise to constitutional challenges at some future time. My analysis at this stage is descriptive, but I accept the normative purpose of the Green Paper and the importance of the state's positive obligations to enhance access to health care services.

In Part III, I consider those aspects of NHI policy which are consistent with the state's constitutional obligations. I seek to show how the essential features of NHI are reasonably related to the purpose of the programme, which is the progressive realisation of access to health care services. In the first subsection, I deal with the redistributive aspects of NHI and show how these are consistent with the state's constitutional mandate in terms of section 9(2) and section 27(2) of the Constitution. In the second subsection, I discuss the constitutionality of universal membership to NHI. I point out the importance of a universal legal entitlement and show how this is plainly consistent with the Constitution. I also argue that universal legal entitlements are insufficient if the physical barriers that impede access to health care services are not removed. In the following subsection, I consider whether NHI is reasonable in terms of section 27(2) of the Constitution.

In Part VI, I consider objections to NHI likely to emanate from middle-income groups. For the most part, these reflect concerns that NHI will cause a scaling down of access to health care for current beneficiaries of the private health sector. I consider various ways in which this may occur and how this may limit constitutional rights. These ways include: Increased rationing under NHI as a result of capacity constraints in the early stages of implementation; the diminished role of medical schemes; redistribution of private hospital resources; and the focus on primary health care. I then consider how these scenarios may violate the negative aspect of the health right as well as the right to freedom and security of the person. I also show how these policies may at times be inconsistent with government's obligations under section 9(2) and 27(2) of the Constitution. I then consider whether any of these rights limitations can be justified in terms of section 36 of the Constitution.

## II. THE FRAMEWORK OF NATIONAL HEALTH INSURANCE IN THE GREEN PAPER – TOWARDS HEALTH CARE AS A UNIVERSAL ENTITLEMENT

I explained in chapter 1 that a hallmark of health care policy in the late apartheid era was the notion that individuals were responsible for securing access to health care services for themselves and their families. As part of this policy, government encouraged the emergence of private hospitals and private health insurance in the form of medical schemes to defray health expenditure for scheme members and their dependants. The public sector was meant to provide residual health care services for persons who could not otherwise afford private hospital rates or premiums charged by medical schemes. Through this quasi-free market setup, the private sector offered health care services primarily to the white minority. Black persons were effectively precluded from accessing health care in the private system because of poverty and unfair discrimination. This all occurred against a background of structural and systemic inequalities inspired by a libertarian discourse that prioritised individual responsibility over collective entitlement. Despite the democratic transition in 1994, individual responsibility in furthering access to high quality health care remains a central feature of the health system.[3]

In stark contrast to the individual responsibility feature of health care policy under apartheid, the Constitution views access to health care as a universal entitlement for which the state bears primary responsibility.[4] This is the foundation of NHI policy as reflected in the Green Paper and various ANC and government documents discussed in chapter 1, where government is to play the central role of financing and facilitating the provision of health care.[5] The central idea of the Green Paper is that only the state is able to ensure universal access to quality health care services[6] – something that the private sector cannot do because of its profit motives and its fee-for-service policy. The government attributes the current inequalities in the health sector to the private-public sector divide, and the fact that most human, financial and technological resources are under the control of the private sector.[7] The

[3] Chapter 1, Part II.

[4] This is explicit from the exhortation of section 27 that 'The state must' enact reasonable measures to bring about the progressive realisation of the right of everyone to have access to health care services. Though the private sector might still have constitutional obligations to its patients. See in this regard M Pieterse 'Indirect Horizontal Application of the Right to Have Access to Health Care Services' (2007) 23 *SAJHR* 157.

[5] Chapter 1, Part III.

[6] See S Fredman *Human Rights Transformed, Positive Rights and Positive Duties* (2008) 9.

[7] Green Paper (note 1 above) paras 1-16.

government's view is that, since the state cannot sufficiently and effectively control or regulate resource distribution between the public and private sectors under current conditions, or otherwise influence private sector business practises, the skewed distribution of resources will be further entrenched in the absence of meaningful policy reform.

The Green Paper acknowledges deficiencies of the public sector. Despite this, the majority of its attention is devoted to private sector challenges. For example, the Green Paper recognises that the private hospital sector attracts a scarce supply of health care professionals away from the public system. Private hospitals are also accused of 'uncontrolled commercialism' and of inappropriately focussing their resources on expensive hospital-based curative treatment as opposed to primary care. In support of these contentions, the Green Paper points to the often-quoted assertion regarding the disproportionate expenditures in the private and public health sectors relative to the number of patients each one serves: 'The 8.3% of GDP spent on health is split as 4.1% in the private sector and 4.2% in the public sector. The 4.1% spent covers 16.2% of the population, (8.2 million people) who are largely on medical schemes. The remaining 4.2% is spent on 84% of the population (42 million people) who mainly utilize the public healthcare sector'.[8]

In the government's view, private healthcare decreases overall access to health care services because the responsibility for guaranteeing payment for services is placed squarely on individual patients and their families. Some people can afford to access private sector services by paying for services out-of-pocket, whilst others who can afford it choose to obtain private health insurance in the form of medical scheme memberships and other hospital insurance products from financial institutions.[9] When costs of health care increase, premiums charged to scheme members also rise. This sometimes causes members to use up their benefits before the year's end, whilst causing others to cease membership altogether. Although medical schemes generally do subsidise treatments in their entirety, members are often required to submit co-payments for amounts not covered by their particular scheme option. For the most part, medical scheme options are too expensive for the majority of South Africans. The escalation in premiums, caused partly by rising hospital costs, only increases

[8] See ibid paras 6, 11-12, 14, 26, 29-31.

[9] For an example of a short term health insurance policy see a product offered by a company called Clientele Life <www.clientele.co.za/landing-pages/hospital/clientele_hospital/?sourceID=3&campaignID=92&utm_source=google&utm_medium=cpc&utm_campaign=ClienteleHospital&gclid=CJvnuvW60bYCFTIQtAodOWsAEQ>; See also H McLeod 'Mutuality and Solidarity in Healthcare in South Africa' (2005) 5 *SA Actuarial Journal* 135, 141. See also H McLeod & S Ramjee 'Medical Schemes' (2007) *SA Health Review* 47, 49.

the proportion of those not covered, which includes the most vulnerable sectors of society such as women, children, ill persons and the elderly.[10]

The Green Paper envisages an NHI which transforms all aspects of the health system, but most notably, its systems of financing and provision of health care. Described crisply, government intends for NHI to finance and procure a comprehensive package of health services for all South Africans and legal residents. All financing will come from a single publicly administered fund called the 'NHI Fund'. This fund will use a redistributive risk pooling mechanism, and will contain money contributed as part of tax revenue and earmarked tax. The NHI Fund will be owned and administered by a state functionary who will negotiate contracts with public and private health care providers. All income earners will be legally obliged to contribute to NHI. The extent of liability of each individual will depend on the extent of their income – wealthier persons will contribute more than those who are less wealthy, while those who earn below a certain threshold will not be liable to contribute to NHI at all.[11]

The intention of the government is to create a universal system based on solidarity principles and cross subsidisation, whereby the compulsory contributions of relatively wealthy sectors of society will pay for the health needs of all persons including the poor.[12] By doing this, money will be diverted away from medical schemes, which serve a small and relatively wealthy and healthy risk pool, to a national fund from which the entire population will be entitled to benefit. Through the imposition of additional taxes, those who currently access health care out-of-pocket would then contribute much of that money towards the NHI fund, while still receiving substantial benefits from NHI.

The fate of medical schemes under NHI is not certain. Despite the government's condemnation of private sector practices as reflected in the NHI Green Paper and outlined above, government will not prohibit the existence of medical schemes or invalidate contracts between medical schemes and members of the public. Rather, government will require those with sufficient income to contribute towards NHI through general tax and earmarked tax. If desired, people can then choose to purchase parallel or supplementary health insurance benefits over and above their NHI membership. In other words, the purchase of medical

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[10] Green Paper (note 1 above) paras 27, 34-7.

[11] Ibid paras 5, 50-1, 55, 131-6.

[12] See ibid paras 52, 55. For an explanation of what is meant by solidarity see H McLeod (note 9 above) 36 citing D Wilkie 'Mutuality and Solidarity: Assessing Risks and Sharing Losses' (Aug 29 1997) 352 *Philosophical Transactions: Biological Sciences* 1039, 1042.

scheme options will be entirely voluntary, but will not exempt a person from the mandatory contribution to the NHI tax. Although middle-income persons may not be able to afford to contribute to both NHI and medical schemes, the government claims that it will attempt to obviate the need for medical scheme cover, by enabling persons to access quality health care services covered by NHI.[13]

One way in which NHI is designed to enhance access to quality health care is by becoming the central role player in negotiating service tariffs and capitation rates with providers – a role currently played by medical schemes in the private sector. Since NHI will be the primary financing mechanism in the national health system, NHI administrators will have leverage in negotiations with providers. This will enable them to impose some of their own terms and conditions on cost calculations, with the goal of enhancing the cost-effectiveness of the system.[14] Under this system, the state will be able to provide a comprehensive package of benefits to all users of the system because more cost-effective health care services will be provided.

Although vague on the content of the package of services that people would be able to access under NHI, the Green Paper states that it will consist of 'primary, secondary, tertiary and quaternary [services] with guaranteed continuity of health care benefits'. Nevertheless, it is clear that there will be an emphasis on primary health care, which in general encompasses basic interventions that prevent disease and promote health. These interventions are much cheaper and have good health outcomes.[15] The primary health care approach, interpreted within the context of the Green Paper as a whole, suggests that fewer resources will be devoted to curative and sophisticated treatments. What *may* transpire from this is that

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[13] Ibid 32-4, 126, 137-9. At para 126, the following is stated:

> 'The intention is that the National Health Insurance benefits, to which all South Africans are entitled, will be of sufficient range and quality that South Africans have a real choice as to whether to continue medical scheme membership or simply draw of their National Health Insurance entitlements.'

[14] Ibid 101-7. See A Hassim 'National Health Insurance: Legal and Civil Society Considerations' (2010) *SA Health Rev* 205, 207.

[15] See ibid paras 66-70. See also N Schaay and D. Sanders 'International Perspective on Primary Health Care Over the Past 30 Years' (2008) *SA Health Review* 3, 4; B Starfield, L Shi & J Macinko 'Contribution of Primary Care to Health Systems and Health' (2005) 83 *The Milbank Quarterly* 457. See also World Health Report 2008 of the World Health Organisation 'Primary Health Care: Now More Than Ever' (2008) <http://www.who.int/whr/2008/en/index.html>.

