DRAFT BACKGROUND PAPER - ANTI - DISCRIMINATION LEGISLATION : ACCESS TO HEALTH CARE SERVICES

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1. Introduction

The achievement of equality and non discrimination is one of the founding values of the South African Constitution.[1] Section 9 of the Constitution entrenches the right to substantive equality and guarantees to every individual the full and equal enjoyment of all rights and freedoms. Section 9(2) of the Constitution allows for legislative and other measures to promote the achievement of equality for individuals or groups who have been disadvantaged by unfair discrimination. Sections 9(3) and 9(4) further prohibit direct or indirect discrimination (policies or laws which, though neutral in their formulation, have a discriminatory impact on certain individuals or groups of individuals) on a host of grounds. The grounds on which discrimination is expressly prohibited in terms of Section 9(3) includes race, gender, sex, sexual orientation, pregnancy, marital status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, language and birth. However, it must be noted that this list is by no means exhaustive and there is nothing to preclude discrimination on any additional ground that is not included within the ambit of Section 9(3).

It must be further recognized that the prohibition of unfair discrimination clearly does not require the identical treatment of all individuals in all circumstances. In fact, it has been largely accepted that the equal and identical treatment of all individuals in a society of deeply entrenched inequalities can actually work so as to perpetuate such inequalities. It would accordingly follow that legislation and policy that appears neutral may have the effect of further entrenching persisting inequalities. This was acknowledged by the Constitutional Court in *President of the Republic of South Africa v Hugo.*[2] In this case the court alluded to a substantive conception of equality which would require an analysis of the *actual circumstances* that a group of persons found themselves in.

Section 27(1)(a) of the Constitution provides for a right of access to health care services, including reproductive health care. Section 27(2) further obliges the state to take reasonable legislative and other measures within its available resources to ensure the progressive realization of the right. In further protecting the right of access to health care services, Section 27(3) expressly provides that no one may be refused emergency medical treatment. Section 27(1)(a), when read with Section 9 of the Constitution unequivocally requires equality in the provision of access to health care services. It further requires special measures to promote the achievement of equality in access to health care services for groups who have been disadvantaged by unfair discrimination.

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[1] The Constitution of the Republic of South Africa Act 108 of 1996. Hereafter referred to as "The Constitution".
[2] Case CCT 11/96 (18 April 1997).

In terms of the Constitution, the state is required to enact national legislation to prevent or prohibit unfair discrimination within 3 years from the date on which the new Constitution took effect. (Section 9(4) read with Item 23(1), Schedule 6). This paper serves as a background paper for the purposes of such legislation. It seeks to draw attention to relevant international human rights instruments and foreign legislation as well as to highlight certain key areas where discrimination is rife in the health sector. It is suggested that these areas need to be taken account of in the formulation of anti discrimination legislation. Discriminatory provisions or practices in relation to health care services will highlighted on specific grounds of discrimination, some of which may extend beyond the list provided for in Section 9 of the Constitution.

2. International Human Rights Law

The state's obligation to ensure access to health care services on the basis of equality is reiterated in international human rights law. The Convention on the Elimination of all forms of Discrimination Against Women,[3] the International Covenant on Economic, Social and Cultural Rights,[4] the Convention on the Rights of the Child, the Convention on the Elimination of Racial Discrimination, the International Conference on Population Development, the Beijing Platform for Action and the Declaration of the World Health Organization serve to illustrate the importance of ensuring substantive equality in the realization of the right of access to health care services.

The International Covenant on Economic, Social and Cultural Rights, though still awaiting ratification by the South African government, accords express attention to the enjoyment of the highest attainable standard of physical and mental health.[5] Article 2 further obliges states parties to guarantee that the rights in the Covenant are exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Article 3 further obliges states parties to undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the Covenant.

Furthermore, whilst the UN Committee on Economic, Social and Cultural Rights has not accorded any specific attention to the right to health care, some attention has been accorded to the right in General Comments dealing with Older Persons and Persons with Disabilities. The General Comment dealing with the rights of Older Persons obliges state parties to pay particular attention to promoting and protecting the economic, social and cultural rights of older persons.[6] It further recognizes that when implementing Article 3 of the Covenant, state parties should pay special attention to older women.[7] In dealing more specifically with the right to physical and mental health of older persons, the General Comment notes that states parties should recognize that maintaining health into old age requires certain investments during the entire life span of the individual. It further stresses that prevention through regular checks suited to the needs of the elderly plays a decisive role in addressing the health needs of older persons.[8]

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[3] CEDAW was ratified by the South African government and is accordingly legally binding.
[4] The ICESCR has been signed by the South African government but still awaits ratification.
[5] Article 12.
[6] General Comment No. 6, UN Doc. E/C.12/95/16/Rev.1 (1995) at Para 13.
[7] *Ibid,* Para. 20.
[8] *Ibid,* Para. 34.

