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INDIRECT HORIZONTAL APPLICATION OF THE RIGHT TO HAVE ACCESS TO HEALTH CARE SERVICES

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ABSTRACT

Apart from their direct application against the state, the justiciability of socio-economic rights also requires the transformation of those aspects of private law that regulate relationships which are crucial for their effective enjoyment. This is acknowledged by the Constitution of the Republic of South Africa, 1996, which determines that rights may sometimes bind private parties and requires courts to develop the common law in accordance with the spirit, purport and objects of the rights in the Bill of Rights. Common-law development is a viable remedial paradigm for the horizontal enforcement of socio-economic rights. This is particularly because the value-based development of common law in the course of private-law litigation is often regarded as an uncontroversial aspect of the judicial function, even in legal cultures to which the notion of rights-based judicial review is novel or alien. To illustrate the necessity of infusing the private law realm with public law values associated with the protection of socio-economic rights, the article considers the effect of the constitutional right of access to health care services, on the body of South African private law pertaining to the regulation of the doctor-patient relationship. After making a case for the seepage of public law norms into the private-law regulation of this relationship, the article points to certain features of such regulation that appear in need of reconceptualisation in light of relevant constitutional guarantees. It then suggests certain modifications to the existing legal position and critically discusses case law in which similar developments have been contemplated.

I INTRODUCTION

Conventional, liberal human rights discourse has often assumed that rights are not fit for application against non-state actors. Much has been made of the 'public law' character of rights, which were initially designed to curb excesses of public power, rather than to regulate 'private' commercial or interpersonal relationships. Over time, however, the distinction between the public and private spheres as respectively being appropriate and inappropriate venues for the application of human rights norms has been unmasked as artificial, counterproductive and oppressive, especially in a lived reality where

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much harm is suffered by vulnerable members of society at the hands of powerful private entities.[1]

Along similar lines, conventional liberal human rights discourse's opposition to the notion of justiciable socio-economic rights has, in recent years, been significantly deflated. Arguments that socio-economic rights are conceptually ill-suited for judicial review and that courts are politically poorly positioned and institutionally ill-equipped to decide matters of social and economic justice are increasingly regarded as overstated,[2] while the lived reality of poverty and material deprivation refutes the notion that respect for and affirmation of inherent human dignity is achievable through the protection of civil liberties alone.[3]

But, notwithstanding increasing acceptance that, first, judicial enforcement of socio-economic rights is both possible and necessary and that, secondly, human rights should sometimes infiltrate the private sphere, suggestions that socio-economic rights should be capable of 'private' enforcement are typically met with skepticism or outright dismissal. In addition to ideological and political objections to the idea that private parties should sometimes be bound to socio-economic rights, it is often argued that such 'horizontal application' of socio-economic rights would impose overly onerous duties on private parties. Given further that the recognition and enforcement of socio-economic rights is typically associated with a particular, social-democratic, view of the state, it is readily assumed that they should bind only the state.[4]

On the other hand, there is nothing inherent in socio-economic rights that render them incapable of horizontal application. This is clearly illustrated by the everyday enforcement of a great many socio-economic

1 On the 'traditional' assumptions against the application of public law norms in the private sphere and their flaws, see, for instance, H Cheadle 'Application' in MH Cheadle et al (eds) *South African Constitutional Law: The Bill of Rights* (2002) 19, 22; H Cheadle & D Davis 'The Application of the 1996 Constitution in the Private Sphere' (1997) 13 *SAJHR* 44, 45-51; DM Chirwa 'The Horizontal Application of Constitutional Rights in a Comparative Perspective' (2006) 10 *Law, Democracy & Development* 21-48; A Cockrell 'Private Law and the Bill of Rights: A Threshold Issue of ''Horizontality''' in *Butterworths Bill of Rights Compendium* (RS13 Oct 2003) ch3A at 3-5; J van der Walt 'Blixen's Difference: Horizontal Application of Fundamental Rights and the Resistance to Neo-colonialism' (2003) *TSAR* 311-31; 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 the Final Constitutions' (1996) 12 *SAJHR* 361, 399-401.

2 See discussion in M Pieterse 'Coming to Terms with Judicial Enforcement of Socio-economic Rights' (2004) 20 *SAJHR* 383, 389-99, and authorities cited there.

3 See N Haysom 'Constitutionalism, Majoritarian Democracy and Socio-economic Rights' (1992) 8 *SAJHR* 451, 452; S Liebenberg 'The Value of Human Dignity in Interpreting Socio-economic Rights' (2005) 21 *SAJHR* 1, 2-3; 7; E Mureinik 'Beyond a Charter of Luxuries: Economic Rights in the Constitution' (1992) 8 *SAJHR* 464, 465; C Scott 'The Interdependence and Permeability of Human Rights Norms: Towards a Partial Fusion of the International Covenants on Human Rights' (1989) 27 *Osgoode Hall LJ* 769, 789-90; 798-99; R West 'Rights, Capabilities and the Good Society' (2001) 69 *Fordham LR* 1901, 1902.

4 See Cheadle & Davis (note 1 above) 59-60; Cockrell (note 1 above) 13; R Künnemann 'A Coherent Approach to Human Rights' (1995) 17 *Human Rights Q* 323, 339-40.

rights and duties contained in legislation and common law.[5] Moreover, there is growing consensus that private entities are every bit as capable of harming the enjoyment of socio-economic rights as the state. Apart from the socio-economic significance of individual actions and interactions, corporations (which typically command substantial power and resources) are increasingly implicated in socio-economic rights violations.[6] The transfer of State power to the private sector through privatization policies has intensified this phenomenon, not only by increasing the social significance of corporate action, but also by transferring many 'welfare-related' functions, once associated exclusively with the state, to the private sector.

The increasing capacity of private entities to determine access to socio-economic amenities clearly suggests that the transfer of state-like powers and functions to the private sector should be accompanied by a similar transfer of socio-economic responsibility and accountability.[7] But, even beyond the corporatisation of welfare functions, it would be incongruous to preclude socio-economic rights from applying in any so-called 'private' interactions, since this would remove the protection awarded by the rights from the very context where the consequences of socio-economic rights violations are most often felt.[8]

This article aims to contribute to the formulation of a coherent and workable theory on the horizontal application of socio-economic rights,

5 KD Ewing 'Social Rights and Constitutional Law' (1999) *Public Law* 104, 119; DL Pearmain 'Contracting for Socio-economic Rights: A Contradiction in Terms?' (2006) 69 *THRHR* 287, 289.

6 See M Heywood 'Debunking "Conglomo-talk": A Case Study of the Amicus Curiae as an Instrument for Advocacy, Investigation and Mobilisation' (2001) 5 *Law, Democracy & Development* 133, 134-35; S Liebenberg 'Violations of Socio-economic Rights: The Role of the South African Human Rights Commission' in P Andrews & S Ellmann (eds) *The Post-Apartheid Constitutions: Perspectives on South Africa's Basic Law* (2001) 405, 414; SR Ratner 'Corporations and Human Rights: A Theory of Legal Responsibility' (2001) 111 *Yale LJ* 443, 462; JJ Paust 'Human Rights Responsibilities of Private Corporations' (2002) 35 *Vanderbilt J of Transnational Law* 801, 802.