The concept of primary health care stems from the Declaration of Alma Ata, which was adopted at the International Conference of Primary Health Care in the Former USSR in 1978. The citation is Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, U.S.S.R., (6-12 September, 1978). See Article VI of the Declaration for a comprehensive definition of primary health care.

government will quite significantly ration the extent to which the NHI will fund expensive tertiary services that have relatively low prognoses for individual patients.

It is evident from the aspects of the Green Paper described above that government has deliberately adopted an egalitarian policy to health care financing and provision as opposed to a libertarian one as described in chapter 2. There, I characterised the egalitarian approach as being premised on equal access for equal needs, or 'equal utilization for equal need.'[16] In other words, all people with the same clinical characteristics should be provided with similar treatment.

For government, the social, economic and human benefit derived from an egalitarian health system justifies NHI, despite any adverse effects that this may hold for privileged groups, in the form of the possible reduction in the level of care currently available to them in the private sector. In the remaining parts of this chapter, I argue that the aspects of NHI described in this section are generally consistent with the constitutional paradigm set out in this thesis. However, as with any socio-economic programme, NHI will succumb to successful constitutional challenges if it is inconsistent with section 27; falls beyond the mandate of the state to devise and implement redistributive measures aimed at the achievement of equality for previously disadvantaged persons, or violates the freedom and security right under section 12 of the Constitution.

## III. FEATURES OF THE PROPOSED NHI THAT ARE GENERALLY CONSISTENT WITH THE STATE'S CONSTITUTIONAL OBLIGATIONS

### a) Redistribution in the public interest

Redistribution is one way in which states achieve distributive equity and avoid vast discrepancies in resource allocation. Redistribution is a central component of substantive equality as applied in NHI policy. I argued in chapter 3 that the positive duty on the state to provide access to health care services and other socio-economic amenities, presupposes redistributive mechanisms that put more resources under the control of the state.[17] In fulfilment of its duty, the state receives revenue by way of taxation, and also appropriates control over resources owned and managed by other parties, to the extent that this is

[16] E Mossialos & S Thomson *Voluntary Health Insurance in the European Union* (2008) 102.

[17] See chapter 3 Parts III and V(c).

mandated and limited by the Constitution. The state does this with the express purpose of using those resources to benefit the entire population on an equitable basis. In other words, the state becomes the conduit for collecting resources and using them to serve the needs of its citizens, especially the most poor and vulnerable.

Although the state can plausibly increase the amount of resources available for health care and use health and financial resources at its disposal more efficiently, this will not be sufficient if vast amounts of health care and resources remain under the effective control of a minority of people. NHI deals with this in at least three ways. First, all individuals earning above a minimum threshold will be required to contribute in differing degrees to an NHI Fund as part of a general and earmarked tax scheme. Secondly, the revenue collected will be pooled into a single fund from which all persons will be entitled to benefit. Thirdly, more people will have access to private hospitals contracted to the NHI. I deal with each of these in turn.

Central to NHI policy is that a greater proportion of income generated and held by private parties will come under government control through taxation. With this tax policy in place, the state will be empowered to determine 'how the social product is shared out among different individuals and groups'.[18] No longer will the private sector and market forces determine who has access to health care services by controlling the costs of health care and imposing a fee-for-service admission policy. Since most health care financing will come from the state purse under NHI, the state will be empowered to direct, in a substantial way, how health care is financed and health resources are distributed, by way of budgetary and negotiation processes with private and public stakeholders.

The distributive effect of taxation under NHI is then manifested in several ways. First, revenue collected by the state will be pooled in a unitary NHI Fund used to benefit the entire population. For the most part, this will cause a diversion of funds away from medical schemes, which by definition only protect *members* from the financial risks associated with injury and disease. By setting up a unitary fund financed by tax revenue, the government will effectively redistribute income usually expended on medical scheme membership by wealthier segments of the community and use those funds to protect all citizens and legal residents from the risks of ill health. Thus, instead of medical schemes almost exclusively financing private hospital operations (together with out-of-pocket expenditure), the NHI

[18] L Murphy & T Nagel 'Taxes, Redistribution and Public Provision' (2001) 30 *Philosophy and Public Affairs* 53, 54.

Fund will finance most health care in South Africa. However, taxation does something more: it redistributes income from *everyone* who earns above a minimum threshold, so even wealthy people who currently pay for health care out of pocket will contribute to the NHI Fund.

Another consequence of redistribution is that all accredited health care providers will become accessible to the entire population. This would include both public and private health care providers.[19] Since citizens and legal residents will have an entitlement to financing of treatments under the basic package of the NHI at accredited public and private providers, no contracted provider will be able to turn away patients on the ground that they have no financial coverage. In theory, this will allow for millions of legal residents to access accredited private providers where admission is currently conditional upon a guarantee of payment. However, the exclusion of foreigners who are either illegal residents or legal non-residents may in some circumstances breach section 9 and the 'everyone' standard inherent to section 27 of the Constitution. I deal with this in more detail in the following subsection.

These redistributive features of NHI are generally consistent with the state's constitutional obligations. In compliance with section 9(2) of the Constitution, NHI is intended to enhance the ability of persons to access health care services by providing access to finance. Although previously disadvantaged persons are by no means the sole beneficiaries of NHI because of the universal nature of entitlement to benefit, this does not render NHI inconsistent with section 9(2).

Aside from the possible exclusion of certain categories of foreigners from an entitlement to benefit, the model of NHI mooted in the Green Paper does not limit the accessibility of financing or health care services on the basis of race, or differentiate between those who are liable to contribute to the NHI Fund and those who are not. Depending on the manner in which NHI is implemented and on the quality and quantity of service provision, adverse effects caused to previously advantaged members of society will generally be constitutionally justifable because of the overall benefit of the NHI programme for the entire population. However, if the level of access to health care services for wealthier persons is simply scaled down to an inadequate level already accessed by poor persons, then these adverse effects may not be justifiable.

As far as section 27(2) is concerned, if conceived and implemented reasonably, NHI fulfils the government's duty to realise access to health care services on a progressive basis.

[19] Green Paper (note 1 above) paras 51, 85, 112, 132, 140.

Furthermore, section 27(2) provides an impetus for the redistributive character of NHI for two reasons: The first reason is that redistribution under NHI entails reaching beyond the state's budget and resources to procure and deliver health care services. In this sense, monies collected through taxation do not by definition originate from state coffers so when the state increases rates of taxation or introduces an earmarked tax, the state is effectively appropriating resources from private individuals and companies. If section 27(2) is given a wide interpretation as referring to 'any resources that the state can marshal to protect the right'[20] then this provides a constitutional justification for increased taxation. The Constitutional Court has not specifically rejected a wider interpretation of 'available resources' that would provide an impetus for the type of redistributive measures discussed in this chapter.

The second reason that would make the redistributive measures to be implemented under NHI consistent with the state's obligations under section 27(2) involves an argument which assumes that there is a bar to what the state can achieve within its own existing resources. This approach acknowledges that even if the state uses its existing resources more efficiently and reduces maladministration in the public sector, it will still not be sufficient to fulfil the transformative ends required by the Constitution. In other words, the only way the state can fulfil the right of 'everyone' to have access to health care services in terms of sections 27(1) and (2) on a progressive and continuous basis is for the state to devise and implement redistributive measures such as those described in this chapter. NHI policy as reflected in the Green Paper recognises the need to improve health care provision in the public sector, but also addresses the need for integrating private hospitals into a unitary health system.

#### b) Universal entitlement to membership

There will be a universal entitlement to benefit from NHI.[21] This means that all South African citizens and legal residents will be entitled to benefit from NHI without

[20] D Moellendorf 'Reasoning about Resources: *Soobramoney* and the Future of Socio-Economic Rights Claims' 1998 14 *SAJHR* 327, 330.

[21] For an extensive analysis of the concept of universal coverage see D McIntyre 'National Health Insurance: Providing a Vocabulary for Public Engagement' (2010) 145 *SA Health Rev* 13, 15 where in reference to the World Health Report of 2000 she defines a universal health system as providing 'all citizens adequate health care at an affordable cost.' She states further that universal health systems have two components with the first being removing barriers preventing access to care and the second financial protection for all users of the system through risk pooling mechanisms.

differentiation based on race, income status, health condition or some other arbitrary classification.[22] In other words, no legislative or regulatory provisions will exclude classes of citizens or legal residents from a general and equal entitlement to benefit.

However, limiting the entitlement to benefit from NHI exclusively to citizens and legal residents may be constitutionally objectionable. Although the Green Paper states that 'refugees and asylum seekers will be covered in line with the provisions of the Refugees Act',[23] it remains unclear whether refugees and asylum seekers will receive health care services as members of NHI or independently of NHI. Moreover, the Green Paper is unclear on the position of undocumented migrants.[24]

There is no indication in section 27(1) that refugees, asylum seekers, and undocumented migrants may be excluded from an entitlement to benefit under NHI. This is implicit in the word 'everyone' as interpreted by the Constitutional Court in *Khosa*. Although permanent residents are given an entitlement to benefit, the reasoning employed by the Constitutional Court in *Khosa* regarding impact and vulnerability applies with even greater force to these categories of foreigners aside from leisure tourists. Most of these persons were forced to flee from their home countries to support themselves and their families. As a result, they have been forced into relationships of dependency with local residents and live as outsiders in society.[25] However, limiting the entitlements of these persons under NHI may be justifiable if giving them the same entitlements as citizens and legal residents will make it difficult for the state to fulfil its obligations to the latter two categories of persons.[26]

Aside from the exclusion of refugees, asylum seekers, and undocumented migrants from a full entitlement to benefit, the guarantee of equal entitlement for citizens and legal residents is generally consistent with section 9 and the 'everyone' standard of section 27(1) of the Constitution. However, the guarantee of equality for citizens and legal residents does

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[22] NHI Green Paper (note 1 above) para 5.

[23] Ibid para 64; Refugees Act 130 of 1998. Section 27(g) of the Refugees Act states 'A refugee is entitle to the same basic health services and basic primary education, which the inhabitants of the Republic receive from time to time.'