The General Comment dealing with Persons with Disabilities further obliges states parties to take appropriate measures to the maximum extent of their available resources to enable such persons to overcome disadvantages in the enjoyment of the rights recognized in the Covenant.[9] The General Comment further notes that states parties are obliged to take positive measures to reduce structural disadvantages and give preferential treatment to people with disabilities in order to achieve their full participation and equality in society.[10]

Article 10 provides that women with disabilities have the right to protection and support in relation to motherhood and pregnancy. It also expressly notes that both sterilization and the performance of an abortion, on a woman with disabilities should not be done without her prior informed consent.

In dealing specifically with the right to physical and mental health, the General Comment notes that state parties should ensure that persons with disabilities, particularly infants and children, are provided with the same level of medical care within the same system as other members of society. It further notes that the right to physical and mental health also implies the right to have access to and benefit from those medical and social services, including orthopedic devices which enable persons with disabilities to become independent, prevent further disabilities and support their social integration. Finally, it notes that all services should be provided in such a way that the persons concerned are able to maintain full respect for their rights and dignity.[11]

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which has been ratified by South Africa also accords specific attention to gender equality in the health sector. It obliges states parties to take all appropriate measures to eliminate discrimination against women in the enjoyment of "the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction."[12] It also provides that all appropriate measures should be taken by states parties to eliminate discrimination against women "in the field of health care to ensure on a basis of equality of men and women, access to health care services, including those related to family planning."[13]

Article 14 further accords express attention to rural women having access to adequate health care facilities, including information, counselling and services in family planning.

These provisions reiterate the fact that access to health care services must be provided on the basis of equality and that women's health needs are reflected within the broader ambit of the right to health.

The International Convention on the Elimination of all forms of Racial Discrimination further obliges state parties to prohibit and eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national

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[9] General Comment No. 5, UN Doc E/C.12/1994/13 (1994) at Para. 9.
[10] *Ibid.*
[11] *Ibid,* Para. 34.
[12] Article 11 (i)(f), CEDAW.
[13] Article 12, CEDAW.

or ethnic origin, to equality before the law and in the enjoyment of the right to public health, medical care, social security and social services.[14]

The International Convention on the Rights of the Child, which South Africa has ratified, obliges state parties to recognize the right of the child to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. It further provides that state parties shall strive to ensure that no child is deprived of his or her right of access to health care services.[15]

The African Charter on Human and Peoples' Rights also guarantees in Article 2, the right of every individual to the enjoyment of the rights and freedoms recognized in the Charter without any distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national or social origin, fortune, birth or other status. Article 16, in dealing specifically with the right to health provides that every individual has the right to the best attainable state of physical and mental health. Finally, the Charter obliges state parties take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

3. Comparative Law

The present section seeks to accord some attention to anti discrimination legislation relating to health care in Canada, Australia, Great Britain and the United States. It must be noted at the outset that most of these jurisdictions (with the notable exception of the USA) prohibit discrimination relating to health care in general anti discrimination legislation as opposed to in specific legislation pertaining to health care. The prohibition is generally encompassed within a paragraph dealing with the prohibition of discrimination in access to goods, services and facilities.

Australia

The Racial Discrimination Act (1975), the Sex Discrimination Act (1984) and the Disability Discrimination Act (1992) are the relevant pieces of legislation prohibiting discrimination in access to services and facilities in Australia.

Section 9(1) of the Racial Discrimination Act prohibits any act involving a distinction, exclusion, restriction or preference based on colour, race, descent, ethnicity or origin that has the purpose or effect of nullifying or impairing any human right or fundamental freedom in the political, economic, social, cultural or any other field of the public life. Section 10(1) of the Act expressly provides for general rights to equality before the law and the prohibition of discrimination in both the enjoyment of a right and the extent of the enjoyment of a right on the ground of race, colour, nationality or ethnic origin.

Section 13 of the Racial Discrimination Act prohibits discrimination with regard to the provision of services. It makes it unlawful for a person who supplies goods or services to the public or any section of the public to refuse or fail to supply these services to another person, or to do so on less favorable terms and conditions than would be supplied to other persons by reason of race, colour, national or ethnic origin of that other person, or any relative or associate of that other person. The Act defines

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[14] Article 5(e)(iv).
[15] Article 24.

