LEGAL SUBMISSIONS ON BEHALF OF NETCARE REGARDING THE RIGHTS OF ACCESS TO HEALTHCARE AND INFORMATION IN THE CONTEXT OF THE HEALTH MARKET INQUIRY

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I. INTRODUCTION

1. Netcare wishes to make submissions to the Health Market Inquiry ("**HMI**") in relation to the right of access to healthcare services (and the right of access to information) as enshrined in the Constitution.[1]

2. In this paper, prepared on behalf of Netcare, we address those rights within the context of the HMI from a legal perspective.

3. These submissions should be read together with Netcare's other submissions in the HMI.

4. In this paper we deal with the following key issues:

4.1 The manner in which the right of access to healthcare services may be relevant to the HMI instituted in terms of the Competition Act[2].

4.2 The meaning and content of the right of access to healthcare services.

4.3 The State's obligation to fulfil the right of access to healthcare services within the constraints of the Constitution.

4.4 The private healthcare sector's role within the framework of the State's obligations in terms of section 27.

4.5 The right of access to information and its relevance to the private healthcare sector.

[1] The Constitution of the Republic of South Africa, 1996.
[2] The Competition Act 89 of 1998.

5. To assist the Panel, we provide below a summary of the key submissions contained in this paper.

II. SUMMARY

6. The key submissions that we advance in this paper are as follows:

A. The contextual relevance of the right of access to healthcare given the HMI's statutory mandate

6.1 The purpose of the Competition Act is to "*promote and maintain competition in the Republic*". The Competition Act recognises that promoting and maintaining competition leads to the attainment of other social goods (e.g. employment, social and economic welfare, and competitive prices).

6.2 However, the attainment of other social goods by <u>any means</u> is not the purpose of the Competition Act – it is only concerned with, and limits the attainment of, those social goods through the promotion and maintenance of competition. Therefore, a market inquiry in terms of the Competition Act is not a licence to consider how best other social goods may be achieved through extra market initiatives, save insofar as they are achievable by ensuring a more competitive market.

6.3 The State can and has sought to ensure the realisation of constitutional rights and general social goods in a number of ways, both through legislation and by other means. One of the means selected by the Legislature is the Competition Act which is a specific mechanism to promote competition in order to achieve efficient markets which are recognised by Parliament as giving rise to a number of socio-economic gains. Therefore, in a market inquiry under the auspices of the Competition Act, it is not permissible to seek the direct enforcement of specific

constitutional rights or to remedy supposed violations of such rights, or to rely on those rights to seek the achievement of goals outside the framework of the Competition Act, or indeed to interrogate how to fully realise those rights, directly or more generally. Rather, the inquiry and the recommendations which may arise from it, should be confined to addressing factors that prevent, distort or restrict competition in the private healthcare sector.

6.4 Thus, while a proper understanding of relevant constitutional rights, as enunciated by the courts, may provide relevant context to the Panel's competition law inquiry under the Competition Act, since the Competition Act correctly accepts that competitive markets may ensure better realisation of a number of social goods, the purpose of the investigation is not a general inquiry into how constitutional rights or other public goods may be secured outside an efficiently operating market.

6.5 In this regard, submissions from certain stakeholders have used the phrase "*market failure*" as a basis for suggesting that intervention is required in relation to the private healthcare sector. However, their use of the phrase "*market failure*" appears to encompass a variety of concerns, which are not necessarily linked to specific competition considerations. In particular, they have used the term "*market failure*" to refer to scenarios where even the most efficient and competitive markets could not deliver the desired outcomes. In other words, given levels of unemployment and income in South Africa, the private healthcare sector is not in a position to deliver quality healthcare to all people in South Africa. This is <u>not</u> a consequence of a "*market failure*". Rather, this could be referred to as a "*non-market deficiency*". Accordingly, the inquiry is not about seeking to redress non-market efficiencies which are outside the scope of the Competition Act. That is for the simple reason

that the Competition Act – and any market inquiry established thereunder – has a singular focus: of maintaining properly functioning competitive markets.

6.6 Therefore, the courts' interpretation of the scope of the constitutional right of access to healthcare services may guide the Panel in contextualising its investigation into the state, nature and form of competition in the private healthcare market.

6.7 However, the scope and nature of the constitutional right of access to healthcare serves only as a background to the HMI's statutorily mandated scope of investigation. The HMI and the nature of any recommendations that may be made at the conclusion of the inquiry occurs under the clear discipline and constraints of its specific statutory regime (the Competition Act), and thus the HMI recommendations must be aimed, to the extent necessary, at remedying anti-competitive conduct or features of a market which restricts or distorts competition within that market and not non-market deficiencies.

6.8 Notwithstanding this clear statutory context, certain parties which have participated in the HMI have sought to suggest that various pricing practices in the private healthcare environment have given rise to what they describe as "violations" of the Bill of Rights, particularly in regard to sections 27 and 28 of the Constitution. It is self-evident that the HMI is not in a position to make any determination of whether there has been a violation of the Bill of Rights and that the courts are the only bodies, which have the constitutional mandate to provide authoritative judgments in such matters. Moreover, it should be pointed out that to date, there has been no finding by any of our courts that private sector healthcare prices amount to constitutional violations of the Bill of Rights. In short, the HMI is not empowered

to conduct an inquiry into the nature and scope of constitutional rights or to determine whether the State or private parties have violated those rights. That is undoubtedly beyond the remit of a market inquiry under the Competition Act.

6.9 The State already has a variety of legislative mechanisms at its disposal, should it wish to consider pricing guidelines or similar measures in relation to private healthcare, including section 90(1)(v) of the National Health Act, 61 of 2003 as well as the relevant provisions of the Medicines and Related Substances Act, 101 0f 1965, as amended. It is suggested that before the HMI will even consider making any recommendations for additional legislation or regulations to be enacted, over and above the existing legislative framework dealing with pricing issues, that it would have to be convinced that the available evidence before it demonstrated that the existing regulatory regime was deficient to cater for pricing issues within the private healthcare environment.

B. The nature of the right of access to health care services

6.10 The right of access to healthcare services is primarily a right to access those services made available by the State in accordance with the State's available resources.

6.11 The State (and no one else) bears a positive obligation to realise the right through reasonable measures in a progressive manner.

6.12 The State's obligation is achieved primarily by progressively expanding public healthcare services, in order to achieve specific social outcomes, which the private healthcare sector which operates in accordance with market principles, would not necessarily be able to deliver (as set out above, this falls outside the scope of the

Competition Act).

6.13 Private parties may, in certain limited circumstances, have a negative obligation to have due regard to whether their actions may impinge the right of access to health care services provided by the State. This is in contrast to – and no substitute for – the overarching and ongoing positive obligation that the State bears to ensure the right of access to healthcare services is progressively realised within the State's available resources.

6.14 Efficient and competitive private health care can beneficially operate alongside public health and thus ensure enhanced access to health care services.

6.15 The State also has an obligation not to detrimentally affect access to private healthcare. Thus, while the State may take steps to regulate the private healthcare sector, as it has already done, its legislation and regulations must be reasonable and must be carefully tailored to progressively realise the right of access to healthcare services. Further, the State may not impede that right by, for instance, unreasonably limiting access to private healthcare services for those willing and able to pay for such services.

6.16 Any regulation of the private healthcare sector that fails the test of legality, which is not reasonable, that impermissibly impinges on the freedom to practise one's occupation, and/or that does not comply with the requirement of lawful and procedurally fair administrative action, will be found to be unconstitutional and invalid.

C. Access to information and PAIA

6.17 The right of access to information, including information held by private bodies, enshrined in section 32 of the Constitution, is given complete legislative expression by the Promotion of Access to Information Act 2 of 2000 ("**PAIA**").

6.18 Therefore, it is to PAIA that the Panel and the public must look in determining the scope of the obligations and rights provided in relation to accessing information held by private bodies.