[24] See 'Comments on the National Health Insurance Policy Paper of 12 August 2011 – Council for Medical Schemes' (19 January 2012) <http://www.medicalschemes.com/files/National%20Health%20Insurance/CMSCommentsOnDraftNHIPolicy_20120119.pdf> 50-51, para 15.2

[25] *Khosa v Minister of Social Development* 2004 (6) SA 505 (CC) paras 42, 71, 76.

[26] Like in the Constitution, the National Health Act 61 of 2003 ('NHA') does not have a positive entitlement to receive emergency medical treatment but only contains a provision (section 5) that no one may be refused emergency medical treatment. Nonetheless for reasons provided for in chapter 3, providing emergency treatment may have some priority status under the NHA as well.

not mean that there will be no differentiation. All health systems allow for differentiation between patients displaying dissimilar clinical characteristics, especially when rationing scare resources. The universality and equality aspects of NHI are not meant to bestow a right to an unlimited set of defined treatments in all circumstances for *all* people, but rather to require that rationing be conducted fairly and consistently on the basis of clinically sound criteria.[27] Thus, all persons will have a common membership regardless of the level of contribution to the NHI scheme and administrators will be required to allocate resources in a manner that treats all persons displaying similar clinical characteristics in a fair and consistent manner.

Equal entitlements for citizens and legal residents to basic health care services under NHI means there cannot be unfair discrimination between them at the level of legal entitlements. However, equal entitlement to financing or provision of health care services will not by itself eradicate the current inequalities in the health system. For this to be achieved, further programmes are necessary over and above NHI. For example, there must be an equitable distribution of health care services so that all sectors of the population are able to access care regardless of their geographical location. In addition to this, regard must be had to the different ways in which access is impeded for different categories of people, taking into account their health conditions and their poverty. Without these, an equal entitlement to health care services means nothing, because people will not be physically able to access health care services.

#### c) The reasonableness of NHI as a means of facilitating access to health care

In chapter 4, I explained that socio-economic programmes must be reasonable to be consistent with section 27(2) of the Constitution. For NHI to be reasonable, it 'must be capable of facilitating the [progressive] realisation of the right' to have access to health care services. A court assessing whether this threshold has been met will not ask whether a better programme can be devised to achieve the state's constitutional obligations. However, NHI must be reasonably conceived and implemented as well as provide for 'short, medium and long term needs'. In doing so, care must also be taken to ensure that NHI provides for the needs of vulnerable persons.[28] Moreover, NHI administrators must adhere to the rule of law by running the NHI according to high standards of administrative justice and free from

[27] See K Syrett *Law Legitimacy and the Rationing of Health Care* (2007) 52-68; N Daniels *Just Health: Meeting Health Needs Fairly* (2008) 110-5.

[28] *Government of the Republic of South Africa v Grootboom* paras 39-44 (Quotes in paras 41, 43).

corruption.[29] In this subsection, I assess whether the functioning model of NHI is consistent with the requirement that a measure must be reasonable in its conception and its implementation. I then consider whether NHI is affordable, having regard to academic debate on the subject. Indeed, NHI can only be capable of realising access to health care services if it is affordable. Lastly, I examine whether NHI, as it is currently framed in the Green Paper, properly serves the interests of vulnerable persons.

*(i) Revenue collection, pooling and purchasing – the three components of delivery*

The functioning model of NHI has three components designed to progressively realise access to health care. These are: revenue collection, pooling, and purchasing of health care.[30]

Revenue collection is the process of channeling funds to NHI from general taxes and specifically earmarked health taxes. In accordance with solidarity principles, wealthier persons will contribute more funds to the NHI Fund than poor persons. Contributions will be proportional to a person's income and membership will be compulsory. People will be permitted to purchase medical scheme options over and above benefits received from NHI, but not in place of them.[31] This policy will allow all sectors of the population to share the risk and burden of each other's health care needs.

The funds collected will be pooled into a single central NHI Fund. This fund will then be used to purchase accredited health care services for all citizens and legal residents.[32] In this way, the financial risk associated with the uncertain need for specific health care services of all persons will be shared amongst the entire population.[33] McIntyre explains that the more people who will belong to the risk pool, the easier it will be to share the financial risk associated with ill health and disease. She explains further that universal systems cannot have 'fragmented risk pools which do not allow for income and risk-cross subsidies from the rich to the poor and the healthy to the ill'.[34] Hence, the idea behind establishing a universal and

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[29] See *Glenister v President of the Republic of South Africa* 2011 (3) SA 347 (CC) paras 166-178.

[30] See McIntyre (note 21 above) 145.

[31] See Green Paper (note 1 above) paras 50-1, 114-115, 125, 130; D McIntyre ibid 150.

[32] Green Paper ibid paras 131-6.

[33] See 'Glossary of Healthcare Financing Terms' <http://www.imsa.org.za/files/Library/NHI/glossary/IMSA%20NHI%20Glossary%20vF4%2027%20October%202009.pdf> 5.

[34] McIntyre (note 21 above) 151.

equitable health system is to unify the financing and provision of health care so that wealthier persons carry the cost of sickness and injury borne by poor people.

Once the NHI funds are pooled, they will be used to purchase health care for the entire population. McIntyre explains that 'purchasing' in the health policy context involves the movement of funds from the risk pool to the service providers so that the population has access to 'appropriate, efficient [and] quality services'.[35] Under current health system arrangements, medical schemes typically purchase health care services in the private hospital sector with a small number paying for services out of pocket. The state is the primary purchaser of health care in the public sector but has little involvement, whether regulatory or otherwise, in the purchasing and delivery of care in the private sector. This allows costs to rise and capitation rates to increase without the state being able to control the level of profit. Under NHI, the state will have greater leverage in negotiations with health care providers. This, in turn, will assist with keeping costs low, curbing excessive profits and also reorienting services to emphasise primary health care.

It is unlikely that a court would hold that the methods of revenue collection, pooling and purchasing of health care would be unreasonable in their conception. Indeed, all three of these aspects of NHI are directed towards enhancing universal access to health care. However, as with all policies, these three processes must be implemented responsibly and supplemented by measures that enhance the ability of health care service providers to respond to increased demand when NHI is introduced. This can only occur if capacity is increased in the overall health system in order to accommodate the increased number of newly insured patients. Governance in the public sector must also improve. The processes of collection, pooling and purchasing essentially mean nothing without the institutional capacity and resource capability to deliver health care at all access points within the health system.

*(ii) The affordability of NHI*

In order for NHI to be capable of facilitating access to health care services, it must be affordable. If NHI is not afforable then it cannot be implemented. The authors of the Green Paper argue that NHI will be affordable because health care services will be traded at 'reasonable costs' and not as an 'ordinary commodity'. Indeed, the focus in the private sector is often on expensive tertiary and curative health services whose benefits are sometimes not

[35] Ibid 152.

justified by their costs. NHI will also have a greater focus on primary health care, which is supposed to lead to better population health and reduce the overall need and demand for tertiary services.[36]

Nevertheless, commentators are divided on whether NHI is affordable. Di McIntrye argues in a paper written before the publication of the Green Paper that the universal nature of a health system does not make it unaffordable but rather 'its inappropriate design.' She suggests a few characteristics of a sustainable health system design: First, she recommends the establishment of an integrated pooling mechanism, which gives greater power to the purchaser in determining the pricing of health care. In this case, the purchaser is a unitary NHI Fund administered by the Department of Health, and is also able to 'promote efficient and equitable provision of appropriate services.' Secondly, she advises that the functions of the NHI Fund and the national and provincial departments of health be clearly defined in order to prevent a duplication of roles and unnecessary costs. Thirdly, she says that the basic package of services must emphasise primary health care, but must also include specialist services. Fourthly, she recommends that payment methods not be based on a fee-for-service model.[37]

Others are more sceptical about the affordability of NHI. First, affordability depends on the extent to which people can be subjected to increased taxation. Alex van den Heever argues that taxpayers cannot generally afford to pay more in income tax.[38] Although high taxes do not necessarily make NHI unreasonable, the amount of money that can be collected through taxation is limited. There is an argument to be said that the South African economy is not big enough to handle a programme of the size of NHI. Accordingly, it would be extremely difficult for taxpayers to fund the health care of the entire population at the level obtained by the members of medical schemes, because of the small tax base.[39]

Whether NHI will be unaffordable cannot be determined in the abstract. Therefore a wait-and-see aproach must be adopted. However, it is important to note that NHI will be implemented in stages. As such, NHI might initially comprise a reduced package of benefits

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[36] Green Paper (note 1 above) paras 52(f), 66-70, 127, 117-30 (Quote at para 52(f)).

[37] McIntyre (note 21 above) 153-4.

[38] A van den Heever 'A Financial Feasibility Review of NHI Proposals for South Africa' (2010) *SA Health Rev* 157, 166. He states there 'Given that approximately 5% of GDP is to be raised in additional taxes from current tax-payers amounts to roughly 24% of GDP, an amount of 5% of GDP raised from existing taxpayers would require a 20% increase in taxes if distributed proportionately. This would require a doubling of existing personal taxes from an average of 20.4% presently to 41.2%.'

[39] See for example J Broomberg '*Health reform must not destroy private sector*' *Cape Times* (2 June 2009) page unavailable.

that is within the resources of the state, and the size of the package will be increased over time in line with what the state can afford. This is consistent with the obligation of the state to progressively realise access to health care services by increasing the level of access over time in addition to the number of people who gain access.[40] This is also consistent with the dictum in *Grootboom*, which states that a 'court considering reasonableness will not enquire whether other more desirable or favourable measures could have been adopted or whether public money could have been better spent'.[41] In other words, it is not expected of the state to provide a package of benefits under NHI that is beyond its available resources and that reaches an optimal threshold of effectiveness.

*(iii) Priority given to vulnerable groups*

Despite the deference accorded to the state in devising and implementing social policy programmes, the reasonableness standard requires some element of priority to be given to vulnerable groups and those whose needs demand urgent attention. To this end, the Court in *Grootboom* stated that no 'significant segment of society' can be left out of consideration in devising and implementing socio economic policy.[42] Although the vulnerability of a group is not an exclusive factor when considering socio-economic entitlements, it is nonetheless crucial in determining whether a measure such as NHI is reasonable.[43]

The central purpose of NHI is to provide for the health care needs of all persons, especially vulnerable groups. In pursuit of this, health care services will be 'free at the point of use' from accredited health care providers. This will be so regardless of whether a person is able to pay for the treatment. This plan will be affordable ostensibly because health care services will be procured by NHI administrators at reasonable costs. In addition, there will be cross-subsidisation between wealthier persons and the poor. By offering free health care services to the entire population, the barrier of affordability will be removed. However, persons in need of funding for specific health care services not approved by the NHI will be permitted to access these services by purchasing supplementary health insurance or by paying

[40] See D Bilchitz *Poverty and Fundamental Rights* (2007) 193.