"services" in Section 1 so as to include services consisting of the provision of facilities by way of banking or insurance or of facilities for grants, loans, credit or finance. However, as the definition is by no means exhaustive, it is clear that access to health care services would be included within the definition of services for the purposes of the said Act.

Section 22 of the Sex Discrimination Act also contains a similar prohibition of discrimination with regard to goods, services and facilities. It specifically provides that it is unlawful for a person who, whether for payment or not, provides goods or services, or makes facilities available, to discriminate against another person on the ground of the other person's sex, marital status, pregnancy or potential pregnancy by refusing to provide the other person with those services, or by providing them subject to terms and conditions or in a manner that is less favorable than is being provided to, to other persons. Section 1 of the Act further defines services to include the kind of services provided by a member of a profession or trade (which would clearly include the services provided by health care workers) and services of the kind provided by a government, government authority or a local government body (which would clearly include the kind of health care services provided in state hospitals or clinics).

The Act also provides for certain exceptions to the provisions relating to equality in the provision of goods and services. The most relevant exception is that relating to insurance as is provided for in terms of Section 41 of the Act. An insurance policy is defined in Section 1 of the Act as an annuity, life insurance, accident insurance or an illness insurance policy. Section 41 expressly notes that discrimination by an insurer against a client is not unlawful if:

- the discrimination is on the ground of the client's sex; and
- the discrimination is in the terms on which an insurance policy is offered to, or may be obtained by, the client; and
- the discrimination is based on actuarial data or statistical data from a source on which it is reasonable for the insurer to rely on; and
- the discrimination is reasonable having regard to the data; and
- the insurer complies with a client's a written request for access to data. (Provided the Commission has not granted an exemption from the operation of this paragraph)

Section 24 of the Disability Discrimination Act, renders it unlawful for a person who, whether for payment or not provides goods or services, to discriminate against another person on the ground of the other persons disability or a disability of any of the other person's associates. However, the section does not render it unlawful to discriminate against a person on the ground of disability if the provision of services would impose an unjustifiable hardship on the provider of the services. Services are defined in Section 1 of the Act as relating to insurance, services of the kind provided by the members of any profession or trade and services of the kind provided by a government, government authority or local government party (which would include health care services).

The Act also allows for certain exceptions to the provision of access to goods, facilities or services on the basis of equality. Section 48 of the Act does not render it unlawful for a person to discriminate against another person on the ground of the other person's disability if:

- the person's disability is an infectious disease; and
- the discrimination is reasonably necessary to protect public health.

Section 46 of the Act grants a further exemption by not rendering it unlawful for a person to discriminate against another person on the grounds of the other person's disability, by refusing to offer the other person:

- an annuity;
- a life insurance policy; or
- a policy of insurance against accident or any other policy of insurance; or
- membership of a superannuation or provident fund; or
- membership of a superannuation or provident scheme;

if

- the discrimination is based on actuarial data or statistical data from a source on which it is reasonable for the insurer to rely on; and
- the discrimination is reasonable having regard to the data and other relevant factors; or
- in a case where no such actuarial or statistical data is available and cannot reasonably be obtained - the discrimination is reasonable having regard to other relevant factors.

Canada

The national legislation prohibiting discrimination in Canada is the Canadian Human Rights Act (1976). The purpose of the Act is to ensure that all individuals have an equal opportunity to make for themselves the lives they are able and wish to have, without being hindered or prevented from doing so by discriminatory practices based on race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, disability or conviction for an offence for which pardon has been granted.[16] Section 5 of the Act makes it a discriminatory practice, in the provision of goods and services customarily available to the general public to deny or deny access to any such good, service, facility or accommodation to any individual or to differentiate adversely in relation to any individual on a prohibited ground of discrimination. However, the Act allows for discrimination to be justified if it is reasonable and in accordance with the guidelines issued by the Canadian Human Rights Commission or if there is a *bona fide* justification for that denial or differentiation.

Great Britain

The Sex Discrimination Act (1975), the Race Relations Act (1976) and the Disability Discrimination Act (1995) are the relevant pieces of legislation that prohibit discrimination in Great Britain.

Section 20 of the Race Relations Act prohibits discrimination in the provision of goods, services and facilities. The section renders it unlawful for any person concerned with the provision (for payment or not) of goods, facilities or services to the public or a section of the public to discriminate against a person who seeks to obtain use of these goods, services or facilities by refusing or deliberately omitting to provide them or by

[16] Article 2.

refusing or deliberately omitting to provide them of the quality, manner or on the terms on which they are provided in relation to other members of the public or members of a particular section of the public. Included within the examples of services and facilities in the section, are the services of any profession or trade or any local or other public authority (which would clearly include the services of health care workers).