6.19 Any other legislation (even if not enacted directly to give effect to section 32 of the Constitution) that obliges private parties to provide certain information, must, as with all legislation, be complied with.

III. THE MANNER IN WHICH THE RIGHT OF ACCESS TO HEALTHCARE SERVICES MAY BE RELEVANT TO THE HMI INSTITUTED IN TERMS OF THE COMPETITION ACT

A. The statutory context and scope of the HMI

7. The HMI was initiated by the Competition Commission (the "**Commission**") in terms of its powers under sections 43A to C of the Competition Act.

8. Section 43A provides that the Commission may institute a formal market inquiry *"in respect of the general state of competition in a market for particular goods or services*."

9. Section 43B(1) provides that:

> *"(1) The Competition Commission, acting within its functions set out in section 21(1), and on its own initiative, or in a response to a request from the Minister [not the Minister of Health, but the Minister of Economic Development], may*

> *conduct a market inquiry at any time ... (i) if it has reason to believe that any feature or combination of features of a market for any goods or services prevents, distorts or restricts competition within that market or (ii) to achieve the purposes of the Act.*" (Emphasis added)

10. Section 2 provides that the overarching purpose of the Competition Act is to "*promote and maintain competition in the Republic*" in order to achieve certain outcomes including "*to promote the efficiency, adaptability and development of the economy,*" "*to provide consumers with competitive prices and product choices,*" and "*to promote employment and advance the social and economic welfare of South Africans.*"[3] In other words, the purpose of the Competition Act is the promotion and maintenance of competition – this purpose, the Competition Act accepts, has certain consequential benefits for society. This is underscored by the Preamble to the Competition Act, which refers to a "*competitive economy,*" "*economic competition,*" "*competing,*" "*competitive economic environment*" and an "*efficiently functioning economy.*"

11. Thus while the purpose of promoting and maintaining competition is to achieve certain objectives, which can be achieved through a competitive economy (or market), the end ultimately sought to be achieved by the Competition Act, is limited to the promotion of competition (or efficient market based outcomes). The Competition Act does not allow, or contemplate, attempts to achieve these subsidiary objectives other than by promoting and maintaining competition. For instance, some may wish to argue that uncompetitive markets (such as a command economy that eschews competitive dynamics) may better achieve social goods such as increasing employment or greater social welfare. However, the HMI need not, and may not, concern itself with such speculation, or

[3] Emphasis added.

attempt to give effect to any such goals that lie beyond the remit of the Competition Act. The Competition Act makes it clear that it is only concerned with achieving the social goals it identifies by promoting competitive markets. The Competition Act is, therefore, not a licence to investigate and achieve extra market outcomes, it is limited to the promotion and maintenance of competitive markets.

12. Section 21 of the Competition Act refers to the fact that one of the functions of the Competition Commission is *"over time, [to] review legislation and public regulation and report to the Minister [of Economic Development] concerning any provision that permits uncompetitive behaviour*" and to "*enquire into and report to the Minister on any matter concerning the purposes of this Act.*" (Emphasis added)

13. In terms of section 43A, read with section 43B, and the Competition Act as a whole, a market inquiry's primary focus, one which the Panel is statutorily enjoined to undertake, is an investigation into competition issues said to arise in a specified market (including regulatory features of the markets in question which may hinder effective competition).

14. The Terms of Reference of the Health Market Inquiry make clear that the purpose of the HMI is in line with this statutory scheme:

> "*A market inquiry is thus a general investigation into the state, nature and form of competition in a market, rather than a narrow investigation of specific conduct by any particular firm.*
>
> *The Commission is initiating an inquiry into the private healthcare sector because it has reason to believe that there are features of the sector that prevent, distort or restrict competition. The Commission further believes that conducting this inquiry will assist in understanding how it may promote competition in the*

healthcare sector, in furtherance of the purpose of the Act."[4]

15. The Terms of Reference do note that one of the main objectives of the HMI is, *inter alia*, to "*[m]ake recommendations on appropriate policy and regulatory mechanisms that would support the goal of achieving accessible, affordable, innovative and quality private healthcare*". (Emphasis added)

16. Of course, this objective must be understood within the context of the Terms of Reference, and *inter vires* the Competition Act, to mean that the HMI can make recommendations on appropriate policy and regulatory mechanisms to promote or maintain competition in the private health care market, which would then support "*the goal of achieving accessible, affordable, innovative and quality private healthcare*", by way of more efficiently operating markets.

17. As the Chairperson of HMI made clear at the start of the HMI, "*[m]arket inquiries are essentially 'research projects conducted to gain in-depth understanding of how sectors, markets, or market practices are working.*' [5] *The purpose of the exercise is to determine whether the process of competition is working well or can be improved effectively in a market as a whole. Market inquiries provide a framework for identifying, analysing and, where appropriate, remedying sector-wide or market-wide competition problems.*" [6] (Emphasis added)

18. As the Chairperson emphasised, although "*[t]he remit of the panel derives from the*

[4] Terms of Reference, para 1, GG pg 75.
[5] Market Studies Good Practice Handbook, International Competition Network (ICN Handbook) at pg 6. (internal original footnote retained).
[6] Remarks by the Chairperson of the Market Inquiry Retired Chief Justice Sandile Ngcobo to the Private Healthcare Market Stakeholders, 16 April 2014, pgs 5-6.

terms of reference… [the Panel's] approach to the inquiry is to proceed wholly independently of what may have prompted the Competition Commission to initiate the inquiry and to cast a fresh pair of eyes on the issues raised in the terms of reference. It is therefore possible that after considering all the evidence the Panel may conclude that there are no features that prevent, distort or restrict competition in the private healthcare markets. This is the approach that is followed in other jurisdictions, in particular, in the UK, and we think this is a sound approach to follow."[7] (Emphasis added)

19. In a speech to stakeholders in February 2016, the Chairperson also correctly stated that "*[i]t is important to emphasise that the scope of our inquiry is limited by the Competition Act as well as the Terms of Reference, which sets out our core mandate.*"[8]

20. Thus, the remit of the inquiry in terms of the Competition Act and the Terms of Reference, is an investigation into whether there are features of the market which prevent, restrict or distort competition and, if so, how this can be remedied. An investigation into the reasons for non-market deficiencies and potential remedies are outside the scope of the Competition Act.

21. Moreover, in addition to the scope of the inquiry, the key point is that the findings of the inquiry must be located within the competition law framework. That means the findings must be focused on issues relating to competition law (i.e. features of the

[7] Remarks by the Chairperson of the Market Inquiry Retired Chief Justice Sandile Ngcobo to the Private Healthcare Market Stakeholders, 16 April 2014, pgs 9-10, referring to UK Competition Commission Guidelines for Market Investigations: Their Role, Procedures, Assessment and Remedies, April 2013. (CC 3 Revised) at paragraph 22.

[8] Chairperson's Remarks at the Information Session on Status of the Health Market Inquiry, February 2016, para 14 (available at http://www.compcom.co.za/speeches/).

market that prevent, distort or restrict competition). Importantly, in section 43C(1)(b), the Competition Act makes clear that the recommendation that may be made to other regulatory authorities (and not the Minister of Economic Development) must relate to "*competition matters.*" This makes it clear that the Panel's findings are limited to dealing with competition matters, in order to remedy market failure.

22. This has been confirmed by the Chairperson, who affirmed that "*[a]t the conclusion of the inquiry, we are required to answer the question whether there are features that prevent, distort or restrict competition in the private healthcare markets. There is a whole range of outcomes that the panel may reach including a finding that the market is functioning well or that it is not functioning well.*"[9] (Emphasis added)

23. In that context, we now consider how the Terms of Reference and Statement of Issues briefly allude to the potential relevance of the right of access to healthcare services.