7 MCR Craven *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development* (1995) 122; I Currie & J De Waal *The New Constitutional and Administrative Law Volume 1: Constitutional Law* (2001) 93-4; DM Chirwa 'Non-state Actors' Responsibility for Socio-economic rights: The Nature of their Obligations under the South African Constitution' (2002) 3(3) *ESR Rev* 2, 6; DM Chirwa 'The Right to Health in International Law: Its Implications for the Obligations of State and Non-state Actors in Ensuring Access to Essential Medicine' (2003) 19 *SAJHR* 541, 559; 561-62; S Gutto 'Modern "Globalisation" and the Challenges to Social, Economic, and Cultural Rights for Human rights Practitioners and Activists in Africa' (Oct-Dec 2000) *Africa Legal Aid* 2; M Pieterse 'Beyond the Welfare State: Globalization of Neo-liberal Culture and the Constitutional Protection of Social and Economic Rights in South Africa' (2003) 14 *Stell LR* 3, 25-6.

8 J Van der Walt '*Progressive* Indirect Horizontal Application of the Bill of Rights: Towards a Co-operative Relation between Common-law and Constitutional Jurisprudence' (2001) 17 *SAJHR* 341, 353. See further Guideline 18 of the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (1998); S Leckie 'Another Step Towards Indivisibility: Identifying the Key Features of Violations of Economic, Social and Cultural Rights' (1998) 20 *Human Rights Q* 81, 108; 111.

by investigating the indirect impact of justiciable socio-economic rights on those aspects of private law that regulate private (personal, contractual or commercial) relationships which are crucial for the effective enjoyment of socio-economic rights. I argue that the judicial development of the common law (of which the bulk of South African private law consists) in resonance with the values underlying justiciable socio-economic rights presents a viable remedial paradigm for the actualisation of socio-economic rights in the private sphere. This is particularly so, I contend, because the value-based development of common-law norms in the course of private-law litigation is typically regarded as an uncontroversial aspect of the judicial function, even in legal cultures to which the notion of rights-based judicial review is novel or alien.

The focus of the article is largely confined to the impact of the right of everyone to have access to health care services, guaranteed by s 27(1)(a) of the Constitution of the Republic of South Africa, 1996 ('the Constitution') on the body of South African private law pertaining to the regulation of the doctor-patient relationship. In section II below, I first discuss the manner and extent to which socio-economic rights are generally capable of applying to 'private' matters, in terms of the provisions governing rights-adjudication under the South African Bill of Rights. I then engage with the content of the right to have access to health care services, in an attempt to ascertain the extent to which the obligations generated by the right are fit for horizontal application. Thereafter, section III discusses the potential of common-law development as remedial paradigm for giving effect to certain of the horizontal dimensions of the right. After making a case for the seepage of public law norms into the private-law regulation of the doctor-patient relationship, I point to features of such regulation that appear in need of reconceptualization, in light of the constitutional guarantee of access to medical care. I suggest modifications to the existing state of common law in this regard and critically discuss case law in which similar modifications have been contemplated.

Overall, the article intends to illustrate that judicial engagement with justiciable socio-economic rights must extend beyond the 'traditional' public-law understanding of rights-based judicial review. Justiciable socio-economic rights ultimately require the reconstruction of the tenets of both the public and private law spheres, whilst highlighting anew the artificiality of their separation.

II The Horizontal Application of the Right of Access to Health Care Services in South Africa

(a) Socio-economic rights and horizontal application

According to s 7(2) of the Constitution, the State must 'respect, protect, promote and fulfill the rights in the Bill of Rights'. The obligation to

'protect' the rights in the Bill of Rights is typically understood to mean that the state must safeguard individual members of society from infringements of their rights by third parties and must ensure the adequacy of legal remedies that prevent or compensate for such infringements. In relation to socio-economic rights, this appears to imply the recognition, regulation and enforcement of so-called 'private' or 'horizontal' socio-economic obligations.[9]

Horizontal application of the rights in the South African Bill of Rights is regulated primarily by subsecs 8(2)-(3) of the Constitution, which determine:

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

While nowhere excluding socio-economic rights from horizontal application, these provisions acknowledge that not every right, and not all obligations imposed by a particular right, are capable of horizontal application. A further factor that is clearly relevant to a judicial decision on whether to allow for the horizontal application of a particular socio-economic right, is the nature or identity of the person or entity against whom the right is to be applied, for the obvious reason that everyone does not have equal capacity to comply with the various obligations imposed by all socio-economic rights.[10] Alfred Cockrell's assertion that that s 8(2) 'proceeds on the assumption that constitutional rights might be agent-relative and context-sensitive, inasmuch as their direct application against private agencies will depend on the circumstances of the case and the characteristics of the particular person'[11] is therefore particularly significant for the horizontal application of socio-economic rights.

9 In relation to the obligation to protect under international law and s 7(2), see, for example, Chirwa (*SAJHR*) (note 7 above) 559-60; P De Vos 'Pious Wishes or Directly Enforceable Human Rights?: Social and Economic Rights in South Africa's 1996 Constitution' (1997) 13 *SAJHR* 67, 83; S Ellmann 'A Constitutional Confluence: American ''State-action'' Law and the Application of South Africa's Socio-economic Rights Guarantees to Private Actors' in Andrews & Ellmann (eds) (note 6 above) 444, 448; Leckie (note 8 above) 109; Liebenberg (note 6 above) 414; S Liebenberg 'South Africa's Evolving Jurisprudence on Socio-economic rights: An Effective Tool in Challenging Poverty?' (2002) 6 *Law, Democracy & Development* 159, 163-64; 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, 74.

10 See Ellmann (note 9 above) 444; 446; 462-67; also Chirwa (*ESR*) (note 7 above) 4; 6; JW Nickel 'How Human Rights Generate Duties to Protect and Provide' (1993) 15 *Human Rights Quarterly* 76, 78; 81-2; Ratner (note 6 above) 497-511; 524-25; H Shue 'The Interdependence of Duties' in P Alston & K Tomasevski (eds) *The Right to Food* (1984) 83, 90.

11 Cockrell (note 1 above) 13.

Stephen Ellman argues that the extent to which a private entity may be held accountable for infringements of socio-economic rights must depend on the nature and extent of the power exercised by the entity, the degree to which the power emulates state powers and the impact of the power on the enjoyment of socio-economic rights. Ellmann accordingly suggests that entities which exercise powers or perform functions that emulate those of the state, or that impact on the exercise of rights by citizens in a similar manner, should be held bound by relevant socio-economic provisions in the Bill of Rights.[12] A further factor to take into account is the relationship between the person or group seeking to enforce their socio-economic rights and the entity against whom horizontal application is sought. It may be argued that private entities should only be regarded as bound by socio-economic obligations where a 'special relationship' exists between them and the relevant rights-bearer(s).[13]

Section 8(3) of the Constitution proceeds to indicate that rights would seldom directly apply to a 'private' dispute. The preferred manner to vindicate them in the private sphere would be by way of legislative enactment or through developing and/or limiting the rules of the common law, which would conceivably generate more effective remedies for private rights-infringements.[14] Further relevant in this respect is s 39(2) of the Constitution, which determines:

> (2) When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.

It appears that South African courts are constitutionally mandated to develop the common law in situations where this is necessary for the effective enjoyment of socio-economic rights, regardless of the manner in which the rights are applied in a given case. Given the plethora of relevant legislative provisions regulating social service delivery and the vast body of common law that may be developed to give effect to socio-economic rights, direct reliance on socio-economic rights in private disputes will thus likely be a rare occurrence. It may therefore be expected

12 Ellmann (note 9 above) 444; 446; 462-67. According to Ellmann, factors considered by US Courts in 'state action cases' (such as the degree to which the power derived from or was granted, compelled or encouraged by the state; the degree to which the state facilitates or regulates the exercise of the power; the degree of co-operation between the entity and the state and whether a particular private power or function is usually exercised by the state) are helpful in exploring the 'public' nature of privately exercised powers or functions. See further Chirwa (*ESR*) (note 7 above) 6; Chirwa (note 1 above) 22-6; Ratner (note 6 above) 497-506; 524-25.

