Tracking South Africa's progress on health care rights: Are we any closer to achieving the goal?[*]

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> *I sometimes wonder whether there is any way of making poverty terribly infectious. If that were to happen, its general elimination would be, I am certain, remarkably rapid.*[1]
>
> Nobel Laureate Amartya Sen

1 INTRODUCTION

'Health for all by the year 2000' was the call of the World Health Organisation (WHO) 20 years ago. Yet in the year 2002, South Africa is still grappling with the legacy of discriminatory and oppressive apartheid policies that pose an ongoing challenge to the health of its people. It is facing a crisis of phenomenal proportions with a significant decline in the average life expectancy of its people.[2] While this decline can to a large extent be attributed to the HIV/AIDS pandemic, on a national level, factors such as the legacy of apartheid, poverty, malnutrition and violence are also largely responsible.

The global context within which health rights are being realised has also contributed to the current crisis. The forces of the globalised market economy have widened the gap between rich and poor, both between and within countries and regions. Health policy, it is said, is part of this global trend.[3] It has been argued that in recent years formal health care services have become increasingly inaccessible for growing numbers of people. The deepening poverty in many nations as well as the costs of basic health care have resulted in a systematic shift in many aspects of health financing from the public sector to the individual consumer.[4]

The growing health disparities between the rich and the poor was acknowledged as follows by the WHO:

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[1] Sen 1995: 21.

[2] Statistics South Africa (SSA) estimates that the life expectancy in 1996 was 52.1 years for men and 61.6 years for women. SSA 1999 "Mid year estimates 1999. Statistical Release PO302" <www.statssa.gov.za/Statistical-releases/Statistical_releases.htm> Accessed 5 January 2002. The Medical Research Council estimates that as a result of the AIDS epidemic, life expectancy has dropped from 63 in 1990 to 57 in 2000 (Timaeus 2000 cited in Bradshaw et al 2000). It is significant that the declining life expectancy in South Africa as with many other African countries is inconsistent with the overall life expectancy in the world, which has increased by 17 years in the last century. See Millen et al 2000: 5.

[3] Werner 1997: 7.

[4] Ibid.

> Never have so many had such broad and advanced access to health care. But never have so many been denied access to health. The developing world carries 90% of the disease burden, yet poorer countries have access to only 10% of the resources that go to health.[5]

Access to health care services in South Africa, as with many other fundamental necessities, has historically been skewed in terms of race, gender, socio-economic status, sexual orientation, disability and a number of other arbitrary grounds. Systems, structures and institutions established to deliver health care services have historically reflected – and continue to reflect – a disproportionate bias in favour of dominant groupings in South African society.

The racist and oppressive apartheid regime manifested itself in every aspect of health. It resulted in:

> …rigid segregation of health facilities; grossly disproportionate spending on the health of whites as compared to blacks, resulting in world class medical care for whites while blacks were usually relegated to overcrowded and filthy facilities; public health policies that ignored diseases primarily affecting black people; and the denial of basic sanitation, clean water supply, and other components of public health to homelands and townships. Health services were deliberately fragmented to perpetuate discrimination. Race bias affected health research and even the keeping of health statistics.[6]

In an attempt to address this legacy of apartheid in the health sector and in accordance with its recognition of fundamental human rights,[7] the South African Constitution[8] has, in section 27(1)(a), entrenched the right of access to health care services, including reproductive health care services. Section 27(2) obliges the state "to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation" of, among others, health care rights. Section 27(3) provides that no-one "may be refused emergency medical treatment". Section 28(1)(c) of the Constitution entitles every child to the right to basic health care services.[9] In addition, section 24(a) recognises the right to an environment that is not harmful to health or well-being.

Since the adoption of the 1996 Constitution, there have been a limited number of cases in which the right of access to health care services has been invoked.[10] As a result, there is a relative scarcity of judicial authority in South

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[5] WHO 1998.

[6] Chapman & Rubenstein 1998: xix.

[7] The constitutional recognition of health care rights was seen as fundamental to the welfare and human dignity of everyone in South Africa as well as being in line with the international recognition of health rights.

[8] The Constitution of the Republic of South Africa Act 108 of 1996.

[9] The focus of this chapter is be limited to ss 27(1)(a) and 27(2).

[10] *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC), 1997 (12) BCLR 1696 (CC); *B and Others v Minister of Correctional Services and Others* 1997 (6) BCLR 789 (C); *Treatment Action Campaign and Others v Minister of Health and Others* 2000 BCLR (4) 356 (T); *Afrox Health Care Beperk v Strydom SCA* (unreported at the date of writing) case no. 172/2001.

Africa on the interpretation of this right. However, in the recent case of *Government of the Republic of South Africa and Others v Grootboom and Others*[11] (hereinafter referred to as *Grootboom*), the Constitutional Court dealt, for the first time, with the interpretation of the right of access to adequate housing as entrenched in section 26 of the Constitution. Although this case did not directly deal with the right of access to health care services, the judgment has certain clear implications for the latter right. This was made explicit by the Constitutional Court in its subsequent decision of *Minister of Health and Others v Treatment Action Campaign and Others*[12] (hereinafter referred to as *TAC*), where much of its reasoning on housing rights was reiterated in respect of health care rights.

Although there are numerous aspects of the Court's interpretation in both these cases that can provide valuable guidance, the focus of this chapter is limited to the Court's criteria in respect of the reasonable measures the state is obliged to take to realise socio-economic rights. These were first enunciated by the Court in *Grootboom* and later confirmed in the *TAC*[13] decision. In this regard, the Court in *Grootboom* noted as follows:

> The programme must be capable of facilitating the realisation of the right. The precise contours and content of the measures to be adopted are primarily a matter for the legislature and the executive. They must however, ensure that the measures they adopt are reasonable.[14]
>
> Policies and programmes must be reasonable both in their conception and their implementation. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the state's obligations.[15]

In line with the Court's approach, this chapter addresses the following two questions:

1. Does the legislative, policy and programmatic framework adopted by the government to give effect to the right of access to health care services represent a reasonable measure aimed at realising this right?
2. Are the relevant laws, policies, and programmes being reasonably implemented?

In order to do justice to the aforementioned objectives, the chapter begins by examining the definition of health care services. It then examines the concept of 'reasonableness' in light of both the *Grootboom* and *TAC* judgments as well as relevant international human rights law, and attempts to extrapolate certain guiding principles that should inform the standard against which access to health care services are measured in South Africa. The final two sections of the chapter

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[11] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC), 2000 (11) BCLR 1169 (CC) (hereafter *Grootboom*).

[12] *Minister of Health and Others v Treatment Action Campaign and Others* 2002 (5) SA 721 (CC), 2002 (10) BCLR 1033 (CC) (hereafter the *TAC* case).

[13] *Grootboom*, *supra* note 11, para. 100.

[14] Ibid. para. 41.

[15] Ibid. para. 42.

deal with an analysis of the policy, legislative and programmatic framework and its implementation. The concluding observations ultimately seek to assess the extent to which both the theoretical framework for realising health care rights and its implementation accord with the criteria laid down in the *Grootboom* and *TAC* cases and in relevant international law principles.