The Sex Discrimination Act contains a similar provision prohibiting discrimination in the provision of goods, services or facilities on the grounds of sex or gender.

The purpose of the Disability Discrimination Act is to ensure that disabled people have the same rights as everyone else, particularly in the field of employment, housing, education, public transport, and provision of goods and services. It prohibits discrimination on the ground of disability in the provision of goods, facilities or services to members of the public, whether paid for or free. The Act renders it unlawful to refuse to serve someone who is disabled or to offer a disabled person a service which is not as good as the service being offered to other people. It also prohibits the provision of a service to a disabled person on terms which are different to terms given to other people. Finally, the Act provides for certain exceptions, if the equal provision of goods, services and facilities would endanger the health and safety of the disabled person or other persons, if the customer was not capable of understanding the terms of the contract, or if providing a service of the same standard would deny the service to other persons.

However, the Disability Discrimination Act has been criticized for introducing a more limited form of protection for people with disabilities than other equality legislation has provided for other vulnerable groups. The criticism has related largely to the terminology used in the Act. For example, the Act makes reference to a "substantial" disability and protection against "unjustifiable" discrimination. The critics have argued that such terminology imposes a more stringent burden of proof than would otherwise be required, and is accordingly problematic.

The United States

Unlike the other jurisdictions that have been examined, the United States has legislation that deals more specifically with equality in the health sector. The Health Insurance Portability and Accountability Act of 1996, although it deals with numerous issues, accords specific attention to discrimination relating to health insurance. The Act applies to all health insurance plans in the country.

Firstly, the Act demands that all age groups from 2-50 must be offered guaranteed issue by all insurance companies offering coverage within the US. Persons over the age of 51 can be underwritten and declined coverage, but once coverage is approved it cannot be withdrawn due to health status or age. Furthermore, health status, physical or mental medical condition, claims experience, genetic information, disability or domestic violence of an individual, group of individuals or dependents cannot be used to justify higher premiums or refusal to an health insurance plan. All members within a particular age groups are accordingly liable for the same amount in premiums, which is calculated on the basis of an average within a particular group.

Secondly, the Act has defined a pre existing condition in a more limited way than had previously been defined. A pre existing condition is defined as a "condition for which medical advice, diagnosis or treatment was received or recommended within the previous 6 months and does not include pregnancy." Coverage for a pre existing condition may not be excluded for more than a 12 month period. Hence, whilst a pre existing condition may justify a 12 month exclusion period, it will not justify a total denial of access to medical insurance or the payment of higher premiums. Finally, an exclusion may not be applied to a new born or adopted child.

4. Types of Inequalities in the Health Sector that Should be Reflected in Anti Discrimination Legislation

This section aims to provide an indication of some of the areas where discrimination is rife or potentially rife in the health sector. It does by no means seek to provide a comprehensive insight of such areas but, serves as an indication of certain aspects that should inform the drafting of anti discrimination legislation in the context of health care services.

Discrimination on the Ground of Gender

In spite of the express prohibition of discrimination on the ground of gender in terms of both the Constitution and international human rights law, gender discrimination in access to health care services is still prevalent in South Africa. In the context of women's access to health care, factors relating to the low social standing of women in society is critical. The lower levels of education that many women have which ultimately results in higher levels of illiteracy among women, the working environment that many women find themselves in and the exceedingly high levels of violence against women all contribute to an overall pathetic state of women's health. These factors unequivocally result in women being more vulnerable to certain health risks.

It must be further recognized that South African women are clearly not an homogenous group, but rather divided along the lines of race, class, age, sexual orientation, marital status, geography (i.e. rural/urban) and ability. These factors result in certain groups of women facing added barriers in gaining access to health care services which must be acknowledged and addressed in the context of anti discrimination legislation.

It must be further acknowledged that women have different body shapes, organ size and volume, and distribution of fat. As a result, health problems need to be analyzed and addressed from the perspective of women. For instance, certain diseases or conditions may affect women and men differently, there are different risk factors for men and women, certain diseases or conditions are unique, more prevalent or serious to women or some groups of women, and forms of intervention may accordingly differ for women and men.

In the formulation of equality legislation, due recognition should accordingly be attributed to the wide range of means that exist to ensure equal access to health care services for women in the international arena. These would include, but are not limited to:

- Safeguards against coercive practices impairing women's freedom of choice regarding health care.