13 See Ratner (ibid) 506-11; 525; Shue (note 10 above) 90.

14 See J De Waal; I Currie & G Erasmus *The Bill of Rights Handbook* 4ed (2001) 37; S Liebenberg 'Socio-economic Rights' in M Chaskalson et al (eds) *Constitutional Law of South Africa* (RS5, 1999) ch 41 at 46; Pearmain (note 5 above) 289-90 and also the separate concurring remarks of Sachs J in *Du Plessis v De Klerk* 1996 (3) SA 850 (CC) para 187.

that the horizontal dimensions of socio-economic rights will for the foreseeable future be limited, either to the vindication of statutory socio-economic obligations against private entities, or to the development of relevant common-law rules or doctrines that regulate private relationships.

(b) Horizontal dimensions of the right to have access to health care services

Section 27 of the Constitution determines, in relevant part:

> (1) Everyone has the right to have access to-
> (a) health care services, including reproductive health care; . . .
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of . . . [this] right]. . ..

The most convincing argument against the horizontal application of socio-economic rights in the Constitution relates to the wording of subsec 27(2), which requires the state (and, by implication, only the state) to take reasonable measures in order to achieve the progressive realisation of the right of access to health care services. This appears to indicate that the obligations engendered by s 27 are too onerous to bind also individuals or other private entities.[15] However, such a view of s 27 is overly simplistic. While the obligation to progressively achieve universal access to health care services by way of reasonable measures indeed attaches only to the state, this is but one of the myriad of (positive and negative) obligations generated by s 27(1). Subject to the (express and implied) limitations on horizontal application derived from s 8 of the Constitution, all obligations inherent in s 27(1)(a) *except* for that set out in s 27(2) should in principle be viewed as capable of attaching to private entities.[16]

However, the South African Constitutional Court's approach to the interpretation of s 27 has thus far not shed much light on the content of these obligations, nor on the extent to which they may be regarded as horizontally enforceable. In *Grootboom*, an access to housing case, the Court developed a so-called 'reasonableness approach' to the adjudication of socio-economic rights, which focuses on the obligation in ss 26(2)

15 Noted by P Carstens & A Kok 'An Assessment of the Use of Disclaimers by South African Hospitals in View of Constitutional Demands, Foreign Law and Medico-legal Considerations' (2003) 18 *SA Public Law* 430, 437; 440; De Waal; Currie & Erasmus (note 14 above) 55; 57; Ellmann (note 9 above) 445; 460; Pearmain (note 5 above) 293 and, in a different context, Ewing (note 5 above) 120.

16 See Ellmann (note 9 above) 461; Liebenberg (note 14 above) 45; F Michelman 'The Constitution, Social Rights and Reason: A Tribute to Etienne Mureinik' (1998) 14 *SAJHR* 499, 504; JC Mubangizi 'Public Health, the South African Bill of Rights and the Socio-economic polemic' (2002) *TSAR* 343, 345; Pieterse (note 7 above) 26.

and 27(2) of the Constitution that measures adopted in pursuit of the progressive realisation of socio-economic rights must be reasonable.[17] The approach was also followed in relation to the right of access to health care services in *Minister of Health v Treatment Action Campaign*. In this case, the Constitutional Court dismissed arguments advanced by the amici curiae that s 27(1)(a) of the Constitution engendered a minimum core obligation to immediately provide essential medicines to those who are unable to access them for themselves and appeared unwilling to award any individually enforceable content to s 27(1)(a), separate from the overarching obligation contained in s 27(2).[18] This approach sparked much criticism for implying that the socio-economic rights in the Constitution amount merely to an amorphous, administrative law-like, state obligation to act reasonably when devising social policy.[19]

While the *Treatment Action Campaign* Court's remarks apply mostly to the question of minimum core obligations and do not in any way touch on the horizontal application of s 27(1)(a), its reluctance to read this subsection separately from s 27(2) significantly frustrates efforts to develop a coherent theory on the horizontal application of the right, since it complicates the process of distinguishing obligations capable of horizontal application from the state-restricted obligation elaborated in s 27(2).[20]

Thus far, the only allusion to the horizontal dimensions of s 27 in the jurisprudence of the Constitutional Court is to be found in a separate concurring judgment in *Soobramoney v Minister of Health, KwaZulu Natal*, where Madala J remarked in passing on the important role played by the private health care sector in rendering complex medical treatment beyond the resource capacity of the state. The judge viewed allegations that the appellant was not informed of his options to access private sector

17 See *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) paras 39-44; 46. According to the Court, the obligation of reasonableness entails that socio-economic measures aimed at the progressive realisation of the right must be comprehensive, coherent, balanced and flexible, must clearly set out the responsibilities of different spheres of government and must ensure that appropriate resources are available for their implementation. Measures must further be inclusive and must cater for the satisfaction of urgent and emergency needs of vulnerable sectors of society.

18 *Minister of Health v Treatment Action Campaign (No 2)* 2002 (5) SA 721 (CC) paras 29-39.

19 See, for example, D Bilchitz 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-economic Rights Jurisprudence' (2003) 19 *SAJHR* 1, 8-10; D Brand 'The Proceduralisation of South African Socio-economic Rights Jurisprudence, or "What are Socio-economic Rights For?"' in H Botha et al (eds) *Rights and Democracy in a Transformative Constitution* (2003) 33, 36-7; 39; 49; 55; C Chetty 'The Right to Health Care Services: Interpreting Section 27 of the Constitution' (2002) 17 *SA Public Law* 453, 455; 461; F Coomans 'Reviewing Implementation of Social and Economic Rights: An Assessment of the Reasonableness Test as Developed by the South African Constitutional Court' (2005) 65 *Heidelberg J of Int L* 167, 188; I Currie 'Bill of Rights Jurisprudence' (2002) *Annual Survey of SA Law* 36, 72; Liebenberg (note 9 above) 176; T Roux 'Understanding *Grootboom* — A Response to Cass R Sunstein' (2002) 12(2) *Constitutional Forum* 41, 46.

20 See Chetty (note 19 above) 455; Chirwa (*ESR*) (note 7 above) 5.

care as 'a serious indictment for the private sector' and concluded that 'the private sector is not before us and we cannot condemn it without hearing it'.[21] This seemed to imply that Madala J would not have difficulty in holding the private health sector accountable under s 27(1) if it were before the Court in an appropriate matter.

Looking towards non-judicial interpretations of the right of access to health care services, it appears that at least three kinds of obligations inherent to the right are capable of horizontal application. First, commentators generally agree that the negative obligation to respect socio-economic rights under s 7(2) of the Constitution must operate horizontally, if private parties are to have any remedy against unlawful private interferences with the exercise of their rights. In relation to s 27(1)(a), this implies an enforceable obligation on private entities to refrain from disrupting, denying, impairing or obstructing existing access to health care services without constitutionally acceptable justification.[22]

Secondly, there appears to be consensus that the equality threshold underlying the determination in s 27(1)(a) that 'everyone' is entitled to have access to health care services,[23] is horizontally enforceable in conjunction with the prohibition on unfair discrimination by private entities under s 9(4) of the Constitution.[24] This means that citizens should be able to demand access to medical treatment from private sources

21 *Soobramoney v Minister of Health, KwaZulu Natal* 1998 (1) SA 765 (CC) para 48. Chaskalson P, writing for the majority, seemed to distance himself from these remarks by declining explicitly to remark on the private sector's attitude in this regard. Ibid para 35.