2 DEFINING HEALTH CARE SERVICES

Unlike the way in which health rights are generally protected in international instruments[16] or many other foreign jurisdictions,[17] the South African Constitution includes a right of access to health care *services*. In examining how one should define the term 'health care services' the WHO's definition of health proves an instructive starting point:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[18]

It is clear that the WHO definition extends beyond that anticipated by the South African Constitution, which refers much more narrowly to health care *services*. In order to sustain a state of overall well-being as envisaged by the WHO, there are numerous preconditions for health. These include sufficient water of adequate quality for consumption and hygienic purposes, a clean and healthy environment, adequate nutrition, adequate housing, education and a life that is free from poverty. Many of these preconditions for health are recognised in the South African Constitution itself, mainly in the form of other socio-economic

[16] Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) protects a right to the enjoyment of the "highest attainable standard of physical and mental health". It obliges states parties to take steps to ensure the full realisation of the right which must include measures necessary for: the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the creation of conditions which would assure to all medical service and medical attention in the event of sickness. Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination prohibits discrimination in respect of the right to public health, medical care, social security and social services. Article 12(1) of the International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) obliges state parties to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Article 24(1) of the Convention on the Rights of the Child recognises the right of the child to the "highest attainable standard of health". It further obliges state parties to strive to ensure that no child is deprived of his or her right of access to health care services. Article 16 of the African Charter on Human and Peoples' Rights accords to every individual the right to enjoy the "best attainable standard of physical and mental health."

[17] For example, the Constitutions of Ecuador and Suriname contain a right to health protection. Brazil, Dominican Republic, El Salvador, Haiti and Uruguay oblige their respective states to protect health. The Finnish Constitution protects a right to health services and the promotion of the health of the population. The Hungarian Constitution protects the right to the highest level of physical and mental health.

[18] WHO Constitution, in WHO 1986.

rights.[19] There is also a direct correlation between poverty, a lack of access to social and economic rights, and health status.[20] Studies have shown that lower levels of education and a lack of clean drinking water, adequate nutrition, sanitation and adequate housing adversely impact on a nation's health status.[21] In other words, health care services are necessary but clearly not sufficient for health.[22] While this chapter recognises this correlation between health status and other social goods, it focuses more specifically on access to health care services, which is but a single strand of the broader health rights that are internationally recognised.

Even in limiting the focus to health care services, the central question is to what, exactly, the right entitles its beneficiaries. The complexities of the question have been acknowledged as follows:

> The benefits of health care vary in importance, from the preservation of life to the elimination of minor inconvenience, and some highly beneficial care is extremely costly. Society's resources are limited. To guarantee universal access to all care of any benefit would be prohibitively expensive, compromising the ability to spend resources on other important social goods which might even have more impact on health through, for example, better nutrition or safer transportation. It seems reasonable to conclude that society must guarantee access only to a limited level of care.[23]

In defining 'health care services' as provided for in section 27(1)(a) of the Constitution, it is accordingly important that the gain made through the adoption of the WHO definition, specifically the expansion of the understanding of health beyond the narrow biomedical model, is retained. However, it is equally important that this gain is balanced by a definition of health care services that is sufficiently precise to be able to give meaningful effect to section 27(1)(a) of the Constitution.

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[19] Section 26 of the Constitution includes the right of access to adequate housing, s 27(1)(b) provides for the rights to sufficient food and water, s 27(1)(c) includes the right to social security and s 29 protects the right to education.

[20] "The most recent assessment of health of 191 countries shows that, in general, richer countries have higher life expectancies than poor countries. The gap in life expectancy is of the order of 40 years. A detailed analysis of the burden of disease at a global level has shown that the poorest 20% of the world's population experienced higher death rates than the richest 20% and it was estimated that 70% of the deaths among the poor could be considered to be an excess if they had experienced the same death rates as the rich. In particular, more than 90% of the deaths due to infectious diseases and maternal causes and 32% of the deaths due to non-communicable diseases could be considered excess." Bradshaw D et al 2000: 90. See also Chopra et al 2001: 16, where the authors note that their study revealed that the nutritional status of children deteriorated at home because of poverty and insufficient food. This, the authors submit, adversely affects their immunity which when combined with the lack of safe water and sanitation, makes these children vulnerable to diarrhoeal disease and other infections.

[21] Bradshaw et al 2000: 124.

[22] Mann et al 1999: 8.

[23] Baily 1994: 167.

This balance has to a large extent been reflected through the primary health care approach, which was articulated at the international WHO-UNICEF meeting on primary health care in Alma Ata in 1978, as follows:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the communities through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination.[24]

The primary health care approach reflects an emphasis on the following key elements: equitable distribution, community involvement, focus on prevention, appropriate technology and a multi-sectoral approach.[25]

Having regard to the above elements that are important to an understanding of health care services, I am of the view that the following three aspects of health should be addressed:

1. The specific health needs that should be included within the ambit of section 27(1)(a).
2. The levels at which health care services should be provided.
3. The specific types of health care services that should be included in the definition.

Each of these specific issues will be dealt with individually.

2.1 Health needs

It is important that a definition of health care services takes account of health needs that must be addressed. In particular, it has been said that individual health needs determines the type, amount and quality of health care services that should be rendered.[26]

The WHO definition refers to "physical, mental and social well-being". The focus on mental as well as physical health represents a significant and important focus on the overall health of individuals. While health has historically focused on physical needs, mental health has for decades been a neglected area in spite of its particular relevance for South Africa. The *White Paper for the Transformation of the Health System in South Africa*[27] (hereafter the *White Paper on Health*) recognises that it often manifests itself in interpersonal violence, gender and age-specific forms of violence, trauma, neurosis of living under continual stress, post-traumatic stress reactions and disorders, substance abuse, suicide and adjustment related reactions and disturbances in children and the elderly.[28]

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[24] Declaration of Alma Ata, 1978, para. vi.

[25] Walt & Vaughan 1981: 23.

[26] Baily 1994: 169.

[27] Department of Health 1997 "White Paper for the Transformation of the Health System in South Africa" <www.gov.za/whitepaper/1997/health> Hereafter referred to as the *White Paper on Health*.

[28] Ibid. 135.

In respect of social well-being, it is submitted that the concept as recognised by the WHO is of very limited value to a definition of health. It is an amorphous and relative concept and there are many other socio-economic rights in the Constitution that are, in any event, aimed at ensuring social well-being.

2.2 Level of service

Health services have traditionally been divided into primary, secondary and tertiary levels. Primary care is the first point of contact with the formal health service. It generally includes maternal and child care, prevention and control of locally endemic diseases, immunisation against the main infectious diseases and appropriate treatment of common diseases and injuries. Secondary health care is of a more specialised character and includes, for example, radiographic diagnosis, general surgery, and care for women with pregnancy or childbirth complications. Tertiary care is generally considered to be the most specialised form of health care services. It includes neurosurgery and heart surgery.[29]

In order to meet the mental and physical health needs identified above, it is vital that health care services are provided at primary, secondary and tertiary levels.[30] It is also critical that there are efficient and workable referral systems between the different levels of care.