- Elimination of spousal authorization practices. Whilst spousal authorization is not a legal requirement in South Africa, practice has indicated that many health clinics still require spousal consent for contraception and sterilization.[17]
- Development of research protocols reflecting women's health needs and circumstances. South African as well as comparative research has indicated that health research very often reflects a male bias which should be addressed in anti discrimination legislation.
- Adoption and enforcement of safeguards against occupational health hazards. Although many women work from home, they experience no fewer health hazards than those in "formal" employment. Safeguards against occupational health hazards in the home are accordingly necessary.
- Delivery of services, education and counseling to women in groups of high risks of maternal mortality or morbidity.
- Delivery of a full spectrum of health care services including services in connection with reproductive and sexual health on the basis of equality. For example, reproductive tract infections are a frequent problem for poor women which often go undiagnosed and untreated. Furthermore, social factors which contribute to the spread of HIV/AIDS, reproductive tract infections and sexually transmitted diseases include the increase in commercial sex work, the shame and secrecy surrounding reproductive tract infections and sexually transmitted diseases and consequently the low priority given to their prevention and treatment in terms of resource allocation. Furthermore, diagnosis is not easy and treatment can be expensive. Matters are further complicated by the non availability of treatment for reproductive tract infections as part of the mother and child health or family planning services. Asymptomatic STD's are also far more common in women than men. Yet there are no screening programmes for asymptomatic STD's in place. The impact of cervical cancer and breast cancer must also be recognized. Although the most common cancers for women in South Africa are cervix, breast and skin, there is no public national breast or cervical cancer screening programme. In view of this reality, it is vital that adequate attention and resources are allocated to such areas so as to adequately reflect gender equality in the provision of access to health care services.
- Addressing problems faced by women as providers of health care within the formal health sectors and as informal carers at home. For example, the nursing profession which is predominated by women, is economically exploited. Similarly, research has indicated that women form the majority of traditional healers, yet the practice of traditional healing is not formally recognized in South Africa.
- Education to eliminate gender stereotyping and measures to ensure women's capacity to influence decision-making processes concerning health policy.
- Furthermore, although the prevalence of female genital mutilation in the South African context is as yet unknown, evidence of its mere existence demands that its particular effect on women's right to equality should be acknowledged and addressed.
- As South Africa has no national medical insurance system, a small proportion of the public are members of private medical aid schemes. Few of these presently cover abortion-related services.[18] Furthermore, comparative research has indicated that many medical aid schemes bear a male bias in terms of the illnesses or diseases

[17] See the South African Country Report on the Implementation of CEDAW.
[18] See the South African Country Report on the Implementation of CEDAW.

that are covered. For example, certain medical aid schemes have been found to cover prostrate cancer but not cervical or breast cancer. Such schemes clearly bear a discriminatory impact on women and need to be researched and addressed.

- Finally, the principles of gender equality need to be reflected in the allocation of resources. This is particularly problematic in view of the recent Constitutional Court decision that allowed for resource constraints to justify a hospital's decision not to provide a patient with certain treatment.[19] It is important that the principles of gender equality are not compromised in access to health care when a lack of resources is used as a justification.

Discrimination on the Ground of Sexual Orientation

In spite of the express constitutional prohibition of discrimination on the ground of sexual orientation, practice has indicated that access to health care services is often compromised on the basis of an individual's sexual orientation. For instance, because gays and lesbians fear the prejudice of health workers, they either stay away from health care workers or avoid disclosing relevant information about their sexual orientation. This ultimately means that they do not get the health care they need.

Furthermore, because lesbians are less likely to have children, they are at greater risk of developing cancer of the breast, ovaries and lining of the womb. In addition, lesbians do not have access to pap smears within the public sector as these are available only to women who visit family planning clinics or ante natal clinics. As lesbians do not need contraception and do not often become pregnant, they are denied this form of testing for cancer.[20] It is accordingly critical that an individual's sexual orientation does not compromise his/her access to health care services.

Furthermore, the partners of many same-sex couples are denied access to medical insurance. Due to the unduly restrictive definition of a "dependent" in terms of many medical aid schemes, many same-sex partners do not qualify for access to such schemes. Although the issue was recently brought to the fore in *Langemaat v Minister of Safety and Security,*[21] it is vital that anti discrimination legislation expressly prohibit such discrimination.