B. The relevance of the right of access to health care services

24. In the Terms of Reference, the following is noted:

> "*Access to health care services is enshrined in the Constitution of the Republic of South Africa as a fundamental human right. Section 27(2) imposes an obligation on the state to take reasonable measures to achieve the progressive realisation of this right. Private healthcare provision takes place within the context of this constitutional commitment to the provision of universal healthcare services to all people in South Africa*."[10] (Emphasis added)

[9] Remarks by the Chairperson of the Market Inquiry Retired Chief Justice Sandile Ngcobo to the Private Healthcare Market Stakeholders, 16 April 2014 pg 7.
[10] The Terms of Reference heading 3, GG pg 80.

25. Similarly, in the Statement of Issues, the Panel notes that:

> "*The Panel appreciates that access to healthcare services is a constitutional right and that this right also informs the competition assessment that it must undertake. The Panel also understands that healthcare markets are distinctive; there are various features that set them apart from conventional commodity markets. This will be borne in mind in the conduct of this Inquiry*."[11]

26. These statements, and the invitation by the Panel and Evidence Leaders to make submissions on access to healthcare services, must be understood within (and *intra vires*) the statutory scheme of the Competition Act, and the purpose of the HMI, as discussed above – and with a proper understanding of the content, scope and application of the constitutional right of access to healthcare.

27. Thus, while the right of access to healthcare may provide context, it does not alter the nature or purpose of the inquiry, which is a competition investigation into a particular market. It also does not permit or empower the HMI to seek to achieve outcomes inconsistent with the statutory remit of the inquiry, or which extend beyond the constitutionally accepted understanding of the right to healthcare as articulated by the Constitutional Court.

28. While the current section 43A market inquiry pertains to the private healthcare market, it is solely concerned with whether that sector is performing competitively, and if not, why not.

29. We emphasise this, so as to delineate between what the Panel may take into account

[11] The Statement of Issues, 1 August 2015, para 19.

contextually (the right of access to healthcare, as interpreted by the courts), as separate from the scope and nature of the investigation being undertaken by the HMI (an investigation into competition in the healthcare market).

30. The focus of the inquiry is not the nature and scope of the right of access to healthcare, or whether the State is progressively realising that right as it is required, or what if any role the private sector has in relation thereto. As will be made plain below, it is to the Constitutional Court that one must look to determine the nature and scope of the right of access to healthcare services and the nature of the State's duty in terms of the Constitution to ensure the progressive realisation of access to healthcare services, within the State's available resources. If it falls short in that duty, courts are empowered to require the State to act appropriately. We emphasise that those issues are not issues for determination by the Panel. It is through the Legislature (or Regulations made lawfully thereunder) that the State should attempt to achieve its constitutional objectives regarding healthcare, including in respect of efforts to regulate the private healthcare industry. If parties believe that the State has fallen short of its section 27 obligation, or that private parties have obligations under section 27 which are not being complied with, then they should approach the courts to remedy the situation, as civil society and individuals have done on numerous occasions in relation to the State's actions, including in the field of healthcare.

31. The HMI certainly has no power or mandate to investigate and determine whether parties have violated any rights enshrined in the Constitution. That is not a competence entrusted by the Competition Act to the Commission or any market inquiry which it undertakes. To the extent that any stakeholder in the HMI would seek to allege that private participants in the private healthcare sector have violated any of the rights in the

Constitution in the manner in which they conduct their business, such serious allegations should be tested and adjudicated in courts. As will be discussed below, our courts have regularly grappled with the nature and extent of the right of access to healthcare services and related rights, both as they relate to the State and private parties. It is to those courts that stakeholders can and should turn if they wish to have such issues fairly adjudicated. It is impermissible, however laudable their aims may be, for parties to try to convert a competition inquiry into a constitutional rights inquiry.

32. Thus, a market inquiry may permissibly rely on the courts' interpretation of the scope of a constitutional right to assist it in contextualisation of the competition inquiry it is tasked with undertaking. This does not mean that the market inquiry can be converted into an inquiry into the fulfilment of various constitutional rights and their scope, not least of all where such a conversion is prompted by, or undertaken pursuant to, contentions from stakeholders which have no mooring in a proper appreciation of the nature and application of those rights, as they have been interpreted by the courts.

33. That any market distortions or factors that restrict competition may lead to impediments to the accessing of services in the private healthcare market do not change the focus of the inquiry. It merely recognises a trite proposition that one of the purposes of a competitive market is to ensure better access, through "*competitive prices and product choices*" to the services that such market provides, and in so doing to promote "*social and economic welfare.*"[12]

[12] For instance, section 2 of the Competition Act provides that "*The purpose of this Act is to promote and maintain competition in the Republic in order-*
(a) to promote the efficiency, adaptability and development of the economy;
(b) to provide consumers with competitive prices and product choices;
(c) to promote employment and advance the social and economic welfare of South Africans;"

34. The issue of prices provides a useful example of the distinction between a competition inquiry, and one concerned with the achievement of other social goals by other means:

34.1 As the Competition Act makes clear it is concerned with achieving competitive markets, which inter alia lead to "*competitive*" prices for goods. A "*competitive price*" may, but is not one that necessarily best achieves other social goals. Under the Act, it is only interested in prices that are the result of a properly functioning competitive market, and in promoting and maintaining competition so as to ensure such competitive prices.

34.2 The CAC has made clear that competition authorities (including the Commission) are not called upon, nor empowered under the Act, to regulate and set prices. Davis JP has stressed that ***"[t]he powers and duties of the competition authorities, and their limitations, are contained in the Act. The authorities are not called upon to set a price for a good or service.*** *It is incumbent on the Tribunal, if necessary to determine whether a specific price is 'excessive' in contravention of s 8(a).* ***There is no suggestion in the Act that the competition authorities should regulate and set prices. To the extent that the enquiry requires the examination of a possible excess of the charged price over economic value, as defined, that enquiry is required by virtue of the express formulation employed by the Act***."[13] (Emphasis added)

34.3 The CAC makes clear, as submitted above, that the only legitimate inquiry under the Competition Act is whether prices are excessive in contravention of section 8.

[13] *Mittal Steel South Africa Limited and Others v Harmony Gold Mining Company Limited and Another* (70/CAC/Apr07) [2009] ZACAC 1 (29 May 2009) para 47.

Evidently, the CAC's emphatic statement, that "***[t]here is no suggestion in the Act that the competition authorities [which includes the Commission] should regulate and set price***," applies with equal force to when the Commission exercises its powers in terms of section 43B to conduct a market inquiry such as the HMI. Indeed, price setting by a regulatory body is the antithesis of a competitively determined price.

34.4 Therefore, it will only be in the most exceptional of circumstances, where a body tasked with competition matters, would suggest that price regulation was appropriate in respect of a particular market. It is suggested that this type of market is only likely to occur where a firm is regarded as "*super dominant*" and which is persistently charging "*excessive*" prices, in circumstances where there is virtually no possibility of that firm's super-dominance being eroded. An example might be a statutory monopoly.

35. In summary:

35.1 The HMI must concern itself with the issue of access to healthcare in a manner that is focused on the purpose of the competition inquiry it is statutorily required to undertake, namely, whether the private health market is operating competitively as required by the Competition Act.

35.2 In answering the question: whether the market is operating competitively as required by the Act; the Panel is not at large to move beyond the meanings of any constitutional rights established by the courts. It is both unhelpful and legally irrelevant for certain stakeholders to promote interpretations and applications of constitutional rights that are inconsistent with the authoritative views of the

Constitutional Court and, worse, to contend that the HMI should move beyond those authoritative views in pursuing expansive regulatory ends that fall outside the remit of the Competition Act and its limitations upon the Commission.