[41] *Grootboom* (note 28 above) para 41.

[42] Ibid paras 43-4.

[43] See ibid. M Wesson '*Grootboom* and Beyond: Reassessing the Socio-Economic Jurisprudence of the South African Constitutional Court' (2004) 20 *SAJHR* 284, 293; C R Sunstein 'Social and Economic Rights? Lessons from South Africa' (1999-2001) 11 *Constitutional Forum.* 123, 130-1.

for them out of pocket. Moreover, persons who are presented for treatment at non-accredited health care centres will not be entitled to funding from NHI. As a consequence of these affordability barriers, it is imperative that NHI covers a vast range of primary, secondary, and tertiary treatments that are subject to responsible rationing guidelines and procedures.[44]

The Green Paper also provides that those with the most urgent health care needs will be given timely access, appropriate for treating their health condition. Moreover, the entitlement to NHI membership will not be based on health status. Thus, a person with pre-existing health conditions will still be able to access treatments for those conditons at the commencement of NHI. This is in stark contrast to applicants for medical scheme membership. Though still accepted as members, they are not entitled to claim for treatments for pre-existing conditions for a specific period of time.[45] In this way, people suffering from debilitating illnesses and conditions at the commencement of NHI will still be able to access accredited health care services.[46]

However, the state is obliged to do much more than merely entitle all people regardless of their poverty and physical health condition. In this respect, the Green Paper states that NHI will remove 'regulatory, cultural, geographic, and administrative' barriers impeding access to health care services for vulnerable persons. In addition, the Green Paper states that in devising a package of benefits under NHI, regard will be had to the ways in which 'barriers to access' can be overcome. In order to fulfil these undertakings, the state must ensure that health care centres are also located in rural areas and that transport is available for people who cannot organise transport to a clinic. Moreover, health care services available under NHI must be culturally appropriate, and medical practitioners who speak local African languages must be available to treat patients and make proper diagnoses.[47] Lastly, the state must ensure that prisoners and undocumented migrants are also given access to health care services.

In this section I have attempted to show how many of the core features of NHI are consistent with government's constitutional obligations. I have advised where further policy reform must be considered to further buttress the reasonableness of the programme. If NHI achieves its goals and delivers what is envisaged in the Green Paper then it will pass the

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[44] Green Paper (note 1 above) paras 69, 51-2, 87, 116, 153.

[45] Chapter 1, Part III(c)

[46] Green Paper (note 1 above) para 17.

[47] Ibid paras 52, 72, 81 (Quote at para 16 fn 11).

reasonableness test. However, NHI is not only susceptible to constitutional challenge from vulnerable persons, but also from wealthy and middle-income groups who have more resources at their disposal and are better positioned to challenge the constitutionality of NHI. Such litigation has already been threatened.[48] I now turn to consider various grounds on which private sector actors and middle-income groups might challenge the constitutionality of NHI.

## IV. AREAS OF CONTROVERSY AND THE INTERESTS OF MIDDLE-INCOME EARNERS

Despite the overall benefit that NHI is likely to bring to the majority of the population, more privileged sectors may endure adverse effects in the form of an increase in taxation or the levelling down of access to care that they currently enjoy in the private sector. I argued in chapter 3 that, as a general principle, adverse effects caused by redistributive measures are not inconsistent with the Constitution.[49] When a privileged minority of the population benefits from the lion's share of scare health resources in a situation of unequal distribution, then redistributive measures can have an adverse impact on them. Nevertheless, diminishing access to care must be measured against the overall gain in the equity of the health system. At its core, the mandate of government to treat everyone with equal concern and respect does not require it to preserve existing inequities that benefit more privileged sectors of society when these impair the ability of others to have meaningful access to health care.

The positive duties on the state to enhance the achievement of equality for previously disadvantaged groups and to progressively realise access to health care services are not blanket constitutional validations of all redistributive measures, regardless of their purpose and consequences. If the impact of a measure is particularly egregious, then there is a greater likelihood of a court finding that a particular policy is inconsistent with the Constitution. In this section, I analyse policy features of NHI which may cause a scaling down of access for private sector beneficiaries. In this analysis, I primarily consider those who currently access private health care services financed by medical schemes, but also to some extent those who access the private sector through out-of-pocket payments.

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[48] See M Belling "If NHI goes wrong, "we'll sue"" (5-12 July 2013) *SA Jewish Report* 5.

[49] Chapter 3, Part III (a-b)

Issues considered here are limited to the following: increased rationing under NHI due to capacity constraints; the diminished role of medical schemes in facilitating access to care; the redistribution of private sector financial and health resources; and the focus on primary care. I then consider constitutional issues that are implicated by the scaling down of care. I do not deal with the economic and trade rights of medical schemes and private heath care service providers as it is beyond the scope of this thesis.[50]

### (a) Increased rationing under NHI and capacity constraints

Since health resources are scarce, the state must adopt an allocation mechanism through health system design, budgetary processes and rationing.[51] However, not all mechanisms have egalitarian results. The type of rationing practised by administrators of universal health systems is distinct to that of market-based systems. Each type of rationing arguably has a negative impact on a different sector of the population. The Green Paper foresees NHI as a universal health system that serves all citizens and legal residents. Currently, South Africa's private sector runs according to market principles by serving only those who can afford its services, whilst the public sector is a non-market health care system that attempts to treat all patients regardless of their ability to pay for services. In this subsection, I argue that NHI may diminish access for middle-income earners because of an increase in health rationing in the private sector. I also argue that the type of rationing implicit in the Green Paper may not be transparent, and that non-transparent rationing may be unreasonable or unfair.

Keith Syrett explains that in market-oriented health systems, the inability of certain sectors of the population to pay for health care lowers the demand for services.[52] There is no demand for what one cannot afford. Market-oriented health systems are generally defined by the prevalence of private health insurance and private hospitals. The 'advantage' of this system for middle to higher income earners is that there is potentially more accessibility to a greater range of health care services. This typically occurs because risk pools are limited to wealthier and healthier sectors of society, and there is a low risk cross-subsidisation for lower income groups who have worse health outcomes and lower life expectancy. Moreover,

[50] For more on constitutional trade and economic rights see *Affordable Medicines Trust v Minister of Health* 2006 (3) SA 247 (CC).

[51] See L M Fleck 'Just Health Care Rationing: A Democratic Decisionmaking Approach' (1992) 140 *Univ of Pennsylvania LR* 1597, 1607 where the author states that 'allocation decisions ultimately imply rationing decisions, and that the need for health care rationing is really inescapable.'

[52] Syrett (note 27 above) 27.

private hospitals do not serve a majority of the population, so they do not in all circumstances operate in excess of their capacity for delivery. In a private system, waiting times may be less onerous for some procedures, and as long as a treatment is available and payment is guaranteed, then the service can be utilised.

In contradistinction to rationing in market-centred systems, rationing in public health systems takes place on the basis of 'need'. Syrett explains that the 'need' for health care can be assessed in relation to ill-health, in the sense that immediate threats to life or intense suffering trumps the health care needs of those not in such extreme positions. Alternatively, 'need' can be assessed in relation to benefit. If a person is unlikely to benefit significantly from treatment, then despite ill health or impending death, a health authority will deny access to treatment because other people can derive greater benefit from it.[53] In public health systems, 'need' is assessed from both perspectives.

Many middle to higher income earners may be less able to bypass rationing processes in tax funded public health systems because these people have less disposable income to spend on health insurance and private health care. So, notwithstanding the availability of health care outside the public system, individuals will be less able to exercise their liberty to secure access to *needed* health care in the private system, and may be forced to endure cumbersome waiting lists and excessive rationing of care inherent in public systems. As a result, middle-income earners will likely endure a significant and possibly adverse impact when a move is made toward a universal health system.

Rationing on the basis of need is likely to become a central feature of NHI in its formative stages because of scarcity and capacity constraints. The reasons for this are that under NHI, all legal residents will have the same generic entitlement to benefit from NHI, which is approximately forty million more people than than those who are currently insured by medical schemes or who otherwise access private health facilities. This is the case despite the probability that the NHI Fund will not have at its disposal significantly more funds than the amounts collected by medical schemes and those already existing in the public health sector, nor will newly accredited private health care centres have more capacity.[54] It is

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[53] Ibid 27-8.

[54] See 'Private Sector Capacity and Occupancy Levels' (2008) *Private Hospital Review - Examination of Factors Impacting on Private Hospitals* 39. However, Chris Bateman sites Kurt Worrall-Clare, the CEO of the Hospital Association of South Africa, who apparently stated that 'spare capacity in private hospitals could continue to be used to treat state patients.' See C Bateman 'Private hospitals offer wide-ranging NHI assistance' (2010) 100 *SA Medical J* 794.

therefore unclear whether private hospitals and primary health care centres will have the capacity to cope with the influx of newly insured patients in the formative stages of NHI.

Richard Posner highlights the problem likely to occur as a result of resource and capacity constraints.[55] He argues that when the state pays for health care, as opposed to insurance companies or individuals themselves, the demand for services will increase whilst initially the supply will correspond with the level of demand as it was prior to the implementation of the policy. If the state does not improve the overall capacity of public and private hospitals and other health care centres to deliver quality health care to all those entitled to it under NHI, then hospitals will likely be overcrowded and the reasonable demand for quality health care services may exceed the ability of the state to supply them – at least in the short-term. In response, the state may implement far-reaching rationing policies like waiting lists and more concentrated need-based rationing in an attempt to gain optimal benefit from limited resources.

Moreover, not only may there be an increase in need-based rationing in the private sector, but such rationing may be less transparent. This view is supported by Clara Findlay, the author of the Mediclinic submission on the Green Paper.[56] Findlay criticises the Green Paper for its failure to define which treatments and services will form part of the basic package. Indeed, the Green Paper states that under NHI there will no specific entitlement to an express list of services, and then contrasts this with the current practice of medical schemes to explicitly list the services to which a member is entitled, such as the list to prescribed minimum benefits. In the words of the Green Paper, the comprehensiveness of the basic package 'is defined in terms of individuals having access to primary health care facilities and to specialist hospital care on referral'.[57] Findlay argues that the idea behind an explicit benefit package is that patients ought to know in specific terms what their entitlements are. This is necessary so that patients are better able to protect their rights and ensure accountability within the NHI system.