22 See, in relation to the obligation to respect the right to health in international law, Nickel (note 10 above) 78; 82; Paust (note 6 above) 819; Shue (note 10 above) 88-9; and in relation to the horizontal operation of the duty under the South African Constitution Chirwa (*ESR*) (note 7 above) 5-6; Chirwa (*SAJHR*) (note 7 above) 559; 564; De Vos (note 9 above) 100; Ellmann (note 9 above) 460-61; Liebenberg (note 6 above) 415; Liebenberg (note 9 above) 178; Pieterse (note 7 above) 26.

23 The 'everyone' threshold to s 27(1)(a) is understood to forbid, first, any group-based distinctions in health care service provision, secondly, the arbitrary or unfair exclusion of any individual from the ambit of policies, laws and programmes which confer health-related benefits and, thirdly, the inequitable provision of health care services. See P De Vos '*Grootboom*, the Right of Access to Housing and Substantive Equality as Contextual Fairness' (2001) 17 *SAJHR* 258, 265-66; Liebenberg (note 14 above) 26-7; C Ngwena 'Access to Health Care as a Fundamental Right: The Scope and Limits of Section 27 of the Constitution' (2000) 25(1) *J for Juridical Science* 1, 3; 7-9; 27; C Ngwena 'Aids in Africa: Access to Health Care as a Human Right' (2000) 15 *SA Public Law* 1, 13; M Pieterse 'Foreigners and Socio-economic Rights: Legal Entitlements or Wishful Thinking?' (2000) 63 *THRHR* 51, 54; 56; South African Human Rights Commission *Third Economic and Social Rights Report* (1999) 189.

24 See Chirwa (*ESR*) (note 7 above) 4; Chirwa (*SAJHR*) (note 7 above) 559; 564-65. Section 9(4) determines that 'no person may 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]' and mandates the enactment of national legislation preventing or prohibiting unfair discrimination in the private sphere.

where such treatment is being withheld arbitrarily or due to unfair discrimination.[25]

Thirdly, horizontally enforceable obligations may well lurk in the requirement that access to health care services must be meaningful. This requirement is not explicit from the wording of s 27(1)(a) but is arguably inherent in the notion of 'access' to health care services.[26] In its 14th General Comment, the UN Committee on Economic, Social and Cultural Rights determined that health care services must be physically accessible, available, affordable, culturally acceptable as well as 'medically appropriate and of good quality' for the meaningful enjoyment of the right to the highest attainable standard of health.[27] There are some indications in South African socio-economic rights jurisprudence that the notion of 'access' in s 27(1)(a) may be understood to imply similar qualitative standards.[28] Such an understanding of 'access' may entail an obligation for certain private entities to ensure that the acceptability, accessibility, availability and quality of health care

25 Examples of instances where private entities may be regarded as being in violation of this equality threshold are to be found in the illustrative list of unfair practices in the health sector contained in item 3 of the Schedule to the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000. The list declares the following practices to be unfair: '(a) Subjecting persons to medical experiments without their informed consent. (b) Unfairly denying or refusing any person access to health care facilities or failing to make health care facilities accessible to any person. (c) Refusing to provide emergency medical treatment to persons of particular groups identified by one or more of the prohibited grounds. (d) Refusing to provide reasonable health services to the elderly'. The list is further augmented by provisions declaring that it amounts to unfair discrimination on the basis of race to provide inferior services to any racial group (s 7(d)) and that it amounts to unfair discrimination on the ground of gender to limit women's access to social benefits such as health benefits (s 8(g)).

26 For arguments that 'access' to care must satisfy certain qualitative standards in order to be meaningful, see A Abbe "'Meaningful Access" to Health Care and the Remedies Available to Medicaid Managed Care Recipients under the ADA and the Rehabilitation Act' (1999) 147 *Univ Pennsylvania LR* 1161-203; M Geldenhuys 'The Rights to Health Care and Housing: Some Aspects of Constitutional Interpretation' (2005) 17 *SA Merc LJ* 182, 193; D Giesen 'Health Care as a Right: Some Practical Implications' (1994) 13 *Medicine & Law* 285, 290; AC Hendriks 'Patients' Rights and Access to Health Care' (2001) 20 *Medicine & Law* 371, 374; D Orentlicher 'Destructuring Disability: Rationing of Health Care and Unfair Discrimination against the Sick' (1996) 31 *Harvard Civil Rights-Civil Liberties LR* 49, 79-82; M Pieterse 'Resuscitating Socio-economic Rights: Constitutional Entitlements to Health Care Services' (2006) 22 *SAJHR* 473, 495-96; KE Tranoy 'Vital Needs, Human Rights, Health Care Law' (1996) 15 *Medicine & Law* 183, 186-88.

27 UNCESCR General Comment 14 'The Right to the Highest Attainable Standard of Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)' (2000) para 12.

28 In relation to housing, there are indications that the Constitutional Court understands the notion of access as imposing substantive standards. See *Grootboom* (note 17 above) paras 35-6. In *Pharmaceutical Society of South Africa v Tshabalala-Msimang* 2005 (3) SA 238 (SCA) paras 42; 53; 77 the SCA held that 'access' to health care services required services to be both physically accessible and affordable, and was of the opinion that prohibitive pricing of medicines may infringe this standard. This view attracted support in the separate concurring judgment by Moseneke J in the case's subsequent appeal to the Constitutional Court. See *Minister of Health v New Clicks SA (Pty) Ltd* 2006 (2) SA 311 (CC) para 706.

services is maintained or, at least, not interfered with.[29] In particular, private health care facilities or practitioners may be regarded as constitutionally obliged to render health care services of appropriate quality.[30]

There has thus far been one prominent attempt at enforcing such an obligation. In *Strydom v Afrox Healthcare*, the Pretoria High Court declared a contractual clause, that insulated a health care facility from delictual liability arising from the negligent conduct of its personnel, to be contra bonos mores and unenforceable. The Court regarded s 27(1)(a) as indirectly applicable to private hospitals and held that the right of access to health care services awarded patients a legitimate expectation that the services to which they have access would be rendered with skill and care by professional and trained health care personnel.[31] This amounts to the most definite affirmation of the horizontal dimensions and implicit quality standards inherent in s 27(1)(a) in South African jurisprudence to date, and is welcomed accordingly.[32] Whereas the SCA overturned this judgment on appeal (since it felt that the exclusion clause did not deny access to treatment and did not explicitly allow for negligent or substandard care), it assumed in favour of the applicant that the right could be horizontally applied and left open the question of whether s 27(1)(a) presupposed a minimum level of care.[33]

It would therefore appear that, notwithstanding the wording of s 27(2) of the Constitution and the Constitutional Court's ambivalent stance towards the interpretation of s 27(1)(a), there may be scope for the horizontal application of certain of the obligations engendered by the right of access to health care services. This conclusion is augmented by increasing acceptance that other health-related rights in the Constitution, notably the right not to be refused emergency medical treatment in s 27(3) and the right of children to 'basic nutrition, shelter, basic health care

29 Chirwa (*SAJHR*) (note 7 above) 565.

30 See Carstens & Kok (note 15 above) 442; AR Chapman 'Core Obligations Related to the Right to Health and their Relevance for South Africa' in D Brand & S Russell (eds) *Exploring the Core Content of Socio-economic Rights: South African and International Perspectives* (2002) 35, 45; K Pillay 'South Africa's Commitment to Health Rights in the Spotlight: Do we Meet the International Standard?' in Brand & Russell (ibid) 61, 63-4; B Toebes 'Towards an Improved Understanding of the International Human Right to Health' (1999) 21 *Human Rights Q* 661, 666-67; 669.