35.3 We emphasise that there are many ways that the State and civil society may investigate, advocate for, and ensure changes to, the manner that the private health sector and the public health sector operate – all with a view to ensuring fuller realisation of the right of access to healthcare services. Such efforts are to be welcomed. They include policy development (including White and Green Papers), public participation, legislation, litigation in courts (the proper avenue for any allegations that any parties, whether public or private, have violated constitutional rights), and advocacy and general expert inquiries into improving access to healthcare services. Yet, the HMI is not such a generalised inquiry nor a public participation process pursuant to the amendment of general health care legislation or regulation – it has a clear and statutorily defined competition mandate. It is required to ask and answer a humbler and more limited question, namely "*whether there are features that prevent, distort or restrict competition in the private healthcare markets*" (as articulated by the Chairperson).[14]

36. Given the proper statutory framework set out above, the nature and scope of section 27 of the Constitution may assist the Panel in contextualising its competition inquiries:

36.1 Part of the relevant context of the right of access to health care services - which should contextualise and inform the Panel's inquiry - is that the right of access to

[14] Remarks by the Chairperson of the Market Inquiry Retired Chief Justice Sandile Ngcobo to the Private Healthcare Market Stakeholders, 16 April 2014 pg 7.

health care is a right which obliges the State (and not private parties) to positively fulfil that right through the provision of public healthcare services within the State's available resources, through reasonable legislative and other measures. Moreover, the State may not through unreasonable, or retrogressive, regulatory measures impede access to the private health care sector, and thus violate section 27(2). It should be noted, this could include regulatory interventions, which could undermine the efficient operation of the relevant market. We discuss these constitutional influences on the Panel's discharge of its statutory mandate in greater detail below.

36.2 The HMI, constrained as it is by the provisions of the Competition Act, may only propose regulatory interference in the private healthcare industry that is aimed at ensuring the market is competitive and remains competitive (this, the Competition Act recognises, will have benefits for the attainment of social goods). It may not propose or advocate regulatory intervention aimed not at achieving or maintaining competition, but promoting access to healthcare through other means.

37. Having properly contextualised the purpose of considering the right of access to healthcare services, we now set out the nature and scope of that right.

IV. THE KEY PRINCIPLES THAT ARISE FROM A DETAILED ANALYSIS OF THE SECTION 27 RIGHT OF ACCESS TO HEALTH CARE SERVICES AND THE RELEVANT CASE LAW

38. In the next three major sections we set out a detailed analysis of the nature and scope of the section 27 right of access to health care services, with particular care to ground our analysis in the binding decisions of the Constitutional Court.

39. Due to the detailed and lengthy nature of this analysis, we believe that is helpful to summarise the key submissions which arise from our analysis at the outset.

40. First, the right of access to health care is a socio-economic right which has as its primary purpose requiring the State to take steps to achieve its progressive realisation, and the holding of the State to account for any failure to act reasonably in doing so, given the particular socio-economic situation in which South Africa finds itself and its available resources.

41. Second, section 27(1) and (2) must be read together - with (2) (the State's obligation to realise) limiting (1) (the right of access). Thus, section 27(1) does not create a self-standing obligation on the State that is separate from section 27(2). Rather, section 27(1) only provides a right to access services – the extent of those services (i.e. the scope of the right of access) is limited or defined by the services that the State is able to make available in terms of its section 27(2) obligation (i.e. a progressive realisation, within the State's available resources). As such, section 27(1) does not create any minimum core of services that the State is under an obligation to provide immediately.

42. Third, section 27(3) separately creates a right to not be refused emergency medical treatment, which is now given statutory effect by the National Health Act.

43. Fourth, it is the State (and no one else) that bears the positive obligation to ensure the realisation, progressively, and within the State's available resources, of the right everyone has to access health care services, through legislative and other measures.

44. Fifth, the State's actions in complying with this obligation are constrained by the requirement that the state must act reasonably and progressively.

45. Sixth, in addition to the State, private parties may have a negative obligation to desist from *"preventing or impairing"* the right of access in certain specific circumstances:

45.1 It is not an obligation to realise the right (only the State bears that positive obligation);

45.2 It is not an obligation to incur expense or endure invasion of one's private property rights;

45.3 It is not an obligation that obstructs private autonomy;

45.4 At its highest, it is an obligation to act in a consultative manner with the State, the primary obligation bearer, to seek to minimise any negative impacts on the rights holders, particularly in circumstances when the private entity has made its private property or facilities available (by agreement) to the State for the State's use in fulfilling the right in question.

46. Seventh, the State's legislative actions to fulfil the right of access (in accordance with its positive obligation) may affect private relationships (although, primarily its efforts will be focused on expanding the provision and quality of services in the public health sector). The State's regulatory power is however subject to constitutional constraints:

46.1 In line with section 27(2) of the Constitution, the State should ensure reasonable regulation of the private healthcare sector that is not retrogressive, and which complies with the requirements of section 22 of the Constitution (and all other rights, including section 25), and, in respect of regulations, that also complies with PAJA including the need for thorough consultation. Furthermore, the State is

always constrained by the principle of legality when it operates in this regulatory space.

46.2 The case law demonstrates that even legislation or schemes with laudable aims must be fine-tuned to the economic realities of the industry that the State seeks to regulate. It will be impermissible for legislation or regulations, however noble their purposes, to lead to the impairment of access to health services by, for instance, forcing parties in the private health sector out of business.

46.3 Any Government policy or legislation that has the effect of inhibiting the access that persons have secured for themselves to private healthcare, through contractual arrangements with private providers of health care, may violate the negative obligation created by the right of access to healthcare services. Moreover, such actions would not constitute a reasonable measure by the State to progressively realise the right of access, but would rather amount to an unreasonable and retrogressive measure, in violation of section 27(2).

V. THE MEANING AND SCOPE OF THE RIGHT OF ACCESS TO HEALTH CARE SERVICES

A. The right in the Constitution

47. Section 27 provides, in relevant part, that:

> "*(1) Everyone has the right to have access to ... [h]ealth care services, including reproductive health care ….*
>
> *(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.*

(3) No one may be refused emergency medical treatment."

B. A contextual-reliant interpretation of this particular socio-economic right within the parameters defined by the Constitutional Court

48. Any understanding of the nature of the right of access to adequate health care must have as its starting point the nature of that right within the framework of the Constitution.

49. First, the right of access to health care services is a socio-economic right. It finds itself within a suite of other socio-economic rights enshrined in the Bill of Rights, including the right of access to adequate housing, sufficient food and water, and social security.

50. Second, in general, socio-economic rights, and particularly those enshrined in sections 26 and 27 of the Constitution, have as their primary purpose requiring the State to achieve their progressive realisation, and the holding of the State to account for any failure to act reasonably in doing so, given the particular socio-economic situation in which South Africa finds itself.

51. As O'Regan J notes in *Mazibuko:*[15]

> *"[59] At the time the Constitution was adopted millions of South Africans did not have access to the basic necessities of life, including water.* ***The purpose of the constitutional entrenchment of social and economic rights was thus to ensure that the State continue to take reasonable legislative and other measures progressively to achieve the realisation of the rights to the basic necessities of life. It was not expected, nor could it have been, that the State would be able to furnish citizens immediately with all the basic necessities of life. Social and economic rights empower citizens to demand of the State that it act reasonably and progressively to ensure that all enjoy the basic necessities***

[15] *Mazibuko v City of Johannesburg* 2010 (4) SA 1 (CC), emphasis added.

> ***<u>of life</u>***. *In so doing, the social and economic rights* ***enable citizens to hold government to account for the manner in which it seeks to pursue the achievement of social and economic rights****."* (Emphasis added)

52. In this statement, O'Regan J elegantly captures the Constitutional Court's interpretation of the core elements of the protection and enforcement of socio-economic rights (in contradistinction to other rights):

52.1 The State cannot be expected to immediately realise the rights;

52.2 These rights empower citizens (and others) to make demands on the State;

52.3 But they can only demand that the State act reasonably and progressively to ensure enjoyment of these rights; and

52.4 The rights are aimed at holding the Government to account.

53. Third, although there has been much academic writing on the nature of the rights of access to healthcare services,[16] it is important to distinguish what the law is (descriptive), from what some may want the law to be (normative). In our constitutional scheme, it is the task of the courts to define the law authoritatively. In what follows we thus look to set out the law as it is and has been interpreted by the courts and in particular the rights in the Bill of Rights, as definitively interpreted by the Constitutional Court.