Without an explicit NHI basic package, administrators can ration the financing and provision of health care without needing to justify such decisions in reference to an objective and predetermined list of defined benefits. In the absence of such a list, it is fair to assume

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[55] R Posner 'Regulatory Aspects of National Health Insurance' (1971) 39 *Univ of Chicago LR* 1-2

[56] C Findlay 'Mediclinic's Submission to the Department of Health in response to the policy paper entitled '*National Health Insurance in South Africa*' (19 December 2011) <http://www.futureofhealthcare.co.za/pdf/Mediclinic%20Submission%20on%20NHI%201.pdf> paras 3.6.1 – 3.6.2.

[57] See Green Paper (note 1 above) para 120.

that methods of rationing and resource allocation under NHI may become unsystematic in the sense that patients will only have an entitlement to a 'lucky packet' of health care services. If a patient is denied access to a specific service, that patient will not be able to point to a specific entitlement to that service, nor will NHI administrators be able to justify the denial in reference to such a list. Perhaps the intention behind the absence of an explicit basic package is to give administrators as much leeway as possible to deny or approve the financing and provision of health care under NHI. In a similar vein, the Green Paper has also failed to explain how waiting lists will be managed, which gives rise to similar concerns.

In the absence of a defined package of services in the Green Paper, it is quite possible that the rationing practices under NHI may be inconsistent with the Constitution. Indeed, in order for rationing to be constitutional, it must be explicit, transparent, and procedurally as well as substantively fair.[58] Without these characteristics, users of the health system might be unable to enforce and enjoy constitutional rights to have access to health care services because there is no clear basis defining the entitlement. The absence of a defined package may also be unreasonable in terms of section 27(2) of the Constitution. Furthermore, rationing under such a system might give rise to unfair discrimination because allocation decisions might not have a rational basis or may be haphazard.[59] Although administrative justice issues are beyond the scope of this thesis, it is necessary to point out that without explicit and procedurally fair rationing guidelines and practises, decisions taken might be inconsistent with the right to just administrative action protected under section 33 of the Constitution, and might also be susceptible to review under the Promotion of Administrative Justice Act 3 of 2000.

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[58] See Daniels (note 27 above) 110-1. Although not from a constitutional law perspective, Norman Daniels lists four conditions that must be satisfied in order for allocation decisions to be fair. These are part of what he calls the 'accountability for reasonableness' model. These conditions are: the publicity condition which requires that the rules upon which these decisions are based are publicly available; secondly he requires that the rules be *relevant* in that they ''provide a reasonable explanation of how the organization seeks to provide 'value for money' in meeting the varied health needs of defined population under reasonable resource constraints'; thirdly, he argues that decisions must be capable of revision and also be subject to an appeal; and lastly that 'There is either voluntary or public regulation of the process to ensure that conditions 1–3 are met.' Arguably without these conditions being satisfied, violations of section 27 are very likely. See also Fleck (note 51 above) 1612 where Fleck argues against the political and moral justifiability of implicit or invisible rationing where there are no formal rules governing allocation decisions but rather doctors are empowered to tell patients as part of an implicit custom that 'nothing more can be done medically' when this is not necessarily the case. Such decision-making cannot be subject to any accountability and might thus be inconsistent with section 33 and 27 of the Constitution. See D Mechanic 'Professional Judgment and the Rationing of Medical Care' (1992) 140 *Univ of Pennsylvania LR* 1713, 1722 where Mechanic defends implicit rationing. For an explanation of the reasons given justifying implicit rationing see Syrett (note 27 above) 55-68.

[59] M Pieterse 'Health Care Rights, Resources and Rationing' (2007) 124 *SALJ* 514, 522-5.

### (b) The diminished role of medical schemes

The fate of medical schemes under NHI is unclear. The Green Paper states that 'it will be up to the general public to continue with voluntary private medical scheme membership if they choose to. Accordingly, medical schemes will continue to exist alongside National Health Insurance'. Despite this, the Green Paper states further 'no South African or legal permanent resident can opt out of contributing to National Health Insurance even if they retain their medical scheme membership'. This statement implies that even if a person cannot afford to be a member of a medical scheme in addition to NHI, that person will not be permitted to opt out of contributing to NHI. Moreover, the Green Paper intimates that the intention of NHI is to reduce the demand for medical schemes by ensuring access to quality medical care under NHI, which would obviate the need for medical scheme membership. The Green Paper says that because of this, 'South Africans will have a real choice… whether to continue medical scheme membership or simply draw on their [NHI] entitlements'. As for the role that medical schemes may play in the future, the Green Paper suggests that they could offer a top-up insurance package.[60]

Despite these statements indicating that medical schemes will have some role to play under NHI, the Green Paper states that the intention of NHI is to 'eliminate the current tiered system'.[61] This statement can have two implications. First, it may imply that the long-term goal of NHI is the creation of a unitary health system with no private sector actors at all. Alternatively, it may be interpreted as describing an end goal where the private sector plays a central role in delivering health care to all South Africans as part of a unitary health system and not as a separate system for wealthier persons. Regardless of which interpretation is the correct one, the reality is that medical schemes will continue to play a central role in the health system in financing health care at least for the foreseeable future. However, the general thrust of the Green Paper is that as time passes, medical schemes will increasingly play a lesser role in the financing of health care.

The fact that medical schemes are likely to play a progressively lesser role under an NHI system may give rise to constitutional rights violations because of a consequential scaling down of access to health care. Even if there are constitutional violations, the

[60] Green Paper (note 1 above) paras 126, 137-9.

[61] Ibid para 50. See Findlay (note 56 above) 9 para 3.4.1. who indicates the uncertainty described above.

likelihood is that these would generally be justified under section 36 of the Constitution. However, in order to explain how these violations may occur, it is necessary to briefly explain the benefits of medical schemes in the current health system.

Medical schemes enable many employed people to access quality health care services in the private sector, often without having to pay for services out-of-pocket, which is beyond the means of most scheme members. Medical schemes do this by charging premiums to their members in exchange for an undertaking of liability to defray health costs for health services covered in terms of individual member's policy.[62] Members' contributions are then placed into a risk pool, to enable the sharing of the financial risk occasioned by members falling ill or being injured. Schemes then use funds from the risk pool to purchase health care from a provider on behalf of their members.[63] This mechanism allows for members to access health care in private hospitals, often totally bypassing the public health system.

Accessing private health care has many benefits. Sometimes, the healthcare required by a patient is not available in the public sector at all.[64] At other times, the appropriate health care may be available in the public sector, but there is a long waiting list and there may also be excessive queues at public hospital consultation points, especially at emergency wards.[65] Also, due to need-based rationing, a patient may not qualify to receive treatment.[66] Private hospitals, on the other hand, tend to offer a wide variety of curative and tertiary health care services with shorter waiting lists. There are also fewer queues at consultation points, including emergency health care wards. Need-based health rationing practised by medical schemes and private hospitals is also not as severe as that practised in the public health system. Since medical schemes make it possible for members to access private hospitals, they enhance their ability to access health care services, which is a constitutionally protected interest under section 27 of the Constitution. Health care services also enhance and protect the physical integrity of human beings; therefore the right to freedom and security of the

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[62] See definition of 'Business of a Medical Scheme' in Section 1 of the Medical Schemes Act 131 of 1998. See also T Matsebula & M Willie 'Private Hospitals' (2007) *SA Health Rev* 159, 166.

[63] See definitions of 'pooling', 'health insurance' and 'purchasing' in *Glossary of Healthcare Financing Terms* in Innovative Medicines of South Africa (note 33 above) 5.

[64] *Law Society of South Africa v Minister for Transport* 2011 (1) SA 400 (CC) paras 87-101.

[65] For a case in point see unpublished dissertation of TC Cimona-Malua 'Waiting time of patients who present at Emergency department of Saint Rita's hospital, Limpopo Province, South Africa' (2010) University of Limpopo <http://ul.netd.ac.za/bitstream/10386/539/1/Part-2-Dissertation-Dr%20Cimona-Final.pdf>.

[66] As occurred in *Soobramoney v Minister of Health* 1998 (1) SA 765 (CC).

person may also be implicated if the NHI system does not allow for the reasonable financing and provision of medical care in the face of a deteriorating medical schemes environment.

Medical schemes are likely to suffer setbacks under NHI because the demand for scheme membership will drop. Many people who currently subscribe to medical scheme options will no longer be able to do so because of the increased taxes to fund NHI. Persons in this category will not be able to afford to purchase two health insurance products. Others may decide that they no longer need medical aid because of the benefits to which they are entitled under NHI. Although the latter case is a preferable scenario to the former, the lessening demand for medical scheme membership will make risk pools weaker, resulting in less cross-subsidisation between members of medical schemes. This may result in medical schemes being increasingly unable to finance a broad range of quality health care. This is acceptable provided that the NHI system fills the void with a substantial range of health care services that are easy to access. To the extent that NHI does not fill this void, the positive and negative aspects of the health right in section 27 will be limited, as well as the right to freedom and security under section 12 of the Constitution.

**(c) Redistribution of private hospital resources**

In this section, I consider how redistribution of private hospital resources may adversely affect access for current users of that system. This may occur under NHI as a consequence of more people having access to private health care. It will likely manifest itself in the scaling down of access to care by way of increased rationing and longer waiting lists. The problem with this is that sometimes adequate health care is only available in the private sector. For example, in *Law Society v Minister for Transport*, it was apparent that private hospitals were the only hospitals capable of providing adequate services to paraplegic and quadriplegic persons whose injuries were caused by vehicle collisions. As a result, the Constitutional Court declared regulations inconsistent with the Constitution because the Road Accident Fund was only required to pay for treatment for these persons on a public hospital scale.[67] Under an NHI system, the private hospital sector must still have the resources and capacity to offer these services to paraplegics and quadriplegics if public hospitals remain unable to do so. There may be other services in the list of prescribed minimum benefits that must be

[67] *Law Society* (note 64 above) paras 87-101, 108d-e.

sufficiently accessible under NHI.[68] In what follows, I explain the logic of integrating private hospitals into the NHI system. I also explain how accessibility to private hospital services might be scaled down for current users of that system. In doing so, I emphasise the importance of private hospitals being able to provide essential services, such as those to paraplegics and quadriplegics, despite operating under tighter resources constraints.