An issue often facing the delivery of health care services at different levels is the allocation of resources and their impact. For instance, South Africa's tertiary health care services were historically extremely well funded but basic, essential health care services were said to be deficient for the poorer two-thirds of the population. South African health policy[31] has accordingly recognised the need to redistribute resources from tertiary level care to primary level care. It recognises the latter to be "most effective, most cost effective and the means to achieve better health".[32] However, health policy recognises that such allocation of resources is often contrary to popular demand for high technology hospitals providing curative care. Hence, it should be acknowledged that while there is both national and international consensus on the value of primary level care, in practice different levels of care often compete for limited resources.

2.3 Types of service

Section 12(2)(c) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) refers to the prevention, treatment and control of diseases.

In its commentary on this section, General Comment No. 14[33] provides that the right to health facilities, goods and services should be understood as:

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[29] Toebes 1999: 247.

[30] This distinction between the three levels of health care services is also sometimes distinguished as primary health care services being the basic first level of entry into the health system, secondary care being hospital care and tertiary care being specialised care. Nadasen 2000: 12.

[31] *White Paper on Health*, *supra* note 27, chapter 3.

[32] Ibid. 42.

[33] General Comment No. 14 (Twenty-second session, 2000) *The right to the highest attainable standard of health (art 12 of the Covenant)* UN doc. E/C.12/2000/4.

> The creation of conditions which would assure to all medical service and medical attention in the event of sickness (art. 12(2)(d)), both physical and mental, includes the provision of equal and timely access to basic preventative, curative, rehabilitative health services, and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventative and curative health services, such as the organisation of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.[34]

In order to ensure the treatment and control of diseases, diagnostic services are also clearly an indispensable aspect of health care services. Furthermore, to ensure the prevention and control of diseases, equally important is that the definition of health care services includes health promotion.

However, it should be borne in mind that while one may argue that the above health care services should fall within the ambit of the term, complex issues in respect of the specific types of treatment required, the costs thereof as well as their possible effectiveness still require extensive research. These are difficult decisions about competing health needs that health planners face on a daily basis. Hence, while the author proposes that broadly speaking health care services refers to the services referred to above, it is critical that there is a system of accountability that can inform the prioritisation of particular health care services, the provision of other services and the exclusion of certain services. [35]

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[34] Ibid. para. 17.

[35] In assessing whether specific programmes or policies meet an appropriate standard, it has been suggested that a rights framework be infused with a public health approach. A public health/human rights impact assessment instrument has been developed by Jonathan Mann and others at the Francois-Xavier Bagnoud Centre for Health and Human Rights at the Harvard School of Public Health. An overview of the impact assessment is discussed in International Federation of Red Cross et al 1999. See also: Gostin & Mann 1999. In brief, the impact assessment requires a consideration of the following questions:

1. To what extent does the proposed policy or programme represent “good public health”?
2. Is the proposed policy or programme respectful or protective of human rights?
3. How can we achieve the best possible combination of public health and human rights quality?
4. How serious is the public health problem?
5. Is the proposed response likely to be effective?
6. What are the severity, scope and duration of the burdens on human rights resulting from the proposed policy or programme?
7. To what extent is the proposed policy or programme restrictive or intrusive?
8. Is the proposed policy or programme over-inclusive or under-inclusive?
9. What procedural safeguards are included in the proposed policy or programme?
10. Will the proposed policy or programme be periodically reviewed to assess both its public health effectiveness and its impact on human rights?
11. Identify specific changes to the proposed policy?

2.4 Towards a definition of the term 'health care services'

Having due regard to the aforementioned aspects, it is submitted that the elements reflected in the table below should inform an understanding of health care services. It must, however, be emphasised that the exact service, its quality and effectiveness are critical to the determination of the provision of specific services, e.g. access to dialysis treatment or cosmetic surgery.

What health needs?	What level of service?	What types of service?
Mental	Primary	Preventative
Physical	Secondary	Diagnostic
	Tertiary	Curative
		Treatment
		Control
		Rehabilitative
		Provision of essential drugs
		Regular screening programmes
		Promotion

3 WHAT CONSTITUTES 'REASONABLE MEASURES'?

As already noted, section 27(2) of the Constitution obliges the state to take reasonable legislative and other measures to realise the right of access to health care services. In determining what constitutes 'reasonable' measures, the *Grootboom* and *TAC* judgments provide some valuable guidance on the broad principles that should inform such an assessment. These broad principles can be complemented by certain specifics in respect of health care rights in terms of General Comment No 14.

3.1 Broad principles enunciated in *Grootboom* and *TAC*

As these principles have been discussed in detail in the chapters by Liebenberg and de Vos in this volume, they will not be comprehensively discussed here. However, when applied to health rights, the broad principles on which this chapter focuses briefly include the following:

- There must be a comprehensive programme, which may include national framework legislation that can facilitate the right of access to health care services.
- There must be a coherent health programme directed at the progressive realisation of the right within its available resources. In assessing whether the programme constitutes a coherent one, regard must be had to the essential elements of the definition of health care services.
- The legislative measures must be supported by appropriate, well-directed policies and programmes.
- The programme must respond to the needs of the most desperate.

3.2 Specific measures in respect of health care rights

General Comment No. 14 provides some useful guidance in terms of the specific standard of health care rights to complement the *Grootboom* and *TAC* standard.

Although the ICESCR does not expressly use the standard of reasonableness, it is submitted that the key elements highlighted by the Committee on Economic, Social and Cultural Rights (CESCR) in any event represent a reasonable standard that needs to be met in respect of health care services. The standard advocated by the CESCR emphasises the need for health services to be available, accessible, acceptable and of a good quality.

The CESCR recognises that functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity. These include hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by WHO's Action Programme on Essential Drugs.[36]

The CESCR further recognises that health facilities, goods and services must be accessible to everyone without discrimination.[37] It emphasises physical accessibility in stating that health facilities, goods and services must be within safe physical reach of all parts of the population, especially of vulnerable or marginalised groups. Among such groups it includes ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons living with HIV/AIDS. It also stresses the importance of health facilities, goods and services being affordable to all. It expressly stipulates that payment for health care services must be based on the principle of equity, ensuring that these services, whether publicly or privately provided, are affordable for all including socially disadvantaged groups. In particular, it notes that equity demands that poorer households should not be disproportionately burdened with health expenses compared with richer households.[38] The CESCR also specifically recognises the right to receive and impart information and ideas concerning health issues, while ensuring that personal health data are treated with confidentiality.

According to the CESCR, all health facilities, goods and services must be respectful, sensitive and acceptable to different cultures, including minority groups and women. Finally, the CESCR recommends that they must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water and adequate sanitation.[39]

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[36] General Comment No. 14, *supra* note 33, para. 12(a).
[37] Ibid. para. 12(b).
[38] Ibid. para. 12(b).
[39] s 12.