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[16] See e.g. Iain Currie and Johan De Waal, *the Bill of Rights Handbook* (2nd ed 2013), chapter 26 (updated by Jason Brickhill and Nick Ferreira); David Bilchitz 'Health' in S Woolman et al (eds) *Constitutional law of South Africa* (2ed) ch56A; Kirsty McLean, *Constitutional Deference, Courts and Socio-Economic Rights in South Africa* (2009); Sandy Liebenberg, *Socio-Economic Rights: adjudication under a transformative Constitution* (2010); M Pieterse, *Can Rights Cure?* (2014).

54. We have, therefore, sought to focus primarily on the Constitutional Court's case-law in relation to section 27 (and related rights) since that Court's pronouncements constitute the binding and definitive determination of the scope of the right in question.

C. Scope of the right of access to health care services

55. The nature of the section 27 right of access of healthcare services (and the other socio-economic rights found in sections 26 and 27) has been definitively interpreted by the Constitutional Court in a series of cases as set out below.

56. In the *TAC* case,[17] a decision specifically concerned with the right of access to healthcare services (in that case the issue was whether the limited scope of the government's HIV/Aids programme was reasonable), the Constitutional Court made clear (in reliance on its earlier socio-economic right decisions of *Soobramoney*[18] and *Grootboom*[19]) the following:[20]

56.1 Sections 27(1) and (2) must be read together.

56.2 Section 27(2) limits the scope of the rights under section 27(1).[21]

56.3 Section 27(1) does not create a self-standing obligation on the State that is separate from section 27(2). Rather, section 27(1) only provides a right to access services –

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[17] *Minister of Health & others v Treatment Action Campaign &* others 2002 (5) SA 721 (CC).
[18] *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC).
[19] *Government of the Republic of South Africa & others v Grootboom & others* 2001 (1) SA 46 (CC).
[20] *TAC* paras 31-39.
[21] *See also Khosa v Minister of Social Development; Mahlaule v Minister of Social Development* 2004 (6) SA 505 (CC) para 43: "*What is clear from these cases is that s 27(1) and s 27(2) cannot be viewed as separate or discrete rights creating entitlements and obligations independently of one another. Section 27(2) exists as an internal limitation on the content of s 27(1) and the ambit of the s 27(1) right can therefore not be determined without reference to the reasonableness of the measures adopted to fulfil the obligation towards those entitled to the right in s 27(1).*"

what those services are (i.e. the scope of the right of access) is limited or defined by the services that the State is able to make available in terms of its section 27(2) obligation (i.e. a progressive realisation, within the State's available resources).

56.4 Section 27(1) does not create any minimum core of services that there is an obligation to provide immediately.

56.5 The key enquiry is the reasonableness of the State's legislative and other actions taken to realise the right.

56.6 The State is not expected to provide core services for everyone immediately. Rather the State must act reasonably within its available resources to achieve progressive realisation of the right.

57. Given its seminal nature and its relevance for determining the scope of section 27, we quote in detail from the relevant portions of the *TAC* decision:[22]

> *"[31] In Soobramoney it was said: 'What is apparent from these provisions is that the obligations imposed on the State by ss 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources.'*
>
> *It is also made clear that s 26 does not expect more of the State than is achievable within its available resources' and does not confer an entitlement to 'claim shelter or housing immediately upon demand' and that* ***as far as the rights of access to housing, health care, sufficient food and water, and social security for those unable to support themselves and their dependants are concerned,***

[22] *TAC* paras 31 -39.

'the State is not obliged to go beyond available resources or to realise these rights immediately'.

….

[35] A purposive reading of ss 26 and 27 does not lead to any other conclusion. It is impossible to give everyone access even to a 'core' service immediately. All that is possible, and all that can be expected of the State, is that it act reasonably to provide access to the socio-economic rights identified in ss 26 and 27 on a progressive basis. In Grootboom the relevant context in which socio-economic rights need to be interpreted was said to be that

'(m)illions of people are living in deplorable conditions and in great poverty.

There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted. . . .'

[36] The State is obliged to take reasonable measures progressively to eliminate or reduce the large areas of severe deprivation that afflict our society. The Courts will guarantee that the democratic processes are protected so as to ensure accountability, responsiveness and openness, as the Constitution requires in s 1. As the Bill of Rights indicates, their function in respect of socio-economic rights is directed towards ensuring that legislative and other measures taken by the State are reasonable. As this Court said in Grootboom, '(i)t is necessary to recognise that a wide range of possible measures could be adopted by the State to meet its obligations.'

……

We therefore conclude that s 27(1) of the Constitution does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in s 27(2). Sections 27(1) and 27(2) must be read together as defining the scope of the positive rights that everyone has and the

corresponding obligations on the State to 'respect, protect, promote and fulfil' such rights. The rights conferred by ss 26(1) and 27(1) are to have 'access' to the services that the State is obliged to provide in terms of ss 26(2) and 27(2)."

(Emphasis added)

58. Consistent with the Constitutional Court's conclusion that section 27(1) "***does not give rise to a self-standing and independent positive right***," in *Mazibuko*, *TAC*, and *Grootboom*, the Constitutional Court has consistently found that none of the rights in sections 26 and 27 have any minimum core of obligations (as similarly affirmed in *Khosa*).[23] This was notwithstanding argument by the litigants to the contrary (in particular with reliance on the "*minimum core*" of such rights under the International Covenant on Economic, Social, and Cultural Rights – and which we discuss further below).

59. Therefore, the Constitutional Court's definitive finding in this regard, renders legally irrelevant any submissions or academic literature (as well as any reliance on any foreign or international jurisprudence), that would seek to suggest a minimum set of rights protected by section 27(1), that everyone is entitled to demand access to healthcare, or that such demands may be made from private actors rather than from the State. The Constitutional Court has been clear: section 27(1) does not entitle anyone to some specific healthcare services, not even as a minimum – and the burden of providing access to the right lies squarely upon the State.

60. The position is summarised well by O'Regan J in *Mazibuko*:

"*[53] In Grootboom this court rejected the argument that the social and economic rights in our Constitution contain a minimum core which the*

[23] See *Khosa* para 41.

State is obliged to furnish, the content of which should be determined by the courts. .....

[54] In Treatment Action Campaign (No 2) this court also refused to accept that s 27 of the Constitution had a minimum core content. ....

[56] The applicants' argument that this court should determine a quantity of water which would constitute the content of the s 27(1)(b) right is in effect an argument similar to a minimum core argument, though it is more extensive because it goes beyond the minimum. The applicants' argument is that the proposed amount (50 litres per person per day) is what is necessary for dignified human life; they expressly reject the notion that it is the minimum core protection required by the right. Their argument is thus that the court should adopt a quantified standard determining the content of the right, not merely its minimum content. The argument must fail for the same reasons that the minimum core argument failed in Grootboom and Treatment Action Campaign (No 2).

.....As appears from the reasoning in both Grootboom and Treatment Action Campaign (No 2), s 27(1) and (2) of the Constitution must be read together to delineate the scope of the positive obligation to provide access to sufficient water imposed upon the State. That obligation requires the State to take reasonable legislative and other measures progressively to achieve the right of access to sufficient water within available resources. It does not confer a right to claim 'sufficient water' from the State immediately."[24]

61. Therefore, the right of access to healthcare services, is according to the Constitutional Court, no more than a right that entitles persons to have access to those services that the State is able to make available, within the State's available resources (and not someone else's resources), through reasonable measures to achieve progressive

[24] *Mazibuko* paras 53 – 57.

realisation.