The private sector will play an essential role under NHI. This must be so because most human and technological health care resources are located in the private hospital sector.[69] Conversely, public hospitals are strained with significant patient loads, more intensive need-based rationing, queues and other difficulties.[70] Accrediting private hospitals with delivering health care services within the NHI basic package will spread the demand for health care away from the public system and further integrate private hospitals into a unitary national health system.[71]

However, the integration of the private sector into the unitary health system means that consumers of private health care may not enjoy the same levels of access that they currently enjoy. Due to the increase in the number of people entitled to access accredited private health care services under NHI, the private sector together with NHI administrators will have to develop rationing mechanisms to effectively manage patient load in a way that is presently not required of private hospitals. At the moment, private hospitals manage patient load through price-based rationing otherwise described as the fee-for-service criterion, which serves to exclude persons from accessing services if they cannot afford it.

Since, under NHI, there will not be rationing on the basis of ability to pay, private hospitals will have to ration health care in other ways. Private hospitals are likely to use rationing by selection, rationing by denial, waiting lists and queues in order to achieve this end. By definition, these rationing strategies either prevent access to beneficial health care

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[68] The list of prescribed minimum benefits is provided for in Regulations to the Medical Schemes Act 131 of 1998 GNR.1262 (20 October 1999) as amended at Annexure A ('prescribed minimum benefits').

[69] See H Wadee & F Khan 'Human Resources for Health' (2007) *SA Health Review* 141, 143-4. See also S Plaks & MBJ Butler 'Access to Healthcare in South Africa' (2012) *SA Actuarial J* 129, 137-8. See also *Public Inquiry: Access to Health Care Services (by the South African Human Rights Commission)* (15 April 2009) 35-8 ('SAHRC Report').

[70] See SAHRC Report ibid 42-3.

[71] Private hospitals will have an incentive to be accredited to provide services covered by NHI for at least two reasons: First, medical schemes will no longer be the primary financing mechanism for health care because there will be a lesser demand for membership. As a consequence, private hospitals will no longer receive as much funding for patient services from medical schemes. Secondly, the NHI will be the largest health financing authority in South Africa. Therefore owing to the light of the lesser role to be played by medical schemes, private hospital groups would want to contract with NHI in order to receive funding for available services.

services outright in order to preserve resources or otherwise delay access to reduce and manage demand.[72] Waiting lists and need-based rationing are not by themselves inconsistent with the Constitution.[73] However, when some types of curative life-saving health care, and treatment designed to prevent suffering are no longer easily accessible, constitutional interests protected under the right to freedom and security of the person and the negative aspect of the health right become engaged and may even be unjustifiably limited in some cases.

The introduction of NHI may also reduce the types of services that are currently available in the private sector. Under current arrangements, private hospital groups negotiate the costs of health care services with medical schemes. This ensures that services provided to scheme members are paid for as part of the package of benefits in terms of a particular policy. In this way, the supply of services in the private sector is directly attributable to the demand for a particular service, and there is a guarantee that there will be payment for that service.

It is possible that the basic benefit package provided by NHI will not consist of the same entitlements currently afforded to members of medical schemes.[74] There is no *express* indication in the Green Paper that the basic package of services to be financed by NHI will cover at least the prescribed minimum benefits available as part of all medical scheme options. Although the Green Paper states that the basic package will be comprehensive, it nevertheless fails to give specific detail as to its meaning. What the Green Paper does do is criticise the private sector for its focus on curative health care. This implies that the basic package of services under NHI, if it is defined at all, will not consist of some forms of tertiary and curative health care currently financed by medical schemes and offered in private hospitals. Owing to the probability that the demand for medical scheme coverage will drop, it is unclear whether medical schemes in the NHI system will offer coverage for all services not covered by NHI or other services subjected to intense need-based rationing. Consequently, if

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[72] See Syrett (note 27 above) 45-7 who defines price rationing as 'restricting medical services to those with the ability to pay for them". He defines rationing by denial as consisting of a 'decision not to provide a particular beneficial treatment either to an individual… or a group of patients with common disease patters.' Rationing by selection 'amounts to an outright exclusion of access to a particular treatment, but in this instance the decision to exclude rests not upon the nature of the treatment which is demanded, but rather on the characteristics of the potential beneficiaries.' See also his commentary on waiting lists as a form of rationing at page 47.

[73] See *Soobramoney v Minister of Health* (note 66 above).

[74] See J Broomberg 'Bring the NHI Debate into the Public Domain' (2 June 2009) *SA Health News Service* <http://www.health-e.org.za/news/article.php?uid=20032322>.

there is no guarantee of payment for particular services by either the NHI or medical schemes, it is likely that hospitals will no longer be able to offer the service at all.

Accessibility in private hospitals will probably be scaled down under an NHI system. This is not necessarily inconsistent with the Constitution. However, this may not always be the case. If under a future NHI system, private hospitals become unable to offer essential services, say for example to quadriplegics and paraplegics, then NHI might be inconsistent with the right to have access to health care services. It is difficult to predict what services, if any, might become inaccessible, but the possibility cannot be discounted as private hospitals will have lesser excess capacity than is currently the case.

**(d) The focus on primary health care**

One of the ways in which the government intends to deal with problems of under-capacity is by introducing an NHI with an emphasis on primary care. This is clear from the Green Paper where the Department of Health criticises the private sector for what it calls 'hospital centrism' and its focus on curative care. The Green Paper also states that one of the central characteristics of NHI will be 'the provision of a comprehensive package of care underpinned by a re-engineered primary health care'. The primary health care approach is confirmed in more detail later on in the Green Paper, where it is stated that NHI will focus on primary health care in the form of 'health promotion [and] preventative care', but still offer 'quality curative and rehabilitative services…' It states further that 'All members of the population will be entitled to a defined comprehensive package of health care services at all levels of care namely: primary, secondary, tertiary and quaternary with guaranteed continuity of healthcare benefits'.[75]

The primary health care approach is likely to draw criticism from the private sector and middle-income groups.[76] Despite the statement that NHI will cover a 'comprehensive' package of health care services, implying that many forms of curative and tertiary services will be included in the basic package, the likelihood is that services classified as secondary, tertiary or quaternary will be subjected to more significant need-based rationing. NHI

[75] Green Paper (note 1 above) paras 6,11-2, 66, 69.

[76] Findlay (note 56 above) para 2.4.

administrators will require a greater threshold of need and likelihood of benefit before authorising the provision of such a service.[77]

The primary health care approach as articulated in the Green Paper undercuts a central purpose of NHI, which is to reduce demand for medical scheme membership by providing benefits of sufficient 'range' and 'quality'.[78] In this sense, the benefits to be obtained from medical scheme membership will be outweighed by the benefits of NHI. However, Alex van den Heever points out that this reasoning is fallacious. People value medical scheme membership because it guarantees timely access to quality health care services for 'major and catastrophic health events' and not so much for facilitating access to primary care.[79] Similarly, membership enables members to access expensive tertiary, curative and rehabilitative health care that is not readily accessible in the public sector.

Consider treatment for chronic renal disease.[80] In the unfortunate circumstance that a person requires renal dialysis but does not qualify for a renal dialysis programme at a public hospital, such a person will still have access to dialysis in a private hospital where the criteria for admission are not as restrictive. Renal dialysis is not a primary health care service, and neither are bypass surgery or operations to remove tumours. If these services and others like them were not sufficiently accessible at a time of need under the NHI system, then people will want to retain their medical scheme membership if at all possible.

In this section, I have explained several ways in which the introduction of NHI *may* cause a scaling down of accessibility to health care for middle-income South Africans. Whether NHI policy will pass constitutional muster if challenged will ultimately depend on two overall criteria: First, the impact of adverse effects caused by the introduction of NHI must not be so disproportionate and severe that a violation of constitutional rights would not be justifiable under section 36 of the Constitution. Secondly, NHI must be reasonably capable of progressively realising access to health care services for all South Africans, especially previously disadvantaged persons. At times, these two goals may conflict with one

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[77] Even if the basic package of health care services under NHI comprises of expressly stated health service benefits, these may not be made available in many cases when they may be clinically beneficial. As a result of this, persons who can no longer afford medical scheme membership may have difficulty accessing curative health care services in the NHI system. Given that government policy does not favour the adoption of an express basic package of benefits, there is a risk that rationing will be undertaken on an ad-hoc basis allowing for NHI administrators to deny authorisation of curative health care interventions because there is no clear expectation that these benefits will be provided.

[78] Green Paper (note 1 above) para 126.

[79] A van den Heever *Evaluation of the Green Paper on National Health Insurance* (20 December 2011) <http://hsf.org.za/siteworkspace/gp-review-alexvdh-dec2011-vf-1.pdf> 97.

[80] See prescribed minimum benefits (note 68 above) at chronic conditions.

another especially when redistributing resources to achieve equity goals. In the following section, I evaluate whether the adverse effects considered in relation to middle-income groups are likely to infringe constitutional rights, and whether these infringements would be justifiable under section 36.

## V. SUMMARY OF THE FINDINGS OF THIS THESIS PERTAINING TO RIGHTS VIOLATIONS CAUSED BY THE LEVELLING DOWN OF ACCESS TO CARE

The first stage of the constitutional paradigm developed in this thesis is that the state bears a positive duty to progressively realise access to health care services under section 27 of the Constitution, and to enhance the achievement of equality through redistributive measures required by section 9(2). NHI is the vehicle the state has chosen to fulfil this duty. The second stage of the paradigm is that adverse effects on previously advantaged groups caused by redistributive measures cannot for that reason alone unjustifiably infringe the constitutional rights of these persons.[81] If this were the case, then almost every redistributive measure would fall foul of the Constitution and render it impossible for the state to devise and implement such measures.[82] Redistributive policies, such as NHI, are essential for achieving equality. The third stage of the paradigm is that the permissibility of adverse effects on previously advantaged groups and other less vulnerable persons is not absolute. Sometimes, adverse effects will violate constitutional rights and sometimes they will not. In cases where rights violations stem from a law of general application, they may be justified if they are reasonable and justifiable in an open and democratic society based on dignity, equality and freedom as provided for by section 36 of the Constitution. In the remainder of this chapter, I show which constitutional rights and obligations may be implicated by the levelling down of access to health care services, and when these violations might be justifiably limited under the limitations clause.

### (a) Section 9(2)

I argued in chapter 3 that the redistribution of socio-economic resources in the public interest is a central theme of section 9(2) of the Constitution. This section requires the state to

[81] *Bato Star Fishing* (note 2 above) para 76.