31 *Strydom v Afrox Healthcare Bpk* [2001] 4 All SA 618 (T), 626b-h; 627f-g.

32 See also Currie (note 19 above) 74.

33 *Afrox Healthcare v Strydom* 2002 (6) SA 21 (SCA) paras 13; 15; 19-21. This finding will be criticised in III(b) below.

services and social services' in s 28(1)(c), entail certain horizontally enforceable obligations.[34]

As set out in II(a) above, the preferred avenue through which to give horizontal effect to human rights appears to be by way of judicial development of the common law. Even on the Constitutional Court's combined reading of subsecs 27(1) and (2) of the Constitution, common-law development appears to be a viable remedial paradigm for giving effect to the horizontal obligations entailed by s 27(1)(a). Jonathan Klaaren argues that, on a reading of the phrase 'reasonable legislative and other measures' in s 27(2) of the Constitution as including also judicial measures, it is possible to view the judicial task under s 27(2) as comprising an obligation to ensure that the common law, as part of the general legal framework for the realisation of socio-economic rights, is 'reasonable'. Hence, Klaaren regards courts as being constitutionally required to develop the common law in situations where this is necessary for the effective enjoyment of socio-economic rights.[35]

Given that South African courts have for many years engaged in developing the common law in accordance with the changing social mores and are now under an explicit constitutional mandate to ensure that the common law resonates with the spirit, purport and objects of the Bill of Rights, they should be able to fulfill the remedial aspects of their role in this regard with relative ease. While the attempt in *Afrox* to align the common law with the values associated with s 27(1)(a) of the Constitution was ultimately unsuccessful, that case illustrates that it would be possible for courts to indirectly enforce certain horizontal aspects of s 27(1)(a), without straying too far from their institutional comfort zone.[36]

In *Carmichele v Minister of Safety and Security*, the Constitutional Court determined that any court which is called upon to develop the common law in accordance with s 39(2) of the Constitution must first establish whether and to what extent the current state of the common law

34 The enforcement of the horizontal dimensions of these rights are beyond the scope of this article. On the horizontal enforcement of s 27(3), see M Pieterse 'Enforcing the Right not to be Refused Emergency Medical Treatment: Towards Appropriate Relief' (2007) 18 *Stell LR* (forthcoming) at text accompanying notes 21-5 and authorities cited there. On the horizontal dimensions of s 28(1)(c), see *Grootboom* (note 17 above) paras 71-8 (holding that s 28(1)(c) operates in the first instance against parents and only in the second instance against the State); *TAC* (note 18 above) paras 77-9 (somewhat qualifying the *Grootboom* position) and discussion in, for instance, M Pieterse 'Reconstructing the Private/Public Dichotomy? The Enforcement of Children's Constitutional Social Rights and Care Entitlements' (2003) *TSAR* 1, 10-11; P Proudlock 'Children's Socio-economic Rights: Do they Have a Right to Special Protection?' (2002) 3(2) *ESR Rev* 6, 7-8; J Sloth-Nielsen 'Too Little? Too Late? The Implications of the *Grootboom* Case for State Responses to Child-headed Households' (2003) 7 *Law, Democracy & Development* 113, 119-21.

35 J Klaaren 'A Remedial Interpretation of the *Treatment Action Campaign* Decision' (2003) 19 *SAJHR* 455, 460-61. See also J Klaaren 'An Institutional Interpretation of Socio-economic Rights and Judicial Remedies After *TAC*' in Botha et al (eds) (note 19 above) 105, 112.

36 See also remarks of Currie (note 19 above) 74; Klaaren (in Botha et al) (note 35 above) 115.

requires development, in light of the circumstances of the case. Thereafter, it should decide on the manner in which developments that are necessary for the common law to reflect the spirit, purport and objects of the Constitution should be effected in the context of the particular matter.[37] In the following section, I illustrate that current common law rules in relation to the regulation of the doctor-patient relationship could easily be applied or developed in a manner that adequately gives effect to the spirit of s 27(1)(a) of the Constitution. Such developments, I argue, may result in more tangible protection of the interests of the beneficiaries of the right of access to health care services in circumstances where their enjoyment of the right is threatened or curtailed by the actions of other private entities.

III The Right of Access to Treatment and the Common-Law Regulation of the Doctor-Patient Relationship

Private health care practitioners and institutions appear to be directly implicated by the constitutional guarantee of a right to have access to health care services, for the obvious reason that they are in the business of rendering the very services that are the object of the constitutional entitlement. The nature of the right to have access to health care services thus suggests the possibility of its horizontal application to private health care practitioners and institutions, whereas section II(b) above has shown that at least certain of the obligations imposed by the right are capable of horizontal application.

The kinds of functions performed by health care practitioners and institutions, as well as their relationship to the public, further suggest that they are capable, in their day-to-day operation, of complying with (at least some of) the obligations inherent to the right of access to care. Private hospitals, especially, appear capable of bearing horizontal obligations. This is so, first, due to the significant resources at their disposal, secondly, to the fact that they render services identical to those rendered by public hospitals (which are directly bound by s 27 in terms of s 8(1) of the Constitution) and, thirdly, to the impact of the exercise of their powers and functions on the enjoyment of the right of access to care.[38] Indeed, from the perspective of rights-holders, there is preciously little difference between public and private health care institutions and it

37 *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC) para 40.

38 See, for example, D Brand 'Disclaimers in Hospital Admission Contracts and Constitutional Health Rights' (2002) 3(2) *ESR Rev* 17, 18 (criticising the SCA for failing to acknowledge the 'public' nature of the functions of private hospitals in *Afrox* (note 33 above)).

would seem incongruous for health-related constitutional rights to operate against some, but not other, health service providers.[39]

Apart from the obvious similarities between the functions fulfilled by private health care practitioners and those of their public sector counterparts, justifications for horizontal application of health-related rights against private doctors include the extent to which the private health care profession has historically been allowed to regulate itself and the significant state investment in the education of health care practitioners.[40] Moreover, given the extent of trust and dependancy within doctor-patient relationships and the imbalances of knowledge, power and resources that are inherent to them, these may be conceived as 'special relationships' to which socio-economic obligations should attach. Indeed, it is accepted in most legal systems that a number of health-related entitlements and obligations flow from a duty of care triggered by the contractual relationship between doctor and patient, that are not necessarily restricted to the terms of such contract.[41]

South African common law of contract and delict provides a detailed framework for the regulation of these entitlements and obligations within the doctor-patient relationship. To a significant extent, this framework already caters for the enforcement of constitutional health-related entitlements within the private realm. It also appears that a few, relatively uncontroversial, developments to the existing state of the common law may go a great length towards aligning it with the spirit, purport and objects of a Bill of Rights that contains a justiciable right to have access to health care services. In what follows, I provide brief examples of possible common law developments that would honour the constitutional obligation to protect the health-related socio-economic rights of the public from infringements by private health care practitioners, first, by crystallising the nature and extent of health care professionals' private socio-economic obligations and, secondly, by allowing for adequate, effective and appropriate relief for the victims of rights-violations that occur within the relationships between patients and private health care providers.

39 Another pertinent example of private actors in the health industry that may be considered bound by health rights along similar lines is that of pharmaceutical companies, due to their vast command over power and resources and the significant consequences of their actions on rights of access to medication. See Ellmann (note 9 above) 460-61 and generally S Joseph 'Pharmaceutical Corporations and Access to Drugs: The "Fourth Wave" of Corporate Human Rights Scrutiny' (2003) 25 *Human Rights Quarterly* 425-52.