62. Of course, as will be discussed in more detail, if the State's measures or legislation are not reasonable, or do not achieve progressive realisation of access, or fail to make proper use of the State's available resources, then they will be in violation of the Constitution, and can be challenged in court.

D. Children and the right of access to health care

63. The Constitution, cognisant of the particular vulnerability of children, has provided in terms of section 28 that, *inter alia*, they have a right of access to basic health care services as part of their right to family or parental care.

64. Section 28(1)*(b)* and *(c)* of the Constitution provide that "*[e]very child has the right - (b) to family care or parental care, or to appropriate alternative care when removed from the family environment; (c) to basic nutrition, shelter, basic health care services and social services.*"

65. In *Grootboom*, the Constitutional Court held that paras *(b)* and *(c)* must be read together, "*[t]hey ensure that children are properly cared for by their parents or families, and that they receive appropriate alternative care in the absence of parental or family care. The section encapsulates the conception of the scope of care that children should receive in our society. Subsection 1(b) defines those responsible for giving care while ss 1(c) lists various aspects of the care entitlement. It follows from ss 1(b) that the Constitution contemplates that a child has the right to parental or family care in the first place, and the right to alternative appropriate care only where that is lacking.*"

66. In *TAC* the Constitutional Court confirmed that the primary obligation to ensure children receive basic healthcare services rests on their families,[25] yet where their parents are not in a position to provide such access (for instance when they are indigent), then the State bears an obligation.[26] This is in recognition of the fact that children must be "*afforded special protection.*"[27]

67. Moreover, the Constitutional Court has held that the reasonableness of Government's policy in terms of section 27(2) to ensure access to healthcare will depend on whether it has taken account of the impact on children, in particular in circumstances where those children's rights to basic healthcare services cannot be ensured by their parents.[28]

E. Section 27 and the right to life

68. In *Soobramoney*, the appellant was suffering from chronic renal failure and sought an order directing a state hospital to admit him to its renal unit so that he could receive necessary life-prolonging dialysis treatment.

69. The appellant argued that section 27(3) should be construed consistently with the right

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[25] *TAC* para 74-77.

[26] *TAC* para 11, the Court held that:

"*[77] While the primary obligation to provide basic health care services no doubt rests on those parents who can afford to pay for such services, it was made clear in Grootboom that '(t)his does not mean . . . that the State incurs no obligation in relation to children who are being cared for by their parents or families'.*

….

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

[27] *TAC* para 4.

[28] *TAC* paras 122 and 135(a)

to life entrenched in section 11 of the Constitution and that everyone requiring life-saving treatment who is unable to pay for such treatment herself or himself is entitled to have the treatment provided at a State hospital without charge.[29]

70. In this case, the Court found that the right to life was not implicated or violated, notwithstanding the State's refusal of life-prolonging treatment to the appellant, and that in South Africa since our Constitution directly provided for, and constrained, the right of access to healthcare, it was not necessary to have recourse to the right to life to ground such a right. We quote in detail from relevant portions of Chaskalson P's judgment where a number of important observations are made:

> "*In India the Supreme Court has developed a jurisprudence around the right to life so as to impose positive obligations on the state in respect of the basic needs of its inhabitants. Whilst the Indian jurisprudence on this subject contains valuable insights it is important to bear in mind that our Constitution is structured differently to the Indian Constitution.* ***Unlike the Indian Constitution ours deals specifically in the bill of rights with certain positive obligations imposed on the State and, where it does so, it is our duty to apply the obligations as formulated in the Constitution and not to draw inferences that would be inconsistent therewith***. …
>
> *[19]* ***In our Constitution the right to medical treatment does not have to be inferred from the nature of the State established by the Constitution or from the right to life which it guarantees. It is dealt with directly in s 27. If s 27(3) were to be construed in accordance with the appellant's contention it would make it substantially more difficult for the State to fulfil its primary obligations under ss 27(1) and (2) to provide health care services to 'everyone' within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses***

[29] Para 14.

over other forms of medical care and would reduce the resources available to the State for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening. In my view, much clearer language than that used in s 27(3) would be required to justify such a conclusion. *...*

[21] *The applicant suffers from chronic renal failure.* ***To be kept alive by dialysis he would require such treatment two to three times a week. This is not an emergency which calls for immediate remedial treatment. It is an ongoing state of affairs resulting from a deterioration of the applicant's renal function which is incurable. In my view, s 27(3) does not apply to these facts****.*

[22] *The appellant's demand to receive dialysis treatment at a State hospital must be determined in accordance with the provisions of s 27(1) and (2) and not s 27(3). These sections entitle everyone to have access to health care services provided by the State 'within its available resources.' ...*

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

[31] ***One cannot but have sympathy for the appellant and his family, who face the cruel dilemma of having to impoverish themselves in order to secure the treatment that the appellant seeks in order to prolong his life. The hard and unpalatable fact is that if the appellant were a***

> ***wealthy man he would be able to procure such treatment from private sources; he is not and has to look to the State to provide him with the treatment. But the State's resources are limited and the appellant does not meet the criteria for admission to the renal dialysis programme.*** *Unfortunately, this is true not only of the appellant but of many others who need access to renal dialysis units or to other health services.* ***There are also those who need access to housing, food and water, employment opportunities, and social security. These too are aspects of the right to***
>
> ***`. . . human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity.'***
>
> ***The State has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt an holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society****.*
>
> *...*
>
> *[36] The State has a constitutional duty to comply with the obligations imposed on it by s 27 of the Constitution. It has not been shown in the present case, however, that the State's failure to provide renal dialysis facilities for all persons suffering from chronic renal failure constitutes a breach of those obligations.*"
>
> (Emphasis added)

F. The International Covenant on Economic, Social and Cultural Rights

71. Section 39(1) of the Constitution requires courts when interpreting the rights in the Bill of Rights to have regard to international law.[30]

72. In this respect, the International Covenant on Economic, Social and Cultural Rights

[30] *Jaftha* paras 23-24.

("**ICESCR**"), which South Africa became a party to in 2015,[31] is of potential relevance to the scope of the right of access to healthcare services.

73. Importantly, the ICESCR has not been enacted into South African law,[32] and therefore, while binding on South Africa on the international plane, its main value is as an interpretative aid when considering rights in the Bill of Rights.

74. Article 12 of the ICESCR provides that:

> "*1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
>
> *2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
>
> *(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
>
> *(b) The improvement of all aspects of environmental and industrial hygiene;*
>
> *(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
>
> *(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*"

75. Article 12, must be read with Article 2, which provides that:

> "*1. Each State Party to the present Covenant undertakes to take steps,*

[31] South Africa signed the ICESCR on 3 Oct 1994, and ratified the treaty on 12 Jan 2015.
[32] See section 231(4) of the Constitution.

> *individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.*"
>
> (Emphasis added)

76. The Constitutional Court has already had regard to the ICESCR when interpreting the right of access to adequate housing (in *Grootboom* and more recently in *Jaftha*[33]) and the right of access to health care services (in *TAC*), and the ICESCR was also referred to in *Mazibuko* in dealing with the rights of access to sufficient water.[34] Evidently the Constitutional Court accepted that it was important to have regard to the ICESCR, even prior to South Africa's ratification of the treaty, given that South Africa had been signatory to the treaty since 1994.

77. In *Jaftha*, the Constitutional Court, before turning to consider the ICESCR, held that "*[i]n terms of s 39(1)(b) of the Constitution, this Court must consider international law when interpreting the Bill of Rights. Therefore, guidance may be sought from international instruments that have considered the meaning of adequate housing.*"

78. Accordingly, this Constitutional Court jurisprudence demonstrates that the rights enshrined in the ICESCR have already been considered by the Constitutional Court when interpreting sections 26 and 27 (as it was required to do in terms of section 39) and developing its own autochthonous, South African socio-economic rights

[33] *Jaftha* paras 23 and 24.
[34] *Mazibuko* paras 52-53, and footnote 31.

jurisprudence.