[82] See *Ferreira v Levin* 1996 (1) SA 984 (CC) para 180.

implement measures that enhance the achievement of equality for previously disadvantaged persons. A measure will fit in the confines of section 9(2) if it is designed to enhance the position of disadvantaged persons and is reasonably capable of doing so, and also does not undermine the achievement of equality in the long term.[83] If this is the case then a redistributive measure that specifically targets members of previously disadvantaged communities will be presumptively fair. Furthermore, the adverse effects that such measures may hold for privileged South Africans and others in a position of relative advantage will not, for the most part, constitute unfair discrimination, as long as the above requirements are met.

In Chapter 3 Part III, I explained the requirements for a measure to be consistent with section 9(2). NHI complies with these requirements. Nevertheless, this is not axiomatic in cases where NHI is likely to lead to the scenario I described in chapter 2 as 'equality of the graveyard'.[84] Section 9(2) states in this regard 'equality includes the full and equal enjoyment of all rights and freedoms'. In other words, the enhancement of equality is not valuable for its own sake but rather because it promotes the enjoyment of other rights as well, including health rights. When a redistributive measure like NHI adversely impacts on the interests of less vulnerable members of society by equalising access to inferior care, then the measure would not fall within the confines of section 9(2) of the Constitution. Such a situation could conceivably result from any of the elements of NHI discussed in this chapter.

Similarly, if NHI is not reasonably capable of ameliorating the barriers of access to care for previously disadvantaged South Africans because it is 'arbitrary, capricious or display[s] naked preference' then it would not fall within section 9(2). In such a situation, NHI would be denigrating its stated purpose of enhancing the achievement of equality for disadvantaged groups. Failure to achieve this purpose would not only put NHI outside the ambit of section 9(2) and negate the presumption of fairness, but it would also not excuse any adverse effects caused on previously advantaged groups and others who are in less vulnerable positions. These adverse effects can only be justified if NHI is 'reasonably capable' of enhancing access to health care services for disadvantaged groups. In other words, in order to bypass a constitutional challenge alleging unfair discrimination against a specific group like medical scheme beneficiaries, it will be necessary to show that NHI is likely to be of benefit to the poor and previously disadvantaged. If NHI does not pass this hurdle, then any scaling

[83] *Minister of Finance v Van Heerden* 2004 (6) SA 121 (CC) paras 38-44.

[84] See Chapter 2 footnote 6 for references to the wording and concept of 'equality of the graveyard'.

down of access to health care services will likely not pass constitutional muster under section 9 of the Constitution.[85]

The third aspect of the *Van Heerden* test is that in order to be afforded the protection under section 9(2), a measure must promote the achievement of equality. This means that despite the permissibility of adverse effects caused to previously advantaged groups and others, these effects cannot be so severe as to undermine the long-term achievement of equality. As explained by Moseneke J in *Van Heerden*, a measure cannot constitute an 'abuse of power or impose such substantial and undue harm on those excluded from its benefits.' NHI is unlikely to fall foul of this test because advantaged persons are also entitled to receive equal benefits under NHI. Nevertheless, it can be argued that if middle-income persons cannot access reasonable health care because taxation is too high or the services offered by NHI are inadequate, then it becomes more likely that NHI will fall foul of the equality clause. Similarly, if NHI is implemented haphazardly and arbitrarily and is characterised by disorganisation and maladministration, then it may constitute an 'abuse of power' causing 'substantial and undue harm' to those who, because of the increased burdens that it imposes, cannot access quality health care services.[86]

If a measure does not fit within the confines of section 9(2) as described above, then it must pass constitutional muster under sections 9(3) of the Constitution. When considering the fairness of a measure that discriminates between groups of persons it is necessary to consider the impact of the discriminatory measure within the claimant group's social context. Persons alleging unfair discrimination on the basis of differential tax burdens or adverse effects on private sector beneficiaries are generally not from previously disadvantaged backgrounds and are not from vulnerable sectors of society. However this is not dispositive of the question of unfairness. In *Harksen*, Goldstone J stated that a court must also consider 'the extent to which the discrimination has affected the rights or interests of complainants and whether it has led to an impairment of their fundamental human dignity or constitutes an impairment of a comparably serious nature'.[87] Therefore, when considering the constitutionality of adverse effects of NHI, regard must be given to the extent of the impact affecting such groups.

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[85] See *Van Heerden* (note 83 above) paras 41, 149. At para 149 Sachs J stated 'Thus, a measure taken for improper or corrupt motives would not pass muster under either section, even if done under the guise of advancing the disadvantaged. Similarly, a scheme that was so lacking in thought and organisation as seriously to threaten the very functioning and survival of the enterprise involved, would lack rationality, and could not be said to advance or be fair to anybody, let alone the disadvantaged.'

[86] Ibid para 44.

[87] *Harksen v Lane* 1991 (1) SA 300 (CC) para 51.

It is important to assess the nature of the impact of a measure against a group alleging unfair discrimination.[88] Often, only mere inconvenience is suffered when the provision of a particular health care service is denied to a patient or group of patients or there is a waiting list. Nevertheless this is not always the case. Sometimes, not having access to particular treatments can result in death, or physical or psychological suffering. For extremely wealthy people, neither an increase in taxes nor a scaling down of access to care will materially affect their ability to access quality health care. However, NHI might unfairly discriminate against those who earn lower incomes and currently subscribe to medical schemes, *if* the services offered under the programme are of inferior quality, and because of the burdens imposed by NHI, such persons will not be in a position to access adequate health care outside the NHI system.

Nevertheless, it is a far jump to argue that the scaling down of access to care denigrates the fundamental dignity of a human being unless it is *arbitrarily* based on a listed ground such as age or an analogous ground such as health status, as I considered in chapter 3. This will occur if NHI policy evinces a stance that the infirm, elderly or the sick are less deserving of health care because their lives are worth less, then this will undermine their basic human dignity.

**(b) Negative right of access to health care services under section 27**

Having regard to what I have argued in chapter 4, negative violations of the right to have access to health care services occur in three types of cases in the context of the scaling down objection. First, a violation can occur when the number of people who have access to particular health services is scaled down or their entitlement to a service is abrogated. This is in violation of the 'everyone' aspect of section 27(1). Second, the negative aspect of the health right is violated in cases where people are prevented from accessing health care services or where their ability to do so is impaired. For example, an increase in taxes, the lesser role played by medical schemes, or the focus on primary health care under NHI, may make it more difficult for middle income earners to access particular services that are not reasonably accessible under NHI. This may violate the accessibility aspect of section 27(1). Third, implicit in the Constitutional Court's jurisprudence is an all-encompassing interpretation of 'health care services' in section 27(1), which includes all clinically

[88] See *Khosa* (note 25 above) paras 76-8.

beneficial health care services. If particular services become unavailable to a segment of the population under NHI who previously had access to such services, then there is a limitation of section 27(1). These are all plausible scenarios that may occur under NHI, and which may violate the negative aspect of the health right. This is not to say that such negative violations cannot be justified under the limitations clause.

### (c) The prohibition against retrogression

I explained in chapter 4 that the Constitutional Court in *Grootboom* has interpreted the notion of progressive realisation as an obligation on the state to increase the amount of persons having access to health care services over a period of time.[89] I argued that despite this, it is not inconsistent with the Constitutional Court's jurisprudence to interpret the notion of progressive realisation as also requiring an increase of the level of access and the range of treatments available over time. If interpreted such, then the idea of retrogression implies that the prohibition is transgressed by the state when the number of people who have access to a particular treatment diminishes, when access becomes more difficult, or when the level of available care decreases.[90] However, whether the prohibition is transgressed depends on whether one interprets progressive realisation as applying to the population as a whole, or to individuals and groups.[91] If the former interpretation is adopted, then the levelling down of access to health care for some individuals and groups would be retrogressive despite the gain to the population as a whole. But if the latter interpretation is adopted, then a measure would still constitute progressive realisation if it advantaged the population in general but adversely affected certain groups and individuals.

It may be argued that if NHI only has the effect of scaling down access to care without significantly benefitting the population as a whole, then regardless of the interpretation adopted, NHI would constitute a retrogressive step because the level of accessibility of the population has on aggregate decreased. In other words, an 'equality of the graveyard' scenario is retrogressive according to any interpretation. However, difficulties arise in cases where the level of accessibility is diminished for some sectors but there is an overall gain in

[89] See *Grootboom* (note 28 above) para 45. See Chapter 4 Part IV(c).

[90] These are consistent with the academic approaches mentioned in Chapter 4 Part IV(c).

[91] Liebenberg *Socio Economic Rights Adjudication under a Transformative Constitution* (2010) 189.

access by the general population.[92] Measures that diminish access for some people but promote access for the general population should not be adjudged as retrogressive unless the scaling down has a significant impact on those adversely affected that any gains to the overall population would not justify such a measure. If NHI has this effect in some way, then one may argue that it would be unreasonable for failing to be balanced and flexible. If NHI causes a retrogressive effect on an individual or group basis, then it is more likely that these would violate the negative right not to impair or prevent existing access to health care services, which could then be justified under section 36 of the Constitution.

**(d) The right to freedom and security of the person and the right to bodily and psychological integrity**

I explained in chapter 3 that section 12 protects freedom and security interests, bodily and psychological integrity, and residual freedom interests. All these categories of interests can include health related interests. However, section 12 is unlikely to be violated by NHI for two main reasons. First, there is a specific health care right in section 27 that protects health related interests. One cannot, without good reason, side-step section 27 and rely on section 12 to buttress a constitutional claim for access to health care services.[93] If this were possible then section 12 would be susceptible to abuse by wealthier segments of society to augment health claims protecting individualist interests. This would undercut the redistributive purpose of section 27. Furthermore, it would also undermine the positive conception of freedom of the general population.

Secondly, only *substantial* violations of section 12 interests will attract constitutional scrutiny. Whether a matter is a substantial violation of freedom and security interests or phyiscal and psycholgical integrity is essentially a matter of degree. If access to health care is diminished for current users of the private system to an extreme degree without adequate services being accessible in the NHI system, then a violation under section 12 may arise. This may occur as a result of the redistribution of private hospital resources or the diminished role of medical schemes under the NHI system. Moreover, some services are so vital in South Africa's constitutional democracy that any scaling down might be constitutionally objectionable. Examples are: HIV/AIDS treatment and medication, and abortion and

[92] Liebenberg ibid.