40 See L Baldwin-Ragaven; J De Gruchy & L London (eds) *An Ambulance of the Wrong Colour: Health Professionals; Human Rights and Ethics in South Africa* (1999) 10; 210-11; D Giesen 'A Right to Health Care? A Comparative Perspective' (1994) 4 *Health Matrix* 277, 286.

41 See Giesen (ibid) 286; 290. In *Magware v Minister of Health* 1981 (4) SA 472 (Z) 475A-B; 476G-H; 477A-B the contractual obligation flowing from taking on a patient was described as a 'special relationship' triggering a duty of care.

(a) Access to care and the common-law regulation of the obligation to treat

An obvious barrier to accessing health care services, especially in the private health care sector, occurs where health care practitioners or establishments refuse to render treatment to particular patients or groups of patients. Such refusal is typically justified on a variety of grounds, including the failure by patients to satisfy hospital admission requirements (such as having to produce proof of medical aid membership or having to sign indemnity forms), the inability of health care practitioners or facilities to render treatment of the kind requested, the inability of patients to pay for treatment and health care professionals' conscientious objection to rendering particular forms of treatment. It is conceivable that, whereas such a denial of care would often be legitimate, it may sometimes amount to an unjustifiable barrier to accessing health care services and may accordingly constitute an infringement of s 27(1)(a) of the Constitution.

At common law, a health care professional is as a general rule free to refuse to accept a particular person as a patient.[42] Once a health care practitioner has accepted a patient, however, she or he is contractually, morally and ethically obliged to continue rendering treatment. Exceptions to this general rule include situations where treatment can feasibly be left to another health care professional who is willing to treat; where the health care practitioner issues sufficient instructions for further treatment; where further treatment is medically unnecessary, futile or likely to do more harm than good; where the patient refuses further treatment or where the practitioner gives the patient reasonable notice of her intention to discontinue treatment while simultaneously ensuring that alternative treatment options are available.[43] It is thus possible to hold a health care professional delictually liable for withholding treatment unreasonably, in circumstances where a doctor-patient relationship has come to be established. In determining whether or not a refusal of treatment was reasonable, courts take into account factors such as the doctor's knowledge of the patient's condition, the nature and seriousness of the patient's condition, the ability of the doctor to assist the patient,

42 See DJ McQuoid-Mason & SA Strauss 'Medicine, Dentistry, Pharmacy and Other Health Professions' in WA Joubert & JA Faris (eds) *The Law of South Africa Volume 17* (1st Reissue 1999) 129, 143 and authorities cited there; SA Strauss 'Medical and Health Law' in F Bosman (ed) *Social Welfare Law* (1982) 511, 519.

43 Factors listed by McQuoid-Mason & Strauss (note 42 above) 145. See also *Magware v Minister of Health* (note 41 above) 475A-B; Giesen (note 40 above) 290; Hendriks (note 26 above) 376; BE Leech 'The Right of the HIV-positive Patient to Medical Care: An Analysis of the Costs of Providing Medical Treatment' (1993) 9 *SAJHR* 39, 48; Strauss (note 42 above) 517.

the availability of alternative treatment, the interests of the doctor's other patients as well as ethical considerations.[44]

The constitutionalisation of a right to have access to health care services must necessarily influence the above assessment. I would argue that the right to have access to health care services challenges the foundation of the common law position that health care professionals are regarded as always being free to refuse treatment, unless a doctor-patient relationship has already been established. At the very least, the horizontal operation of the right to equality and the concomitant equality guarantee underlying the right of access to health care services should have the effect of precluding any arbitrary refusal of treatment or any refusal that is motivated by unfair discrimination.[45] The common law should accordingly be developed to reflect this. In addition, I would argue that the values associated with the right to have access to health care services would be better served by reversing the starting point of the common law inquiry. This would entail that health care professionals are regarded as duty-bound to provide treatment, regardless of the presence of a pre-existing doctor-patient relationship, unless they can offer constitutionally acceptable justification for refusing to do so. Accordingly, health care professionals would incur delictual liability for damages suffered as a result of any unjustifiable refusal to render treatment.

Developing the common law in the manner described here would serve either to secure access to health care services for patients who were at risk of being denied access without constitutionally acceptable justification, or to tangibly compensate such patients for damages suffered as a result of such denial of access. Whereas there obviously has to be guarded against placing an undue burden on health care professionals to render care regardless of the circumstances or their reasons for refusal, it is submitted that health care professionals' interests in this regard could be adequately protected by developing rules of common law that limit patients' right of access to care, in accordance with s 8(3)(b) of the Constitution. The accepted common law grounds of justification for refusal to continue treating existing patients and the factors to be taken into account in determining the reasonableness or otherwise of such refusal, could serve as a useful starting point in this respect.

An inquiry into the reasonableness and justifiability of a refusal to render particular treatment would often boil down to balancing interests of health care professionals against those of their would-be patients. One particularly controversial example of this is where a refusal to treat relates to a health care professional's moral, religious or ethical objection

44 McQuoid-Mason & Strauss (note 42 above) 145. This exposition of the common law is substantially similar to my statement of the same rules in relation to the provision of emergency medical treatment in Pieterse (2007) (note 34 above).

45 See in this regard also Hendriks (note 26 above) 377; Leech (note 43 above) 67.

to rendering particular kinds of treatment. The context in which such conscientious objection appears to arise most often is the provision of termination of pregnancy services under the Choice on Termination of Pregnancy Act 92 of 1996. Especially in rural areas, several instances of health care professionals refusing to terminate pregnancies, out of moral or religious objection, have been documented. This has resulted in a de facto denial of access to termination services in situations where the requested treatment is not accessible or available elsewhere in the vicinity.[46] An inquiry into the constitutional acceptability of justification for refusing to perform a termination of pregnancy due to conscientious objection must necessarily involve a balance between the implied right of health care professionals to conscientious objection (derived from the right to freedom of conscience, religion, belief and opinion in s 15 of the Constitution) and the express right of patients to have access to reproductive health care services.[47]

The Choice on Termination of Pregnancy Act does not indicate how this balance should be struck, although the determination in s 6 that women who request termination services should be informed of their rights in terms of the Act does impose limited restrictions on rights of conscientious objection. Similarly, Charles Ngwena argues that refusal to perform a termination of pregnancy out of conscientious objection would generally amount to a reasonable and justifiable limitation on the right of access to reproductive health care services, unless the termination is required as a matter of medical emergency. Ngwena nevertheless regards health care professionals as duty-bound, notwithstanding their rights of conscientious objection, to refer the patient to a facility where a termination service may in the alternative be accessed. Ngwena further hints that rights of conscientious objection may more readily be limited in rural areas where such alternative facilities are not available or accessible.[48]

I would go further to suggest that, in circumstances where a refusal to provide medical treatment due to conscientious objection amounts to a de facto denial of access to care, implied rights of conscientious objection should be overruled by the express right of access to health care services. In other words, the interests of patients should generally be held to outweigh those of medical practitioners in this context. Refusal to treat due to conscientious objection would, on my suggestion, be regarded as reasonable and justifiable only in circumstances where alternative

46 See cases discussed by C Ngwena 'Conscientious Objection and Legal Abortion in South Africa: Delineating the Parameters' (2003) 28(1) *J for Juridical Science* 1, 4.