79. Therefore, within the HMI, stakeholders, the Evidence Leaders and the Panel are to look to the Court's binding interpretation of the rights in our Constitution in assisting the Panel in the discharge of its statutory function.

80. This is not only because that jurisprudence has already taken account of the ICESCR to the extent necessary, in interpreting the relevant rights, but also because the framing of the socio-economic rights in our Constitution is different from, and therefore have been interpreted differently to, the framing of the rights in the ICESCR.

81. For instance, in *Grootboom*, the Constitutional Court noted that:

> "*[27] The amici submitted that the International Covenant on Economic, Social and Cultural Rights (the Covenant) is of significance in understanding the positive obligations created by the socio-economic rights in the Constitution. Article 11.1 of the Covenant provides:*
>
> > *'The States Parties to the present Covenant recognise the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realisation of this right, recognising to this effect the essential importance of international co-operation based on free consent.*
>
> *'This article must be read with art 2.1 which provides:*
>
> > *'Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of*

its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.'

[28] The differences between the relevant provisions of the Covenant and our Constitution are significant in determining the extent to which the provisions of the Covenant may be a guide to an interpretation of s 26. These differences, insofar as they relate to housing, are:
(a) The Covenant provides for a right to adequate housing while s 26 provides for the right of access to adequate housing.
(b) The Covenant obliges states parties to take appropriate steps which must include legislation while the Constitution obliges the South African state to take reasonable legislative and other measures."[35]

(Emphasis added)

82. The same significant distinction appears in relation to the right of access to healthcare services (in section 27(1)), and the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (in article 12 of the ICESCR).

83. Furthermore, as discussed above, it is neither permissible nor helpful to reinterpret (or worse, reinvent) the rights in our domestic context without proper regard to what the Constitutional Court has already said about them. Thus, the Constitutional Court expressly rejected the argument that section 27 creates a minimum core obligation, which is immediately realisable. This was notwithstanding the submission made in the *TAC* case that a minimum core obligation had been recognised as flowing from the ICESCR. In particular, the Court indicated that:

"*[I]t is necessary to consider a line of argument presented on behalf of the first*

[35] Paras 27 to 28 (emphasis added).

and second amici. It was contended that s 27(1) of the Constitution establishes an individual right vested in everyone. This right, so the contention went, has a minimum core to which every person in need is entitled. The concept of 'minimum core' was developed by the United Nations Committee on Economic, Social and Cultural Rights, which is charged with monitoring the obligations undertaken by State parties to the International Covenant on Economic, Social and Cultural Rights.

'[A] State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its raison d'être. By the same token, it must be noted that any assessment as to whether a State has discharged its minimum core obligations must also take account of resource constraints applying within the country concerned. Article 2(1) obligates each State party to take the necessary steps "to the maximum of its available resources". In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations."[36]

84. The Constitutional Court then had regard to the structure of the right in our Constitution, and, as discussed above, firmly rejected the minimum core argument, notwithstanding its acceptance by the Committee on Economic, Social and Cultural Rights (which, as noted in the TAC judgment, quoted above, is charged with monitoring state parties compliance with the ICESCR – although, it is a body not provided for by the ICESCR, and was created by the UN's Economic and Social Council after the

[36] Para 26.

ICESCR was adopted).[37] It held in TAC, that:

> "*It is made clear in [Grootboom] that ss 26(1) and 26(2) 'are related and must be read together.' Yacoob J said:*
>
> *'The section has been carefully crafted. It contains three subsections. The first confers a general right of access to adequate housing. The second establishes and delimits the scope of the positive obligation imposed upon the State. . . .'*
>
> *It is also made clear that's 26 does not expect more of the State than is achievable within its available resources' and does not confer an entitlement to 'claim shelter or housing immediately upon demand' and that as far as the rights of access to housing, health care, sufficient food and water, and social security for those unable to support themselves and their dependants are concerned, 'the State is not obliged to go beyond available resources or to realise these rights immediately.'*
>
> *[33] In Grootboom reliance was also placed on the provisions of the Covenant. Yacoob J held that in terms of our Constitution the question is*
>
> *'whether the measures taken by the State to realise the right afforded by s 26 are reasonable.'*
>
> *[34] Although Yacoob J indicated that evidence in a particular case may show that there is a minimum core of a particular service that should be taken into account in determining whether measures adopted by the State are*

[37] As Professor Malcolm Shaw summarises the position "*in 1985 it was decided to establish a new committee of eighteen members, this time composed of independent experts. Accordingly in 1987 the new Committee of Economic, Social and Cultural Rights commenced operation. <u>But it is to be especially noted that unlike, for example, the Racial Discrimination Committee, the Human Rights Committee and the Torture Committee, the Economic Committee is not autonomous and it is responsible not to the states parties but to a main organ of the United Nations</u>.*
……In December 2008, the Optional Protocol to the Covenant was adopted by the UN General Assembly [which Protocol South Africa is not a party to], under which the Committee was enabled to hear individual petitions, and was provided with an inter-state complaint competence with regard to states accepting this procedure. Although the Committee was not as such established by treaty, it is now regarded as one of the (currently) 10 UN human rights treaty bodies." M Shaw International Law (7th ed, 2014) pgs 223-4.

reasonable, the socio- economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them. Minimum core was thus treated as possibly being relevant to reasonableness under s 26(2), and not as a self-standing right conferred on everyone under s 26(1).

[35] A purposive reading of ss 26 and 27 does not lead to any other conclusion. It is impossible to give everyone access even to a 'core' service immediately. All that is possible, and all that can be expected of the State, is that it act reasonably to provide access to the socio-economic rights identified in ss 26 and 27 on a progressive basis.

...

"We therefore conclude that s 27(1) of the Constitution does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in s 27(2). Sections 27(1) and 27(2) must be read together as defining the scope of the positive rights that everyone has and the corresponding obligations on the State to 'respect, protect, promote and fulfil' such rights. The rights conferred by ss 26(1) and 27(1) are to have 'access' to the services that the State is obliged to provide in terms of ss 26(2) and 27(2)."[38]

85. However, where the ICESRC and comments by the Committee on Economic, Social and Cultural Rights are relevant and applicable, the Constitutional Court has been willing to have regard thereto. In particular, the Court had regard to comments by the Committee in determining what is required by "*progressive realization*". In *Grootboom*, Yacoob J held that:

"*[45] The extent and content of the obligation consist in what must be achieved, that is, 'the progressive realisation of this right'. It links ss (1) and (2) by making it quite clear that the right referred to is the right of*

[38] Paras 32-29.

> *access to adequate housing. The term 'progressive realisation' shows that it was contemplated that the right could not be realised immediately.*

But the goal of the Constitution is that the basic needs of all in our society be effectively met and the requirement of progressive realisation means that the State must take steps to achieve this goal. It means that accessibility should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and, where possible, lowered over time. Housing must be made more accessible not only to a larger number of people but to a wider range of people as time progresses. ***The phrase is taken from international law and art 2.1 of the Covenant in particular. The committee has helpfully analysed this requirement in the context of housing as follows****:*

'Nevertheless, the fact that realisation over time, or in other words progressively, is foreseen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realisation of economic, social and cultural rights. On the other hand, the phrase must be read in the light of the overall objective, indeed the raison d'être, of the Covenant which is to establish clear obligations for State parties in respect of the full realisation of the rights in question. It thus imposes an obligation to move as expeditiously and effectively as possible towards that goal. Moreover, any deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources.'