4 DO THE HEALTH CARE MEASURES ADOPTED SATISFY THE STANDARD OF 'REASONABLENESS'?

This section assesses whether the measures that have been adopted by the South African government do, in fact, constitute reasonable measures in terms of the aforesaid standard. However, it must be pointed out that this section merely attempts to assess the *overall* reasonableness of the health framework. As a result, it does not in any way preclude a potential claim that the failure to provide certain *specific* treatment or undertake any other *specific* measure is unreasonable. In other words, the focus is on the extent to which the overall health framework is informed by the principles laid down in *Grootboom* and *TAC* and the ICESCR, as opposed to whether specific measures or the absence thereof meets a standard of reasonableness.

4.1 Is there a comprehensive programme and a national framework to facilitate the realisation of the right of access to health care services?

Three key documents constitute the national framework for the realisation of health care rights in South Africa: the *White Paper on Health*, the National Health Bill and the Mental Health Care Bill. This section provides an overview of the content of this framework. In addition, there are various other key pieces of issue-specific health legislation, policies and programmes. Some of these are also briefly discussed.

However, it should be noted at the outset that the highly delayed passage of the National Health Bill and the Mental Health Care Bill are cause for concern in terms of the *Grootboom* requirement for a comprehensive programme that may require a national framework to facilitate the right of access to health care services. Although neither the *Grootboom* nor the *TAC* judgments stipulated the circumstances in which national framework legislation is mandatory, it is submitted that such framework legislation is necessary in the health sector. The historically fragmented health system, the changes envisaged by the *White Paper on Health* regarding the systems and institutions responsible for the delivery of health care services and the reconceptualisation of health care services all necessitate such framework legislation. This acknowledgement seems to be echoed by the Department of Health given that it has, for a substantial period of time,[40] had both national health legislation and mental health care legislation in the pipeline. Although the *White Paper on Health* does to some extent provide a national framework, the absence of appropriate overarching legislation that creates legally binding obligations[41] in terms of general and mental health care nevertheless compromises the requirement of a national framework.

[40] The National Health Bill has been in the pipeline since 1998.

[41] Although the Health Act No. 63 of 1977 and the National Policy for Health Act No. 116 of 1990 are still in force, they do not adequately deal with the new health framework as laid down by the *White Paper on Health*.

In assessing whether there is in fact a comprehensive health programme directed at the progressive realisation of the right within its available resources, the key elements of the definition of health care services must be examined. In particular, the following aspects need to be assessed: the health needs that are covered by the programme, the level at which health care services are provided and the types of health care services that are provided for. The *White Paper on Health*, the National Health Bill and the Mental Health Care Bill make it clear that both the physical and mental health needs of the people of South Africa are covered by health measures that are being adopted. Equally clear is that the legislative framework makes provision for health care services at primary, secondary and tertiary levels, with an effective referral system at each level. In terms of the package of services that is offered, it is also clear that they include the services included in the definition in 2.4 above. There is accordingly little doubt that the key principles informing the overall health framework represents a coherent health programme directed at the progressive realisation of health care rights within available resources.[42]

Furthermore, both the Choice on Termination of Pregnancy Act[43] and the Sterilisation Act[44] reflect a commitment to appropriate and accessible reproductive health care services.

4.1.1 The *White Paper on the Transformation of the Health System in South Africa*

The *White Paper on Health* is the key policy that informs the national health framework in South Africa. It has numerous goals and objectives, including unifying fragmented health services (through the provision of primary health care services, with effective referral systems at primary, secondary and tertiary levels), promoting equity and accessibility in the use of health services, extending availability and appropriateness of health services and fostering community participation.

The *White Paper on Health* further outlines the role of national and provincial governments in respect of health as well as the principles, goals and role of the District Health System. In respect of the latter, the *White Paper on Health* notes that it is "at the core of the entire health strategy".[45] In terms of the district health system, responsibility for service delivery is entrusted to the district level. The country is to be divided into geographically coherent, functional health districts, each of which will have a team responsible for the planning and management of all local health services for a defined population. The team will arrange for the delivery of a comprehensive set of services.

The *White Paper on Health* details its adoption of the primary health care approach. The services provided by the public health sector include the following:

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[42] However, while the overall health programme might constitute a comprehensive one, this does not mean that particular programmes, when specifically analysed, cannot be considered to be unreasonable.

[43] Choice on Termination of Pregnancy Act 92 of 1996.

[44] Sterilisation Act 44 of 1998.

[45] *White Paper on Health*, *supra* note 27, 30.

- promotive and preventative services, including health education, nutrition services, family planning, immunisation, screening for common diseases;
- personal curative services for communicable and some chronic diseases;
- maternal and child health service;
- provision of essential drugs;
- primary health care level investigative services including radiology and pathology;
- basic rehabilitative and physical therapy;
- basic oral health services;
- basic optometry services;
- mental health services; and
- medical social work services.[46]

The *White Paper on Health* specifically recognises that services must be accessible to the majority of the population with a special focus on the most vulnerable groups, especially women and children, and the rural, peri-urban and urban poor. It also notes that services should be comprehensive and provided in an integrated manner. It further stipulates that the probability of success, acceptability and participation of the communities should be taken into account.[47] Its specific focus and commitment to meeting the health needs of the most vulnerable groups in society accords to a large extent with the *Grootboom* focus on these groups, as does its aim to provide comprehensive services in an integrated manner.

The *White Paper on Health* further recognises the need to develop human resources for health. It stipulates that there should be a national framework for the training and development of health personnel and that the skills, experience and expertise of all health personnel should be used optimally to ensure maximum coverage and cost effectiveness.[48]

4.1.2 Draft National Health Bill

The purpose of this Bill is to provide the framework for the provision of the "best possible health care services that available resources can afford".[49]

The Bill deals with a broad range of health care issues that include the participation of users in decisions, users having full knowledge of the relevant health issues, users consenting to treatment and procedures, treatment for experimental or research purposes, obligations to keep records, principles of confidentiality, access to records, laying of complaints and the right to non-discrimination.

The Bill also deals with the powers, duties and functions of the national, provincial and district health systems. To a large extent, these accord with those outlined in the *White Paper on Health*.

However, the provisions relating to the delivery of basic health care services, (which clearly have significant implications for the realisation of health

[46] Ibid. 37.
[47] Ibid. 47.
[48] Ibid. 54.
[49] Section 3 of the Draft National Health Bill.

care rights), have been particularly controversial. Section 4(1)(d) provides that the Minister is "responsible within the limits of available resources to ensure the rendering of basic health care services", which are defined in section 1 as "those services as prescribed by the Minister, after consultation with the National Health Authority". As has been pointed out in a submission by the AIDS Law Project, AIDS Consortium and Treatment Action Campaign,[50] this definition empowers the Minister to make decisions that have the potential to limit access to health care services without any direction being given to the factors that should inform such a determination. The provision has the potential to severely limit transparency and accountability. For instance, the submission notes that it fails to require a consideration of factors such as the health needs of communities, the burden of disease, the cost-effectiveness of interventions, and the availability of human and institutional resources and mechanisms through which they can be made available.[51] Anticipated trends in future costs and developments should also be considered.

4.1.3 Mental Health Care Bill

The Mental Health Care Bill seeks to ensure that appropriate care, treatment and rehabilitation services are made available to people with mental health care problems in line with the primary health care approach. The Bill represents a significant departure from the previous approach to mental health care. Mental health care needs have historically been neglected in the South African health context, which has largely been preoccupied with addressing physical, curative health needs.