[93] See *Soobramoney* (note 66 above) para 19.

reproductive services. The latter are protected under section 12(2)(a) and (b) of the Constitution. However, a greater degree of need-based rationing is unlikely to be 'sufficiently' substantial to buttress a claim under section 12.

### (e) Limitations clause

In chapter 4, I considered the importance of section 36 of the Constitution in relation to negative breaches of the health right. This clause provides that rights may be limited by a law of general application as long as the limitation is 'reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom'. All relevant factors must be considered, including a list of factors assessing whether the limitation is proportional in relation to its intended purpose. The levelling down of access to health care services may, in some cases, breach the negative aspect of the right to have access to health care services. If a court finds that a breach has occurred, then the court must consider whether the violation is justifiable in terms of section 36.

Negative limitations of the health right will likely be justifiable under section 36 if the scaling down of access to care under NHI is directed at achieiving equitable access to care for all people, especially the poor and disadvantaged, and must also be capable of doing so. If, however, the scaling down of access is directed at a purpose inconsistent with values underlying the Constitution or cannot contribute in any meaningul way to the objective of progressive realisation, then the negative rights violation will not be justifiable under section 36. Moreover, the negative impact of the limitation on those adversely affected by it must be proportional in relation to its intended purpose of increasing access of the general population.

Sometimes, the impact of a negative rights violation will be so severe that it cannot be justified by its purpose of enhacing access to health care services. In the latter instance, the private sector might be better able to give life-saving health care for certain categories of people than the public sector, such as treatment for paraplegics and quadriplegics. If the private sector becomes unable to offer these services and the public sector fails to improve its ability to do so, then the scaling down of access to care might not pass the limitations test under section 36. Similarly, the Green Paper does not indicate expressly whether the prescribed minimum benefits currently offered to all medical scheme members will be made accessible to all persons under NHI. The Green Paper does indicate that NHI will offer 'a defined package of health services, at all levels of care namely: primary, secondary, tertiary and quarternary with guaranteed continuity of health benefits.' Yet, the Green Paper states

later on that the package of benefits under NHI will be based on a 'public sector framework' and as such the benefits will not be expressly listed.[94] This gives rise to the concern that even the prescribed minimum benefits might not be accessible as an immediately enforceable entitlement under NHI in the same way that medical scheme members currently access these benefits in the private sector. If this occurs, this may violate the negative content of the health care right in an unjustifiable manner because of the importance of these services to the health of a patient.[95]

## VI. SCOPE FOR FURTHER RESEARCH AND CONCLUSION

In this thesis, I have constructed a constitutional law paradigm for balancing constitutional health rights and interests of the poor with those of private sector beneficiaries in the context of NHI. The paradigm proceeds on the basis that the state has a positive constitutional obligation to progressively realise access to health care services within its available resources as required by section 27(2) read with section 7(2) and section 27(1)(a) of the Constitution. Due to the inequity of the divide between private and public health sectors, the implementation of redistributive policies is required, of which NHI is one such measure, to bridge the divide between the two sectors. The purpose of NHI is to integrate existing mechanisms for funding and providing health care, so that a unitary health system emerges. It is hoped that a unified health system will be more equitable than the current two-tier system of private and public sectors. This policy is consistent with the constitutional values and rights of equality, freedom, and the positive dimension of the right to have access to health care services.

Redistributive measures in the health care industry such as NHI may have adverse effects on high income groups. These will not in themselves be inconsistent with the Constitution unless the impact of a negative limitation of the right to have access to health care services is disproportional in relation to its intended purpose of enhancing access to health care. In all circumstances, care must be taken to contextualise the limitation of a constitutional interest within the values espoused by the Constitution, which includes the achievement of equality.

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[94] Green Paper (note 1 above) paras 69 and 120.

[95] note 68 above.

In this thesis, I did not consider the constitutional value of dignity because the purpose of chapters two and three of this thesis was to contrast equality and freedom from a jurisprudential and constitutional perspective. Nevertheless, dignity does have individualist connotations that might inhibit the redistribution of health resources.[96] Any conception of dignity must be interpreted as allowing for a proper balancing of interests between differently situated individuals and groups. More research should be conducted to determine the precise nature of dignity as a value and as a right, in the context of the tensions implicated by redistribution of health resources in South Africa. Any interpretation of dignity must avoid extreme interpretations of individual liberty that might hinder redistribution.

Moreover, there are other constitutional rights implicated by a possible future NHI policy. One of those is the right to lawful, reasonable and procedurally fair administrative action as provided for in section 33 of the Constitution and codified in the Promotion of Administrative Justice Act. Sometimes, decisions that will be made by NHI administrators will amount to administrative action and at other times not. In any event, all decisions made by NHI administrators must conform to the principle of legality and must be transparent so that the NHI system is accountable to those it serves. However, without framework legislation and regulations governing the implementation and management of NHI, it is too early to determine the infuence of administrative law rights and obligations on the functioning of the NHI. However, it is clear that there must be a dispute resolution mechanism, similar to the Council for Medical Schemes, where disputes between patients and the NHI can be adjudicated. Research must be conducted on how this dispute resolution body will best fulfil the state's administrative law obligations to the beneficiaries of NHI.

I have not dealt with the horizontal dimensions of the right to have access to health care services. The horizontal apsect of the health right regulates the relationship between natural and judicial persons. This is important because accredited private health care institutions will provide health care services under NHI. This means that private institutions will essentially be contracted to fulfil the state's constitutional obligations. In *Eldridge v Attorney General of British Columbia*, the Supreme Court of Canada held that it is constitutionally impermissible for the government to escape liability merely by contracting

[96] See S Cowen 'Can 'Dignity' Guide South Africa's Equality Jurisprudence' (2001) 17 *SAJHR* 34, 42-5; C Albertyn & B Goldblatt 'Facing the Challenge of Transformation: Difficulties in the Development of an Indigenous Jurisprudence of Equality' (1998) 14 *SAJHR* 248, 250-4. For a description of various interpretations of dignity in American constitutional law see N Rao 'Three Concepts of Dignity in Constitutional Law' (2011) 86 *Notre Dame LR* 183.

others to fulfil its obligations.[97] In South Africa, constitutional rights, including socio-economic rights, are capable of horizontal application in terms of section 8(2) of the Constitution. Research has also been conducted on the horizontal application of the right to have access to health care services, where it has been argued that the obligations under section 27(1)(a) should be capable of attaching to private entities.[98] However, there is insufficient research on the nature of the state's constitutional liability where private instutions are contracted by the state to provide access to health care services. There is a tripartite relationship between the patient, the private provider, and the state. This differentiates it from pure forms of horizontal and vertical relationships where there is little legal accountability and responsibility between the state and the private provider. This could give users of the NHI system greater leverage in holding NHI institutions accountable to them.

A further right relevant to the introduction of NHI is the 'right of every citizen to choose their trade, occupation and profession freely' as provided for in section 22 of the Constitution. This section also states that '[t]he practice of a trade, occupation or profession may be regulated by law'. The meaning of this section was considered by the Constitutional Court in *Affordable Medicines Trust v Minister of Health*. There, the Court held that this section allowed a person to practice a chosen profession. However, the practice of the vocation may be regulated by the state to protect the public.[99] Although a judicial person, such as a medical scheme, is not a 'citizen' and so is not a subject of this right, shareholders, administrators, trustees, and employees do have a right to run a medical aid scheme. Similarly, people who choose to become doctors and who pass the requisite university courses are entitled to practice their chosen profession. However, the exercise of these rights can be regulated by law. In order to protect the integrity of the NHI system, the state might enact laws restricting the role medical schemes might play in the health system. Similarly, the state might enact laws that regulate the geographical distribution of doctors through mechanisms such as the certificate of need.[100]

The implementation of redistributive measures that bridge the divide between the public and private sectors is necessary for the state to fulfil its constitutional obligation to

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[97] *Eldridge v B.C. (A.G.)* [1997] 3 S.C.R. 624 para 42.

[98] M Pieterse 'Indirect Horizontal Application of the Right to have Access to Health Care Services' (2007) 23 *SAJHR* 157, 163.

[99] *Affordable Medicines Trust* (note 50 above) paras 57-63.

[100] NHA sections 36-40.

progressively realise access to health care services. NHI is aimed at achieving this objective. Nevertheless, the constitutionality of NHI will be tested in relation to its effectiveness in enhancing access to health care services for *all* residents of South Africa, especially the poor and disadvantaged. For NHI to be effective, the government must improve the capacity of the health system to cope with an increasing demand for quality health care services by all sectors of society. Merely equalising inadequate access or maintaining the current inequalities inherent in the divide between the public and private sectors will not be consistent with the Constitution.

# ANNEXURE A

# TEXT OF RELEVANT PROVISIONS IN THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996

## *SECTION 7 OF THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996*

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

(2) The state must respect, protect, promote and fulfil the rights in the Bill of Rights.

(3) The rights in the Bill of Rights are subject to the limitations contained or referred to in section 36, or elsewhere in the Bill.

## *SECTION 9 OF THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996*

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

(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.

***SECTION 11 OF THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996***

Everyone has the right to life.

***SECTION 12 OF THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996***

12 (1) Everyone has the right to freedom and security of the person, which includes the right—

(*a*) not to be deprived of freedom arbitrarily or without just cause;

(*b*) not to be detained without trial;

(*c*) to be free from all forms of violence from either public or private sources;

(*d*) not to be tortured in any way; and

(*e*) not to be treated or punished in a cruel, inhuman or degrading way.

(2) Everyone has the right to bodily and psychological integrity, which includes the right—

(*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.

***SECTION 27 OF THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996***

(1) Everyone has the right to have access to—

(*a*) health care services, including reproductive health care;

(*b*) sufficient food and water; and

(*c*) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

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

(3) No one may be refused emergency medical treatment.

***SECTION 36 OF THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996***

(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.

# ANNEXURE B

## PROVISIONS OF CANADIAN LEGISLATION SURVEYED IN CHAPTER 2

### *Text of section 15 of the Health Insurance Act, R.S.Q., c. A-29*

No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is furnished or under which all or part of the cost of such a service is paid to a resident or a deemed resident of Québec or to another person on his behalf.

### *Text of section 11 of the Hospital Insurance Act, R.S.Q., c. A-28*

1) No one shall make or renew, or make a payment under a contract under which
(*a*) a resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services;
(*b*) payment is conditional upon the hospitalization of a resident; or
(*c*) payment is dependent upon the length of time the resident is a patient in a facility maintained by an institution contemplated in section 2.

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