Discrimination on the Ground of Age

In spite of the constitutional prohibition of discrimination on the ground of age, many individuals are still denied access to medical aid schemes on the basis of their age. For instance, most medical aid schemes in South Africa require that the applicant be below the age of 55 years in terms of an eligibility criteria. Should an individual not meet the age criterion, there is absolutely no possibility of gaining access to such medical aid scheme. In short, neither the health status of the individual nor the possibility of "loaded" premiums are taken account of.

This prevailing policy of most medical aid schemes is particularly problematic for 2 reasons. The first represents the very basis for such exclusion, the fact that an individual's health deteriorates with age. As a result, persons above the age of 55 whilst more susceptible to adverse health conditions, face greater difficulties in gaining

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[19] *Soobramoney v Minister of Health (Kwa Zulu Natal) CCT 32/97,*

[20] Goosen and Klugman (eds.) The South African Women's Health Book (1996) at page 484.

[21] Case number 19077/97

access to state health care services. For instance, transport costs, waiting in long queues and the overall inconvenience in gaining access to state health services impinges on many peoples right of access to health care services. Furthermore, as the *Soobramoney* case recently revealed, access to state health care does not necessarily guarantee access to all required health services. An individual may accordingly be denied access to certain treatment at state expense on the basis of resource constraints.

The second problem with the age criteria relates to the retirement of many individuals in society. As many people tend to retire at the age of 55, their medical aid which is subsidized by their employer is also terminated. Due to the age criteria for access to private medical aid schemes, such persons are denied access to alternative medical aid schemes. As a result, most people are denied access to medical aid schemes at an age when they are most vulnerable to adverse health conditions on account of their age.

Whilst the obvious rationale for this age eligibility criterion of the medical aid scheme can be understood, the possibility of it being justified in terms of the limitation clause is unlikely. It is accordingly suggested that further research be undertaken into the possibility of certain variables being used to determine eligibility, as opposed to a blanket requirement relating to age. These should include the possibility of "loaded premiums", the health status of the individual at the time of applying for such medical aid, and the reasons for the application being made at that particular time, for example the fact that an individual's medical aid was terminated due to retirement.

Discrimination on the Ground of Birth Weight

Recent articles in the press have indicated a prevalent discriminatory policy relating to the birth weight of new born babies. In terms of the internal policies of many hospitals, new born babies have to weigh in excess of 1 000 grams before they will be provided with access to respiratory systems at a hospital. Due to resource constraints, many hospitals claim that it is not financially viable for babies weighing less than 1000 grams to gain access to respiratory systems.

Whilst some may argue that the policy is justified on the basis of the limited resources that the health care system is operating within, it must be recognized that it has a particularly detrimental impact on certain groups in society. For instance, research has indicated that approximately 16% of babies born to poorly nourished mothers will have low birth weight.[22] The birth weight criteria is accordingly closely related to the mother's level of nourishment, with the inevitable consequence of poor women's children having a lessor chance to live than those in better socio economic circumstances. Policies of this nature may accordingly constitute indirect discrimination against poor mothers and requires further research and revision.

Discrimination on the Grounds of Religion, Culture and Belief

South Africa has numerous traditional health workers. These include traditional healers and traditional birth attendants. Although no statistics are available, it is clear that the

[22] See the South African Country Report on the Implementation of CEDAW.

majority of traditional health workers are women.[23] Furthermore, research has indicated that one in every 300 South Africans across the religious spectrum consult a traditional healer. However, in spite of this, traditional healers and traditional forms of medicine are currently not recognized or regulated in any formal way. The absence of such regulation leaves the practice of traditional healing open to abuse as well as undermines a form of healing and medicine that is utilized by a significant portion of the South African population. Whilst the possibility of a separate statutory council to govern traditional healers is currently being debated, at present no such council exists. The absence of any formal regulation further creates an implicit hierarchy that operates in favour of Western forms of medicine and healing to the exclusion of forms of healing and medicine that is relied upon by persons of different religions, cultures and beliefs.

Discrimination on the Ground of HIV/AIDS

Pre Employment Testing

Numerous rationales are used to justify pre employment HIV testing and to legitimate workplace discrimination on the basis of HIV. These broadly relate to concern over employers' rights such as freedom of choice as to whom to employ; workplace transmission; impaired occupational capacity arising from HIV related causes; the costs of including people with HIV in the workforce and problems of providing benefits to persons with HIV. However, equally strong rationales exist against HIV pre employment testing. These broadly relate to infringing on the employees right to privacy and facilitating unfair discrimination. It must be noted that whilst a pre employment HIV test on its own may not violate the right to equality, or constitute unfair discrimination, knowledge of HIV status is likely to discourage an employer from making an offer of employment to an otherwise qualified applicant. Unfair discrimination on this basis may violate the right to equality of the applicant for employment.