The objectives of the Bill include ensuring the provision of the best possible mental health care, treatment and rehabilitation that available resources can afford, making effective mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interests of the mental health care user, and coordinating and integrating access to and the provision of mental health care services within the general health services environment.

The Bill is a welcome initiative, particularly in respect of its integrated approach to mental health care. However, its shift in focus from institutionalised care to community and home-based care has been highly controversial. Particular concerns have been raised in respect of the gender implications of such a shift as it is likely to result in a particularly onerous burden being placed on women.[52]

4.1.4 Tobacco Products Control Amendment Act

This Act[53] prohibits the advertising and promotion of tobacco products and places certain prohibitions and restrictions on the marketing, sale and consumption of tobacco products. It also prescribes maximum yields of tar, nicotine and other

[50] Berger 2002.
[51] Ibid. 7.
[52] Orner 2002: 23.
[53] Tobacco Products Control Amendment Act 12 of 1999.

constituents in tobacco products and increases fines in connection with matters referred to in the legislation.

4.1.5 Choice on Termination of Pregnancy Act

This Act promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs. It sets out the circumstances under which a pregnancy may be terminated and the place where such termination may take place. It also addresses the issues of consent, counselling and information concerning the termination of pregnancy.

4.1.6 Sterilisation Act

This Act provides for the right to sterilisation and determines the circumstances under which sterilisation may be performed.

4.2 Are health care services available?

Legislation aimed at addressing the shortage of doctors, dentists and pharmacists[54] in the public health sector, as well as programmes such as the clinic building programme[55] and national drug programme, clearly aim at ensuring the availability of health care services and facilities. These issue-specific measures complement the broader objectives of, for instance, the *White Paper on Health*, which, as mentioned, commits itself to the development of physical and human resources for health.

4.2.1 Pharmacy Amendment Act

In an attempt to address shortages of pharmacists in the public health sector, this Act[56] introduces community service for newly qualified pharmacists, for whom it makes a 12-month period of community service mandatory.

4.2.2 Medical, Dental and Supplementary Health Service Professions Amendment Act

In line with the objectives of the Pharmacy Amendment Act, this Act[57] introduces community service for doctors and dentists.

4.3 Are health care services affordable?

Although the principle of affordability underpins the vision of the *White Paper on Health*, there have, in addition, been two legislative measures aimed at specifically ensuring the affordability of health care services. Both are discussed

[54] For instance, the Pharmacy Amendment Act is expected to make an additional 500 pharmacists a year available to public health institutions.

[55] Discussed in more detail in the next section.

[56] Pharmacy Amendment Act 88 of 1997.

[57] Medical, Dental and Supplementary Health Service Professions Amendment Act 89 of 1997.

in this section. The policy measure providing for free health care to pregnant women and children under the age of six is a further measure to ensure the affordability of health care services.

The absence of further research into social health insurance is concerning, however. Social health insurance represents an important mechanism through which affordability can potentially be increased. As the *White Paper on Health* recognises, there are currently large numbers of employed workers who are not members of medical schemes, who often attend public hospitals without paying the prescribed fees even though they can afford to do so. The *White Paper on Health* further notes that medical scheme members may also attend public hospitals when their scheme is exhausted but not pay the prescribed fees. A social health insurance scheme will require all formally employed people to be insured for the costs of treatment of themselves and their dependants in public hospitals. The *White Paper on Health* envisages that contributions will be shared between employers and employees and will be related to income and family size.[58] Although a possible social health insurance scheme raises complex issues of its effectiveness within the South African context, given the large-scale unemployment, it is hoped that it will be researched further.

4.3.1 The Medical Schemes Act

The Medical Schemes Act[59] goes a long way in facilitating access to affordable health care services. The Act requires that contributions to medical schemes be made only on the basis of income or number of dependants, or both income and dependants. In other words, it explicitly prohibits contributions being determined on the basis of past or present state of health or the frequency of using health care services.[60] By limiting the basis on which contributions are made, the Act effectively disallows the 'loading' of premiums on the basis of health status. This in turn makes health care services more affordable to those who need them. The Act also limits cancellation or suspension of membership to instances of failure to comply with the rules, fraudulent activities and non-disclosure of material information.[61]

4.3.2 Medicines and Related Substances Control Amendment Act

This Act[62] was passed to reduce the costs of medicines, thereby making access to this element of health care services increasingly accessible, affordable and available. In line with its objectives, section 15(c) permits the Minister of Health to take measures to ensure the supply of more affordable medicines by prescribing conditions so as to protect the health of the public.[63]

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[58] *White Paper on Health*, *supra* note 27, 45.
[59] Medical Schemes Act 131 of 1998.
[60] Ibid. s 29(1)(n).
[61] Ibid. s 29(2).
[62] Medicines and Related Substances Control Amendment Act 90 of 1999.
[63] This provision has been the subject of much controversy and is discussed in more detail in the chapter dealing with HIV/AIDS.

4.4 Are health care services accessible?

The principles underpinning the national health policy, such as those of non-discrimination and equality, serve to facilitate increased access to health care services. Attempts have been made at ensuring physical accessibility through the adoption of the District Health System.

However, in spite of certain positive measures, health care services still remain highly inaccessible in some respects. The issue of language barriers in the health system and the absence of comprehensive policies in respect of interpreter and translation services is but one example of a health care system that is extremely inaccessible to the majority of its users.

4.5 Are health care services appropriate?

Initiatives such as the National Patients' Rights Charter and *Batho Pele* aim to enhance both the quality and acceptability of health care services.

4.5.1 National Patients' Rights Charter

The Charter[64] aims to improve the quality of health care by defining twelve core health rights for those who use health care facilities. Although the success of the Charter is largely dependent on the extent to which users have knowledge of it and are willing and prepared to assert their rights, the actual adoption of the Charter nevertheless represents a commitment to ensuring the provision of appropriate and good quality health care services. However, a significant problem is that the Charter refers to 'consumer rights', which accordingly offers little recourse to people who are unable to gain access to health care services in the first place. A further concern is that the Charter is heavily weighted in favour of curative care with little attention to promotive or preventative care.

4.5.2 Batho Pele

Batho Pele identified certain broad principles that should govern public service delivery. These include setting service standards, ensuring accessible service, promoting consultation with users of the service and ensuring that services are provided in a courteous manner. It recommends that consultation with users of the service takes place through mechanisms such as surveys, interviews with individual users, consultation groups, and meetings with consumer representative bodies, NGOs and CBOs.

4.6 Is there a clear allocation of responsibilities and tasks to the different spheres of government and are the appropriate financial and human resources available?