47 Ibid 9-10. See also Ellmann (note 9 above) 458.

48 See C Ngwena 'Accessing Abortion Services under the Choice on Termination of Pregnancy Act: Realising Substantive Equality' (2000) 25 *J for Juridical Science* 19, 39; Ngwena (note 46 above) 5; 9; 11-3; 16.

services are practically available and accessible to the patient and where the patient was alerted to such options by the health care professional.

(b) Quality of care and the common law on medical negligence

As argued under II(b) above, the s 27(1)(a) right to have access to health care services must be understood to imply a justiciable standard of quality of care, for it to comply with relevant international human rights norms and to have practical significance for those who suffer damages through receiving negligent or substandard care. Furthermore, the state's obligation to protect citizens from private infringements of the right to have access to care requires the presence of effective and practicable remedial avenues which ensure that rights-bearers are in the position to demand that the health care services they receive satisfy at least minimum standards of professionalism and scientific appropriateness. Patients should further be entitled to adequate compensation for damages suffered as a result of receiving care which falls short of such standards. There have been welcome obiter remarks by South African High Courts which acknowledge that the enjoyment of the right of access to health care services is significantly compromised where quality standards are not adhered to or are not enforced.[49]

The task of establishing when the quality of treatment received is to be regarded as adequate, so as to satisfy the quality standard inherent in s 27(1)(a), has been significantly simplified by the development of a quality yardstick in common-law cases dealing with medical negligence. This standard involves that failure by a health care professional to exercise a degree of skill and care that may reasonably be expected of the average, reasonably skilled practitioner in his or her field of medical expertise in similar circumstances, can lead to contractual or delictual liability.[50] I would submit that the implied standard of 'reasonable care' is sufficiently flexible to accommodate quality concerns in relation to s 27(1)(a), while simultaneously remaining realistic and sensitive to the

49 See *Strydom v Afrox Health Care* (note 31 above) 626b-e; 627f-g; *Korf v Health Professions Council of South Africa* 2000 (1) SA 1171 (T), 1179B-D.

50 See, for example, *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) 723C-E; *Blyth v Van den Heever* 1980 (1) SA 191 (A) 193B-94A; 221A; 221D-E; *Magware v Minister of Health* (note 41 above) 477A-B; *Correira v Berwind* 1986 (4) SA 60 (ZHC) 63E-F; I; 66C-D; *S v Kramer* 1987 (1) SA 887 (W) 893E-94J; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W) 385A-D; 396H-I; *Applicant v Administrator, Transvaal* 1993 (4) SA 733 (W) 738D-F; *Collins v Administrator, Cape* 1995 (4) SA 73 (C) 81J-82B; *Oldwage v Lourens* [2004] 1 All SA 532 (C) paras 40-6; *Van der Walt v De Beer* 2005 (5) SA 151 (C); *McDonald v Wroe* [2006] 3 All SA 565 (C) para 6; also NJB Claassen & T Verschoor *Medical Negligence in South Africa* (1992) 13-4; McQuoid-Mason & Strauss (note 42 above) 152-53; 198-99; SA Strauss *Doctor, Patient and the Law* (3ed 1991) 95-6; 252; Strauss (note 42 above) 517; N van Dokkum 'Hospital Consent Forms' (1996) 7 *Stell LR* 249; N van Dokkum 'The Evolution of Medical Malpractice Law in South Africa' (1997) 41 *J of African Law* 175, 190; F van Oosten 'Financial Resources and the Patient's Right to Health Care: Myth and Reality' (1999) 32 *De Jure* 1, 4-5; 8.

context within which health care services are rendered. The standard thus strikes a fair balance between the competing interests of health care professionals and patients in this regard. Common law accordingly presents a viable remedial avenue for recipients of negligent or substandard care.

However, there are practical impediments regarding the application of the common law quality standard to concrete cases, that significantly restrict its remedial potency and accordingly diminish its effectiveness. The spirit, purport and objects of a Constitution which takes health rights seriously require that these be acknowledged and addressed, either through a development of the relevant legal principles or through a change in the manner in which courts currently apply them.

One such impediment, relating to the application (rather than the content) of the medical negligence standard, is occasioned by the inherent imbalance in scientific knowledge (and other resources) between patients and doctors. This imbalance, coupled with the discipline-specific and scientific nature of a test inquiring into 'reasonable care' rendered by a 'reasonable practitioner', make it notoriously difficult for a patient to prove negligence or wrongdoing on the part of a health care professional.[51] An obvious manner in which to alleviate this difficulty would be to apply the maxim of res ipsa loquitur in medical negligence cases where an inference of negligence seems justified by the circumstances of the case. However, South African courts have historically been unwilling to apply the maxim in cases of alleged medical negligence, out of deference to the medical profession and in empathy with the often difficult conditions under which health care professionals operate.[52]

Whereas one must remain sympathetic to these conditions, I agree with suggestions that res ipsa loquitur should, at least where 'the prejudicial result is clearly in contrast with the acknowledged therapeutic objectives and technique of the operation or treatment in question', find application in cases of alleged medical negligence.[53] This is required not only by the

51 See Claassen & Verschoor (note 50 above) 27; L Hebblethwaite 'Mishap or Malpractice? Liability in Delict for Medical Negligence' (1991) 108 *SALJ* 38, 38-9; 43. On the various difficulties associated with the imbalances in knowledge and bargaining power in the doctor-patient relationship see also E Elhauge 'Allocating Health Care Morally' (1994) 82 *California LR* 1451, 1542; DM Frankford 'Privatizing Health Care: Economic Magic to Cure Legal Medicine' (1992) 66 *Southern California LR* 1, 15-6; 55-7; 59-60; 93; P Gertler & J Van der Gaag *The Willingness to Pay for Medical Care: Evidence from Two Developing Countries* (1990) 16-7; 21; MA Hall 'Rationing Health Care at the Bedside' (1994) 69 *New York Univ LR* 693, 700-01.

52 See *Mitchell v Dixon* 1914 AD 519; *Van Wyk v Lewis* 1924 AD 438; also authorities cited and discussed by PA Carstens 'Die toepassing van res ipsa loquitur in gevalle van mediese nalatigheid' (1999) 32 *De Jure* 19, 21-4; Claassen & Verschoor (note 50 above) 28-30; McQuoid-Mason & Strauss (note 42 above) 204.

53 Claassen & Verschoor (note 50 above) 28. See also authorities cited there. Carstens (note 52 above) 21-2; 24; 26 further lists several examples of cases clearly calling for application of res ipsa loquitur. These include cases where there has been physical injury to a body part other than that which was treated, where the wrong body part was treated, where the wrong limb

constitutional guarantees of equality and a fair trial,[54] but also by the values associated with s 27(1)(a). The application of the maxim in such cases would significantly enhance the potential of s 27(1)(a) to address the imbalances in power inherent to the doctor-patient relationship and to result in adequate compensation for those whose rights to receive care of an appropriate quality have been infringed.