However, at present there is no statutory prohibition on pre employment testing in South Africa. The South African Law Commission has recently released three interim reports on Aspects of the Law Relating to AIDS. The recommendations emanating from these reports will be encapsulated in legislation. However, it remains an open question as to whether this will be done in the form of a separate statute or as part of existing or prospective labour legislation. Nevertheless, it is critical that anti discrimination legislation make similar reference to the necessary provisions.

The South African Law Commission has recommended the adoption of a specific statute in order to regulate those instances where an employer may ask an applicant for employment to take an HIV test and to prevent an employer from refusing an individual employment on the grounds of that individual's HIV status or perceived HIV status unless such refusal is deemed fair and justifiable. Justification for testing should be based on medical facts, employment conditions, social policy, the fair distribution of employee benefits and the inherent requirements of a particular job. All these factors should be considered jointly and individually in ascertaining whether testing is fair and justifiable.

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[23] See the South African Country Report on the Implementation of CEDAW.

It has further recommended that specific jurisdiction be given to the Labour Court to determine under what circumstances HIV testing or taking HIV status into account in hiring may be permissible. Finally, the Law Commission has suggested that the employer bear the onus of proof in demonstrating that it is fair and justifiable that the employee or prospective employee undergo an HIV test or be refused employment on the grounds of that individual's HIV status. In short, the Law Commission has recommended that while the employer's rights are recognized, they are limited by prohibiting pre employment testing for HIV except where such testing is reasonably, justifiably and rationally warranted. This approach accords with the approach taken in many other comparable jurisdictions such as the USA.

HIV/AIDS and Discrimination in Schools

The South African Law Commission has also proposed a draft national policy on HIV/AIDS in schools. A policy dealing with HIV/AIDS discrimination in schools needs to reflect a delicate balance between the rights of learners with HIV and those without HIV. The draft national policy recognizes that compulsory testing of learners as a pre requisite for admission to any school, or any unfair discriminatory treatment (such as refusal of continued school attendance on the basis of the HIV status of the individual) is not justified. It further recognized that special measures in respect of learners with HIV may be necessary. These must be fair and justifiable in the light of medical facts, school conditions and the best interests of learners with and without HIV. It further confirms the learner's rights to privacy. Where HIV related information is disclosed to a member of staff, the policy provides that, except where statutory or other legal authorization exists, such information may be divulged only with the informed consent of the learner (above the age of 14 years) or in other cases with the consent of the guardian.

The national policy further calls for all schools to implement standard precautionary measures aimed at the prevention of HIV/AIDS to exclude the risk of transmission of HIV in all school environments. It further gives all learners the right to be educated on HIV/AIDS, sexuality and healthy lifestyles in order to protect themselves against the HIV infection. Finally, the policy allows for school governing bodies to adopt an HIV/AIDS policy at school level to give operational effect to the national policy. This would however have to take place within the framework of national policy.

It is suggested that the key provisions of this policy be incorporated in the anti discrimination legislation.

Discrimination in Gaining Access to Medical Insurance on the basis of Pre existing Conditions

A standard requirement for access to most health insurance schemes relates to the medical history and existence of possible pre existing conditions of the applicant. Should there be any disclosure or evidence of the existence of a pre existing condition, the applicant is either denied access to medical aid or is faced with "loaded premiums" for such medical aid. The most convincing reason for this policy is the need to ensure that those in low risk categories are not having to subsidize the health needs of those in high risk categories. Another reason relates to the survival of the insurance industry. For example in 1986 many insurers gave up doing business in the US District of Columbia which enacted the *Prohibition of Discrimination in the Provision of Insurance*

Act. The Act prohibited health, life and disability insurers from discriminating on the basis of HIV/AIDS. However, on the other hand an applicant with a pre existing condition may claim that his/her rights to equality are violated on the ground of such pre existing conditions should he/she be denied access to medical insurance or be subjected to higher premiums.

As has been noted, the Australian Sex Discrimination Act contains a general exemption from discrimination in insurance provided the discrimination is based on actuarial or statistical data from a source on which it is reasonable for the insurer to rely and the discrimination is reasonable having regard to those data and any other relevant factors. In other words, discrimination is permitted in the insurance field subject to a reasonableness test.

The Health Insurance Portability and Accountability Act in the US has limited exclusions for pre existing conditions and prohibited discrimination based on health status as has been noted.