Certain key provisions of the Constitution inform the roles and functions of different spheres of government. For instance, section 27(2) obliges the state to take measures to realise health care rights. An 'organ of state' is defined in

[64] Launched on 2 November 1999.

section 239 of the Constitution as including national, provincial and local spheres of government. Schedule 4, Part A of the Constitution enlists health care services as an area of concurrent national and provincial legislative competency, while Part B of the same Schedule enlists municipal health services as a local government competency. Furthermore, the *White Paper on Health* and the Draft National Health Bill attempt to allocate responsibilities and tasks to all spheres of government. However, in spite of these legislative attempts at the allocation of responsibilities, in practice the issue of which sphere of government is ultimately responsible for the delivery of a particular health service often remains a vexed question. For instance, it is still unclear what 'municipal health services' constitute and what the distinction is between them and 'health care services' as referred to in Part A of Schedule 4. This lack of clarity has impeded the realisation of the right at different levels.

The *Grootboom* judgment requires that a reasonable programme should "clearly allocate responsibilities and tasks to different spheres of government and ensure that the appropriate financial and human resources are available".[65] Although the judgment itself provides no guidance on what constitutes "appropriate" resources, it is clear in terms of the constitutional imperative that this must be informed by the availability of resources. First, Section 27(2) of the Constitution makes the realisation of access to health care services subject to "available resources". Second, it is submitted that the "appropriateness" of resources must be informed by a degree of adequacy. In other words, there must be some correlation between the tasks and functions allocated to different spheres of government and the resources made available for such purposes.

It is, however, beyond the ambit of this chapter to undertake an in-depth analysis into whether there has been an appropriate allocation of resources to the different spheres of government. This is an issue that needs to be researched and analysed in great detail. However, it is nevertheless concerning to note that a recent National Health Accounts Project reveals that from 1997 there has been a decline in public *per capita* funding of health care, increased inequity in provincial resource allocation and a decline in *per capita* funding of primary health care. This emerging trend of declining health care funding raises serious questions about the appropriate allocation of resources to different spheres of government.[66] The process of resource allocation being devolved to provinces enhances the problem, as provinces often exercise their discretion to shift money from health to other sectors.

4.7 Are the legislative measures supported by appropriate, well-directed policies and programmes?

The requirement in terms of the *Grootboom* judgment is that programmes and policies support the legislative measures. This section does not attempt to comprehensively examine all policies and programmes adopted to support legislative measures, but it does highlight some that do.

[65] *Grootboom*, *supra* note 11, para. 39.
[66] Thomas 2000.

However, a problem with the *Grootboom* requirement, when applied to the health sector, is that some of the key legislative measures have not yet been adopted, nor, when analysed against the backdrop of the draft legislation that is currently in place, are certain necessary policies and programmes in place. For instance, as already mentioned there is no policy in place to ensure that the issue of language barriers in the health sector is addressed. However, some of the more positive measures that have been adopted are discussed in this section.

4.7.1 National Drug Policy

The cost of drugs is a critical element in determining access to health care services in South Africa. In South Africa, as with many other developing countries, drug costs are second only to personnel costs in the health sector.[67] A National Drug Policy[68] (NDP) was adopted for South Africa in 1996. Among the priority issues it outlined were strengthening the Medicines Control Council, rationalising drug registration, controlling the registration of practitioners and the licensing of premises, enhancing the inspectorate and laboratory functions and promoting other quality assurance measures.

With regard to ensuring the availability of safe and effective drugs at the lowest possible cost, the NDP established a pricing committee, promoted the use of generic drugs and suggested the possibility of engaging in parallel importing and international tendering.

4.7.2 Free health care to pregnant women and children under six

The government policy[69] of providing free health care to pregnant women and children under six was adopted in 1994. This policy is an appropriate and important measure aimed at making health care services increasingly accessible to a particularly vulnerable sector of health users.

4.7.3 Cervical cancer screening programme

This programme is intended to reduce the incidence of cervical cancer by detecting and treating pre-invasive stages of the illness. It allows for three free pap smears during the course of a woman's life.[70] In light of the prevalence of cervical cancer in South Africa, this programme is a formidable preventative measure.

4.7.4 Clinic building and upgrading programme

This programme attempts to address infrastructure backlogs and disparities in health facilities, with a strong emphasis on rural areas. It entails the construction of new clinics and the rehabilitation of existing ones. It is aimed at ensuring the

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[67] Gray 2000: 203.

[68] Department of Health 1996 *National drug policy for South Africa* Pretoria: Department of Health.

[69] Government Notice 657 of 1 July 1994.

[70] See <www.gov.za/yearbook/2001/health.html> Accessed 15 January 2002.

availability of physical structures and institutions for the provision of health care services.

4.8 Are the needs of the most desperate responded to?

The *Grootboom* judgment specifically requires that those whose needs are most urgent and whose ability to enjoy all rights is therefore most in peril, must not be ignored by the measures aimed at ensuring the realisation of the right.[71] It further noted that if measures, though statistically successful, fail to respond to the needs of the most desperate, they may not pass the test.[72]

However, the Court in *Grootboom* provided little guidance in terms of determining the category of people who are to be considered 'most desperate'. The only guidance it provided is that they would be "those whose needs are most urgent and whose ability to enjoy all rights is most in peril".[73] As mentioned above, the CESCR[74] has stressed the need for special regard for the health needs of vulnerable groups. In particular, it highlights special health measures for women,[75] children,[76] older persons,[77] persons with disabilities[78] and indigenous peoples,[79] through the adoption of particular programmes and policies that are particularly receptive to their health needs.

The *White Paper on Health* gives special attention to meeting the health needs of the poor, the under-served, the aged, women and children, who are considered to be among the most vulnerable.[80] However, it provides no insight as to how this determination was made and it is unclear why it does not, for instance, specifically include people living with HIV/AIDS, people with disabilities, etc. Instead, it uses vague terminology like the "under-served" with little guidance as to exactly who would be included in such a category. A severe shortcoming is accordingly the failure of the national health framework to determine the criteria in terms of which 'vulnerable groups" are identified. A second – and equally serious – shortcoming is its failure to identify groups who should clearly fall within the ambit of those desperate groups envisaged by the Court in the *Grootboom* judgment. This lack of clarity on prioritisation processes, values, weightings, etc. raises serious challenges for the realisation of health care rights.

A further question is the extent to which the overall health programme genuinely does respond to the health needs of the most desperate sectors of society. For instance, the *White Paper on Health* itself identifies women and children as vulnerable groups that require special attention. Yet the specific measures that have been put in place to address the needs of these groups are extremely limited. For instance, with the exception of the policy of free health

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[71] *Grootboom*, *supra* note 11, para. 44.
[72] Ibid.
[73] Ibid.
[74] General Comment No. 14, supra note 33 para. 18 to 27.
[75] Ibid. para. 21.
[76] Ibid. para. 22.
[77] Ibid. para. 25.
[78] Ibid. para. 26.
[79] Ibid. para. 27.
[80] *White Paper on Health*, *supra* note 27, 13.

care to pregnant women and children under six, little else seems to have been done. Furthermore, the policy applies only to pregnant women and accordingly does not reflect a special measure in respect of women generally. Similarly, although the *White Paper on Health* has identified children generally as requiring special attention, only children under the age of six are entitled to free health care. Hence, even where special measures are adopted, the groups to which it applies are extremely limited. The health framework seems to recognise the overall vulnerability of certain groups and then adopt special measures for particular categories within those groups. Further, the nature of the health services provided clearly fail to actually respond to the health needs of these groups. For instance, despite the prevalence of HIV, the state has failed to adopt a policy aimed at universal access to treatment, thereby failing to respond to the needs of a particularly desperate sector of society.