A further, and arguably more pernicious, impediment to the effectiveness of the relevant common law principles in securing tangible relief for patients whose rights to receive care of an adequate quality have been infringed, is that the principles are increasingly excluded from application in the majority of doctor-patient relationships in the private health care sector. The great majority of private health care institutions indemnify themselves against damages resulting from substandard or negligent care administered by their personnel, by insisting that patients waive their remedies in this regard upon entering into a contract of admission to the institution. So prevalent is this practice that virtually no patient of a private health care institution can nowadays successfully hold the institution liable for rendering negligent or substandard care.[55]

In *Afrox Healthcare v Strydom*, the Supreme Court of Appeal overturned a finding of the High Court that the terms of such an exclusion clause were contra bonos mores and unenforceable by virtue of infringing s 27(1)(a), since it felt that the terms of the exclusion clause did not deny access to treatment and did not explicitly allow for the rendering of negligent or substandard care. The argument that s 27(1)(a) presupposed a minimum level of care was accordingly held not to be relevant in the circumstances.[56] While the Court was arguably correct that exclusion clauses do not themselves deny access to care or condone negligent or substandard care,[57] it failed to appreciate that such clauses prevent patients from availing themselves of their only meaningful remedy where the quality guarantee underlying their right to have access to health care services has been dishonoured.[58] This is patently

was amputated, where there is operated on the wrong patient or the wrong operation is carried out on a patient, where a patient is given the wrong medication or an over-dosage of medication, or where medical instruments are left inside the body after an operation.

54 As argued by Carstens (ibid) 26-7.

55 See Brand (note 38 above) 18. For an exposition of the relevant principles from the common law of contract, see Van Dokkum (1996) (note 50 above) 250-53.

56 *Afrox* (note 33 above) paras 13; 15; 19-21. The SCA emphasised that s 27(1)(a) would not preclude private hospitals from charging fees or from setting conditions for rendering care. See also remarks of Carstens & Kok (note 15 above) 439.

57 Refusing to admit a patient who refuses to agree to an exclusion clause may however fall foul of s 27(1)(a). Carstens & Kok (ibid) 441; 444.

58 See Brand (note 38 above) 18; Carstens & Kok (note 15 above) 444; 452; RM Jansen & BM Smith 'Hospital Disclaimers: *Afrox Healthcare v Strydom*' (2003) 28(2) *J for Juridical Science* 210, 215; Pearmain (note 5 above) 289; 300; P van den Heever 'Exclusion of Liability of Private Hospitals in South Africa' (April 2003) *De Rebus* 47-8. Such disclaimers are also incompatible with medical ethics. Carstens & Kok (ibid) 450.

incompatible with the ethos of a Bill of Rights that regards this right as justiciable and promises appropriate relief for its infringement.

Such a de facto expurgation of the common law pertaining to medical negligence from private doctor-patient relationships may clearly be avoided, by limiting the ambit of the common law understanding of freedom of contract in order for it to resonate with the values associated with s 27(1)(a) of the Constitution. It has for example been argued that, given that exemption clauses amount to a de facto waiver of the quality-guarantee underlying the right of access to health care services, private hospitals should be under an obligation to alert prospective patients to their existence.[59] I would, however, argue that exclusion clauses in hospital admission contracts should per se be viewed as being against public policy (given that the concept of public policy must be understood as also embodying the values underlying the rights in the Bill of Rights, including the various rights associated with the right to health) and as accordingly being unenforceable.[60] It is hoped that *Afrox* will not be the last word on the constitutionality of such exclusion clauses and that the SCA or the Constitutional Court will adopt an approach that is more sympathetic to the dilemma of individual patients attempting to assert their right of access to health care services against the powerful collective of the private health care sector.

IV Conclusion

In order for justiciable socio-economic rights to have meaningful significance for their beneficiaries, the rights must, in appropriate circumstances, be capable of tangibly contributing to the satisfaction of the needs that prompted their constitutional inclusion.[61] One manner in which the effectiveness of socio-economic rights may be enhanced in this respect is by allowing for the rights, or the values associated with their protection, to infiltrate the legal regulation of 'private' relationships that are crucial for their enjoyment.

In this article, I have argued for the indirect horizontal application of socio-economic rights to such relationships. I have shown that the South

59 See Jansen & Smith (note 58 above) 218.

60 See Jansen & Smith (ibid) 215-16 and authorities there cited; Pearmain (note 5 above) 299; DL Pearmain 'Contracting for Socio-economic Rights: A Contradiction in Terms? (Part 2)' (2006) 69 *THRHR* 466, 475. For a 'pure' contract-law argument to the same effect, see T Naude & G Lubbe 'Exemption Clauses — A Rethink Occasioned by *Afrox Healthcare Bpk v Strydom*' (2005) 122 *SALJ* 441, 456-57. Carstens & Kok (note 15 above) 455 call on the legislature to outlaw disclaimers in standard-form hospital admission contracts. The position of patients in this regard will likely be ameliorated somewhat by the National Health Act 61 of 2003, s 46 of which determines that '[e]very private health establishment must maintain insurance cover sufficient to indemnify a user for damages that he or she might suffer as a consequence of a wrongful act by any member of its staff or by any of its employees'.

61 See Heywood (note 6 above) 133; 147; Liebenberg (note 9 above) 159; 176; Liebenberg (note 3 above) 18; Pieterse (note 26 above) 478.

African constitutional text allows for the application of some of the obligations imposed by socio-economic rights to certain private entities, but also acknowledged that such application should, for the most part, be indirect (by way of legislative regulation and/or common law development). I then identified and elaborated upon several obligations inherent to the right of access to health care services that appear capable of such horizontal application. I proceeded to focus on the indirect horizontal impact of these obligations on the private-law regulation of the doctor-patient relationship, one of a number of 'special relationships' that is central to the actualisation of the right.[62] I provided examples of instances where the rules of common law that regulate aspects of this relationship may be developed, or applied differently, in order to give better effect to the spirit, purport and objects of the right to have access to health care services and in order to honour the State's constitutional obligation to protect individual members of society from infringements of this right by private entities.

I believe that there is significant unexplored potential for the actualisation of socio-economic rights through their indirect horizontal application. This is so, first, because of the fairly extensive body of common law principles applicable to the doctor-patient relationship and other 'special relationships' from which socio-economic obligations may flow. These rules often present a detailed and context-sensitive legal framework for the elaboration and enforcement of private socio-economic obligations and allow for the granting of effective remedies to individuals whose interests have been adversely affected by other private entities' non-compliance with these obligations. In many instances, the current state of common law already gives effect to constitutional socio-economic guarantees in this respect, or requires only minimal developments or shifts in application in order for it to do so. Secondly, South African courts are likely to be more comfortable with the evaluative and remedial paradigms associated with common law development than with the direct application of socio-economic rights. This is because South African legal culture, like legal cultures in most liberal democracies, tends to be skeptical of direct judicial involvement in socio-economic matters but accepts the judicial development of common law rules, in accordance with prevailing societal morality, as uncontroversial.[63] Common law therefore not only offers a wide array of

62 Other 'special relationships' that may be equally significant for the enjoyment of the right of access to care include the parent-child relationship, the employer-employee relationship and contractual relationships such as those between Medical Aid Schemes and their members. The values associated with the constitutional protection of the right to have access to health care services may also usefully infiltrate the regulation of these relationships.

63 On the challenges posed by liberal-democratic legal culture, and in particular the conservative South African variant thereof, for the judicial enforcement of socio-economic rights, see Pieterse (note 2 above) 396-99 and authorities cited there.

potential remedies that may amount to adequate reparation for infringements of socio-economic rights, but also provides the ideal environment for an exploration of their horizontal dimensions.

Overall, this article has shown that the legal consequences of justiciable socio-economic rights may extend beyond the effects of asserting concrete, positive claims against states in public law litigation. Since meaningful access to socio-economic amenities is often dependent on the assertion of and compliance with socio-economic claims within private relationships, the actualisation of justiciable socio-economic rights also requires the transformation of those aspects of private law that regulate such relationships. Moreover, since it cannot be denied that the effects of poverty and associated socio-economic deprivation transcend the public and private spheres, it is essential that the legal tools occupied with the alleviation thereof do the same.