A further alternative which has been proposed is for health insurance discrimination to continue, but to subsidize from public funds, the premiums of people disadvantaged by discrimination. This option may prove particularly problematic in the South African context in light of the limited availability of resources.

As is evident, insurance discrimination is particularly contentious and requires extensive research, before the problem is addressed. For the present purposes, suffice it to note that there is discrimination in access to insurance on the basis of pre existing conditions. Depending on the fairness of such discrimination, alternatives may be required.

5. Some Suggestions for South African Anti Discrimination Relating to Health Care Services

In view of the international human rights instruments referred to, the comparative approaches that have been examined as well as discriminatory practices that are prevalent or potentially prevalent in the health sector in South Africa, it is clear that a broad range of issues need to be taken account of in the formulation of anti discrimination legislation. The present section, whilst by no means comprehensive, seeks to highlight some of the key issues that should be addressed in anti discrimination legislation.

Firstly, it must be recognized that legislation that seeks to treat all person equally in a society of deeply ingrained structural inequalities will not achieve the goal of equality. Whilst it is clearly impractical to suggest that each person be treated in accordance with a specific need, equality legislation clearly should accord special attention to certain vulnerable groups who are in need of special measures so as to ensure their access to health care services.

It must be further recognized that equality legislation cannot be formulated in isolation from the relevant stakeholders. For example, the White Paper on Health has, as one of its fundamental objectives, the achievement of equality in access to health care services and a recognition of special measures that are required for certain groups of

individuals. The Law Commission processes relating to HIV/AIDS and discrimination provides another example of the need for collaboration in the formulation of anti discrimination legislation. It is accordingly recommended that anti discrimination legislation is formulated in a consultative and collaborative way so as to avoid duplication or a conflict of laws on the relevant issues.

In the actual formulation of anti discrimination legislation, it is important that cognizance be taken of the different options that exist. For example, it may be formulated as a single comprehensive piece of legislation dealing with all of the different grounds on which discrimination is prohibited as well as the various areas of conduct that are governed by such legislation as was evident in the Canadian approach. Alternatively, there may be different pieces of legislation in accordance with the different grounds of discrimination, as is done in Australia and the UK. A final option might be different pieces of legislation dealing with specific areas of prohibited discrimination, similar to the Health Insurance Portability and Accountability Act in the US. It is suggested that the first approach be adopted for South Africa at present. Once in force, the possibility of particular equality legislation dealing with specific rights such as health care in a more in-depth way should be investigated. The suggestion is based on the numerous criticisms of a fragmented approach resulting from the other two alternatives.

Once the specific approach to be used in formulating legislation has been determined, the particular grounds on which discrimination is to be prohibited must be outlined. Whilst Section 9(2) of the Constitution lays down certain clear grounds on which discrimination is prohibited, as has been noted, this list is by no means an exhaustive one. Attention should therefore be accorded to any additional grounds that may be included in anti discrimination legislation. For instance, it is suggested that the socio economic standing of an individual or group of individuals as well as the birth weight of new born babies are included as additional grounds on which discrimination is prohibited. The possibility of prohibiting discrimination in access to medical insurance on the ground of pre existing medical conditions should also be further investigated.

Attention should further be accorded to the implication of the terminology that is used in drafting anti discrimination legislation. The Disability Discrimination Act in the UK for instance has been criticized for the stringent terminology used which may result in negating the underlying purpose of the Act.

The implications of resource constraints in ensuring access to health care services on the basis of equality should also be borne in mind. Since access to health care services in the Constitution is subject to the internal qualifier of "within its available resources," it is important that resource constraints not be used so as to justify and perpetuate unequal access to health care services in South Africa. For example, should resource constraints be used to justify the non availability of treatment for cervical or breast cancer, it would bear a disproportionately detrimental impact on women rights of access to health care services. It is accordingly vital that anti discrimination legislation reflect the need for resources to be allocated in a way that does not compromise the attainment of equality in access to health care services.

The examination of equality legislation in other jurisdictions has also revealed the importance of such legislation applying to equal access to both free and paid services. For example, the fact that pregnant women and children under the age of six gain

access to free health care in South Africa should not preclude them from the ambit of equality legislation.

Furthermore, it is important that anti discrimination legislation provides for both equal access to health care services as well as the conditions or terms relating to such services as was evident in many of the foreign jurisdictions examined.

Finally, it is suggested that the various practices referred to in the course of this paper, which have implications for equal access to health care services be recognized, thoroughly investigated and addressed in the formulation of equality legislation. The relevant international human rights instruments and the Constitution should form the framework within which the aforementioned issues are addressed in the context of anti discrimination legislation.