5 ARE THE HEALTH CARE MEASURES ADOPTED BEING REASONABLY IMPLEMENTED?

Although this analysis is by no means comprehensive, it provides a snapshot of the extent to which health legislation, policies and programmes are being implemented. Extensive reliance has been placed on empirical research published in the *South African Health Review*.

The *Grootboom* judgment states that measures adopted must be reasonably implemented.[81] This gives rise to the critical question of what constitutes reasonable implementation. It is my submission that reasonable implementation must be construed as focusing on outcomes and the extent to which the measures are actually achieving their proposed objectives. In other words, a critical element of the assessment must be on impact and output in respect of measures adopted.

As this analysis cannot be undertaken comprehensively, the focus is on the following broad areas:

- implementation of national health legislation;
- access to health facilities;
- implementation of primary level health care services;
- access to drugs; and
- quality of health care services.

5.1 Implementation of national health legislation

As was discussed in the preceding section, a wide range of national health legislation has been adopted. However, as both the National Health Bill and the Mental Health Care Bill have not yet been passed, their implementation cannot be assessed at this stage.

The adoption of the Choice on Termination of Pregnancy Act is an important measure in relation to removing legal barriers to ensure that women gain access to termination of pregnancy services. However, research has

[81] *Grootboom*, *supra* note 11, para. 42.

indicated that implementing the Act is an ongoing challenge. Of the 246 public health facilities designated to provide the service, only 73 currently do so and 99% of these are hospitals. Furthermore, there are disparities between different provinces – for example, a recent study indicated that 49% of all termination of pregnancies were done in Gauteng while only 1% were done in the North West.[82]

5.2 Availability of health care services

5.2.1 Clinics

Over 400 clinics have either been constructed or rehabilitated in terms of the programme for building and upgrading clinics. According to the Department of Health this has resulted in higher utilisation rates, as communities now travel shorter distances to health care facilities.[83]

5.2.2 Hospitals

Public hospitals account for 62% of the public health sector expenditure.[84] A study in 2000 on the state of hospital restructuring made the following key findings:

- Despite some convergence between provinces there continue to be large inter-provincial inequities in hospital spending (R173–R958 per capita), bed availability (1.82–3.54 beds/1000 population) and staffing (0.8–6.5 doctors/10 000 population).
- There have been reductions in numbers of beds in use in most provinces. However, relatively low bed occupancies and inability to maintain the existing hospital bed infrastructure suggests that further bed reductions are required.
- Access to hospital services in terms of admission rates is on aggregate satisfactory.
- Capital infrastructure and equipment are deteriorating at levels significantly exceeding existing spending on rehabilitation, maintenance and replacement.
- Real increases in funding for hospital services have on aggregate not translated into increased staffing or outputs but are likely to have been spent largely on increased salaries and benefits.[85]

5.2.3 Health Personnel

Community service has significantly improved access to health care professionals. It has been estimated that 26% of public sector dental posts and 31% of pharmacy posts were filled through community service in 2001.[86]

[82] Varkey & Fonn 1999: 360.
[83] South African Human Rights Commission (SAHRC) 2001: 218.
[84] Boulle 2000: 231.
[85] Ibid.
[86] Minister of Health 2001 "Budget speech" 4 June. <196.36.153.56/doh/docs/sp/2002/sp0604.html> at p. 4. Accessed 17 January 2002.

5.3 Primary level health care services

The extent to which primary level health care services have been implemented has been assessed in the *Primary health care facilities survey*.[87] The survey assessed many different aspects of primary health care facilities. This section refers to those aspects that have the potential to strongly impact on delivery.

5.3.1 Infrastructure

In respect of communication, the survey concluded that although the availability of telephones at fixed clinics has increased substantially in most provinces since 1998, (from 71% in 1998 to 80.5% in 2000),[88] it remains unsatisfactory in that about a fifth of fixed clinics do not have a telephone available.

The national availability of electricity at fixed clinics has increased substantially from 65% in 1997 to 92% in 2000.[89] Although the majority of clinics (67% of fixed clinics and 75% of satellite clinics) have a municipal source of water, water supply still remains a problem adversely affecting primary health care. For instance, 12.5% of satellite clinics still depend on water delivered by a tanker, almost 5% of satellites obtain their water from a river or dam, while 12.4 % of fixed clinics rely on rainwater.[90] The situation regarding sanitary facilities is fairly positive with 90% of fixed clinics being equipped with at least one flush toilet, and only 2% having no sanitary facilities available at all.[91]

5.3.2 Availability of services

The survey concluded that the national availability of immunisation on a daily basis at fixed clinics improved from 66.7% in 1998 to 73.7% in 2000.

The availability of family planning on a daily basis has increased moderately, with notable progress in KwaZulu-Natal (an increase of 37%). On a national level, there has been an increase in availability at fixed clinics from 83% in 1998 to 87.1% in 2000.[92] Access to antenatal care has also increased from 50.5% in 1998 to 59.3% in 2000, again with a marked increase in KwaZulu-Natal. Access to care for tuberculosis (TB) and for sexually transmitted diseases (STDs) have each increased marginally by less than 2% since 1998.[93] On average, the availability of HIV testing at fixed clinics has remained at its incredibly low rate of 56% since 1998, which poses a serious challenge to combating HIV.[94] The availability of emergency medical services varies. In those provinces where fixed clinics are more typically located long distances from hospitals, there is a greater availability of 24-hour emergency medical services at clinic level. For example, 56% of fixed clinics in the Northern Province have

[87] Van Rensburg 2000. Ten per cent of primary health care facilities in South Africa were sampled. The survey findings provide a cross-section snapshot of the nine provinces.
[88] Ibid. 8.
[89] Ibid. 10.
[90] Ibid. 12.
[91] Ibid. 13.
[92] Ibid. 16.
[93] Ibid. 19.
[94] Ibid. 20.

emergency services available, compared to only 6.7% in the Western Cape.[95]

5.3.3 Human resources

Nurses at fixed facilities have a substantially lower patient load than in 1997. Skills updating in the field of HIV/AIDS increased somewhat, whereas skills updating in the STD syndromic management approach and TB received lesser priority than in 1998.[96] The availability of doctors at fixed clinics has improved markedly since 1997 (from 54% to 63% in 2000).

5.3.4 Equipment

Nationally, 6.3% of fixed clinics did not have baby scales or refrigerators, 5.7% did not have blood pressure apparatus and 20% of all fixed clinics disposed of medical waste by means other than incineration.[97]

5.3.5 Availability of drugs

The availability of drugs and supplies has improved in some cases and deteriorated in others.[98]

5.4 Access to drugs

While the South African drug policy and the relevant legislation aimed at making access to medication more affordable are welcomed, their effectiveness is questionable. Currently, public sector drug costs are extremely high. It has been said:

> Pharmaceutical profits are substantial in this country and the amount spent on medicine is nearly double to triple that of other major countries.[99]

The median price increase of drugs was 7.8% per annum between 1997 and 1999. During this period the largest increase was 93.2% while the greatest price decrease was 7.5% per annum.[100] Given the already exorbitant price of drugs, as well as the policies aimed at reducing costs, the median price increase is of concern.

5.5 Quality of health care services

A 2000 survey on the quality of health care services made the following observation:

> A low percentage of people, generally, believed that access (31%), availability of medicines (26%), waiting times (20%) and quality of

[95] Ibid. 29.
[96] Ibid. 33.
[97] Ibid. 37.
[98] Ibid. 41.
[99] Gray & Matsebula 2000: 204.
[100] Ibid.

doctors (28%) had improved over the last four years. Africans perceived the greatest improvement. Rural Africans particularly experienced an improvement in waiting times. Most of the suggested priorities for the improvement of public health service related to the improvement in quality of care. Interpersonal relationships, technical competence and access to drugs rated highest. The reasons for not seeking treatment also related to access and affordability. Services were unavailable or inaccessible to 23% of respondents and 66% said they could not afford to seek medical attention.[101]

6 CONCLUSION AND RECOMMENDATIONS

This chapter has sought to contribute to the understanding of the term 'health care services' as provided for in section 27(1)(a) of the Constitution. It is submitted that a clear understanding of the term is critical in delineating the ambit of the right. However, it is equally important that the term extends beyond a narrow biomedical model, while retaining a degree of precision so as to ensure its effective implementation and enforcement.

The chapter has also attempted to provide some guidance on the criteria that should inform an assessment of reasonable measures as required by section 27(2) of the Constitution. The criteria suggested include the broad principles enunciated by the Court in *Grootboom* and affirmed in *TAC*, as well as certain guiding principles suggested by the CESCR.

In line with the *Grootboom* and *TAC* requirement that measures must be reasonably implemented, the chapter has also assessed the extent to which this has in fact been done.

The overall conclusions of this chapter are that many legislative, policy and programmatic measures meet the aforesaid criteria of reasonableness. However, the failure to adopt certain measures (though not assessed in any comprehensive way) as well as the failure to reasonably implement existing measures, are areas of concern in respect of realising the right of access to health care services.

The health sector provides many challenges for government and civil society. On the basis of the assessment undertaken in this chapter, it is submitted that the following areas are immediate priorities:

- lobbying for the passage of the National Health Bill and the Mental Health Care Bill and to ensure that this legislation reflects a commitment to the broad principles of both the *Grootboom and TAC* judgments as well as the CESCR;
- monitoring the implementation of legislation, policies and programmes, particularly the extent to which they ensure the availability, accessibility and affordability of quality health care services;
- assessing specific health measures or the absence thereof in relation to the criteria for reasonableness;
- analysing the barriers that impede access to health care services;

[101] Morris 1999: 178.

- undertaking research to determine the criteria for “people living in desperate circumstances”;
- identifing such categories in relation to health care services and identifing the health care services that are necessary to meet the health needs of such categories of persons; and
- assessing whether there is an appropriate allocation of human and financial resources to different spheres of government to fulfil the tasks and functions allocated to them.

The challenge posed by transforming an historically fragmented and discriminatory health system into a unified one that is responsive to the health needs of its people is formidable. Although we have made some progress in this regard, equitable access to quality health care services is still far from a reality for the majority of people. It is accordingly critical that both the extent and the pace of progress be tracked so as to ensure that the ambitious but critical goal of ‘health for all’ becomes a reality.

Sources

Berger J 2002 “Submission on the Draft National Health Bill 2001” Johannesburg: AIDS Law Project, AIDS Consortium, Treatment Action Campaign.

Baily M 1994 “Defining the decent minimum” in Chapman A (ed) *Health care reform: A human rights approach* Georgetown: Georgetown University Press.

Boulle A Blecher M & Burn A 2000 “Hospital restructuring” in Ntuli A Crisp N, Clark E & Barron P (eds) *South African health review* Durban: Health Systems Trust.

Bradshaw D Masiteng K & Nannan N 2000 “Health status and determinants” in Ntuli A et al (eds) *South African health review* Durban: Health Systems Trust.

Chapman A & Rubenstein L 1998 *Health and human rights: The legacy of apartheid* United States of America: American Association for the Advancement of Science.

Chopra M et al 2001/ 2002 “Poverty wipes out health care gains” in Desmond C (ed) *Children First* Durban: Children First.

Gray A & Matsebula T 2000 “Drug pricing” in Ntuli A et al (eds) *South African health review* Durban: Health Systems Trust.

Gostin L & Mann J 1999 “Toward the development of a human rights impact assessment for the formulation and evaluation of public health policies” in Mann J et al (eds) *Health and human rights: A reader* New York and London: Routledge.

International Federation of Red Cross and Red Crescent Societies and the Francois-Xavier Bagnoud Center for Health and Human Rights 1999 “Public health: An introduction” in Mann J et al (eds), *Health and human rights: A reader* New York and London: Routledge.

Mann M et al 1999 “Health and human rights” in Mann J et al (eds), *Health and human rights: A reader* New York and London: Routledge.

Millen J et al 2000 “Introduction: What is growing? Who is dying?” in Yong Kim, J et al (eds), *Dying for growth: Global inequality and the health of the poor* Monroe, Maine: Common Courage Press.

Morris G 1999 “Improving quality of services” in Crisp N & Ntuli A (eds) *South African health review* Durban: Health Systems Trust.

Nadasen S 2000 *Public health law in South Africa* Durban: Butterworths.

Sen A 1995 *Commodities and capabilities* Amsterdam: Northern–Holland.

South African Human Rights Commission (SAHRC) 2001 *Report on socio-economic rights* Johannesburg: SAHRC.

Toebes B 1999 *The right to health as a human right in international law* Antwerpen-Groningen-Oxford: Hart Intersentia.

Thomas S Muirhead D Doherty J & Muheki C 2000 “Public sector financing” in Ntuli A et al (eds) *South African health review* Durban: Health Systems Trust.

Orner P 2002 “Our mental health policy: Gender blind?” 41 *Women’s Health Project Review* Johannesburg: Women’s Health Project.

Van Rensburg D et al 2000 “Primary health care facilities survey” in Ntuli A et al (eds) *South African health review* Durban: Health Systems Trust.

Varkey S & Fonn S 1999 “Termination of pregnancy” in Crisp N & Ntuli A (eds) *South African health review* Durban: Health Systems Trust

Walt G & Vaughan P 1981 *An introduction to the primary health care approach in developing countries: A review with selected annotated references* London: Ross Institute of Tropical Hygiene: London School of Hygiene and Tropical Medicine Publication 13.

Werner D 1997 “Key note address at the international conference: The New World Order – A Challenge to Health for All by the Year 2000” in International People’s Health Council, National Progressive Primary Health Care Network and the South African Health and Social Services Organisation *Lighten the burden of third world health* Cape Town.

World Health Organisation (WHO)1986 *Basic documents* 36th ed. Geneva: WHO.

WHO 1998 “WHO Boss sets out stance on health and human rights” Geneva: WHO Press release 8 December.