Although the committee's analysis is intended to explain the scope of State parties' obligations under the Covenant, it is also helpful in plumbing the meaning of 'progressive realisation' in the context of our Constitution. The meaning ascribed to the phrase is in harmony with the context in which the phrase is used in our Constitution and there is no reason not to accept that it bears the same meaning in the Constitution as in the document from which it

was so clearly derived."[39]

(Emphasis added)

86. The authoritative and influential nature of the Constitutional Court's socio-economic jurisprudence for the way these rights should be interpreted, both in international human rights law and in foreign domestic law, has been well recognised. For instance, Prof Christine Chinkin (Professor of International Law at the London School of Economics), writing recently in the International Human Rights Law (2nd ed) has stated, with reference to the *Grootboom* and *TAC* cases, that "***the decisions of the South African Constitutional Court with respect to the understanding of economic and social rights have been influential***. *The importance of this jurisprudence may have been enhanced because of the lack of judicial decision-making on these rights at the international and regional level: the Committee on Economic, Social and Cultural Rights historically has not had competence to hear individual complaints, and the ECHR and ACHR are primarily focused on civil and political rights.*"[40] (Emphasis added)

87. In addition, since the rest of the world looks to the Constitutional Court for authoritative pronouncements on the nature of the obligations imposed by socio-economic rights, including in particular the right of access to health care services, Panellists and stakeholders jointly have the benefit of the Constitutional Court's views as an authoritative guide to the right and the limits of its application in this defined domestic context.

[39] Para 45, emphasis added.
[40] Christine Chinkin "Sources" in Moeckli (ed) et al, *International Human Rights Law* (2nd ed, 2014, Oxford) pg 88.

88. While the ICESCR has now been ratified by South Africa, that does not change the nature of the rights as they are domestically understood and applied in South Africa through the Constitutional Court's decisions (an approach which has received global recognition), particularly since the ICESCR remains as yet undomesticated. Even if the ICESCR were domesticated, and in assessing South Africa's international commitments, it is well established that a margin of appreciation[41] is afforded by the Committee to countries in their domestic efforts to give effect to the socio-economic rights in their own particular contexts, the test effectively being whether the measures taken are "*reasonable.*"[42] There can be little doubt that the Committee on Economic, Social and Cultural Rights will be guided by the South African Constitutional Court's own careful consideration of the rights' meanings within our domestic constitutional

[41] See e.g. the Report of the UN High Commissioner for Human Rights in 2007 to the UN Economic and Social Council (http://www.ohchr.org/Documents/Issues/ESCR/E_2007_82_en.pdf), where the UN High Commissioner affirmed that "As the Committee on Economic, Social and Cultural Rights has pointed out, the **most appropriate means of implementing these rights will inevitably differ from one State to another depending on their particular circumstances**. **Accordingly, States parties are afforded a wide margin of appreciation in determining their own approaches and measures**."(para 29). See also the Committee on Economic, Social and Cultural Rights a statement in 2007 in response to the initial adoption of a draft protocol to give it the right to receive individual complaint, (available at http://www.ohchr.org/english/bodies/cescr/docs/e_c_12_2007_1.pdf, paras 11 and 12) "At all times the Committee bears in mind its own role as an international treaty body and the role of the State in formulating or adopting, funding and implementing laws and policies concerning economic, social and cultural rights**. To this end, and in accordance with the practice of judicial and other quasi-judicial human rights treaty bodies, the Committee always respects the margin of appreciation of States to take steps and adopt measures most suited to their specific circumstances**.
12. Where the Committee considers that a State party has not taken reasonable or adequate steps, it will make relevant recommendations to the State party. **In line with the practice of other treaty bodies, the Committee will respect the margin of appreciation of the State party to determine the optimum use of its resources and to adopt national policies and prioritize certain resource demands over others**." (Emphasis added)

[42] The standard of review under the Covenant is that of 'reasonableness' (See Art 8(4) Optional Protocol-ICESCR, which gives the Committee jurisdiction to hear individual complaints against state parties, but which South Africa has not signed or ratified) and there is no explicit reference to the 'margin of appreciation' of states. The particular provision reads:
"*When examining communications under the present Protocol, the Committee shall consider the reasonableness of the steps taken by the state party in accordance with part II of the Covenant. In doing so, the Committee shall bear in mind that the state party may adopt a range of possible policy measures for the implementation of the rights set forth in the Covenant.*"

scheme in assessing the reasonableness of any governmental measure.[43]

89. A useful example of how regional human rights bodies will approach South Africa's domestic implementation of human rights, and our courts' consideration of the scope of those rights, is the African Commission[44] matter of *Prince*.[45] The matter involved consideration of a complaint by Mr Prince, a Rastafarian who wished to be admitted as an attorney, notwithstanding convictions for possession of cannabis and his stated intention to continue using it. Mr Prince averred that his rights under the African Charter on Human and Peoples' Rights had been violated. The case in the African Commission followed a determination in Mr Prince's case by the South Africa Constitutional Court that failure to make provision for an exemption in respect of the possession and use of cannabis by Rastafari was reasonable and justifiable under our Constitution.[46] In considering the complaint, the African Commission affirmed the principle of subsidiarity[47] (that and the margin of appreciation applied by it and other international human rights bodies).[48] It found no violation of Mr Prince's rights under

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[43] As we detail further below, the South African Constitutional Court's jurisprudence is to the effect that, in order for measures to be reasonable, they must aim at the effective and expeditious progressive realisation of the right in question, within the State's available resources for implementation. The measures must be comprehensive, coherent, inclusive, balance, flexible, transparent, be properly conceived and properly implemented, and make short, medium and long-term provision for those in desperate need or in crisis situations. The measures must further clearly set out the responsibilities of the different spheres of government and ensure that financial and human resources are available for their implementation. See L Chenwi 'Putting flesh on the skeleton: South African judicial enforcement of the right to adequate housing of those subject to evictions' (2008) 8 Human Rights Law Review 105 119.

[44] The African Commission on Human and Peoples' Rights ("**African Commission**"), the institution charged with ensuring compliance with the African Charter.

[45] Garreth Anver Prince / South Africa (255/02) (7 December 2004), available at http://www.achpr.org/communications/decision/255.02/.

[46] *Prince v President, Cape Law Society, And Others* 2002 (2) SA 794 (CC).

[47] In the principle that "*the national authorities should have the initial responsibility to guarantee rights and freedoms within the domestic legal orders of the respective states, and in discharging this duty, should be able to decide on appropriate means of implementation.*" As submitted to the African Commission in *Prince* para 37

[48] In particular, the Commission held that:

"*The African Commission notes the meaning attached to these doctrines by the Respondent State as*

the Charter. In coming to that conclusion the Commission, no doubt with a view to the fact that the Constitutional Court had already considered and pronounced on the case, held that *"[t]he African Commission is aware of the fact that* ***it is a regional body and cannot, in all fairness, claim to be better situated than local courts in advancing human and peoples' rights in Member States***".[49] (Emphasis added)

G. The Right to Emergency Medical Treatment

90. Although the focus of this submission is the right of access to healthcare services (enshrined in section 27(1) read with 27(2)), it should be noted that section 27(3) separately provides that "*[n]o one may be refused emergency medical treatment.*"

91. Most recently in *Oppelt,*[50] the Constitutional Court summarized the Court's interpretation of section 27(3) in reliance on *Soobramoney* as follows:

> "*Chaskalson P in Soobramoney stated that the purpose of the right granted in terms of s 27(3) was to ensure that treatment be given in an emergency. He said:*

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outlined in its submissions to the former. The principle of subsidiarity indeed informs the African Charter, like any other international and/or regional human rights instrument does to its respective supervisory body established under it, in that the African Commission could not substitute itself for internal/domestic procedures found in the Respondent State that strive to give effect to the promotion and protection of human and peoples' rights enshrined under the African Charter.
51. Similarly, the margin of appreciation doctrine informs the African Charter in that it recognises the Respondent State in being better disposed in adopting national rules, policies and guidelines in promoting and protecting human and peoples' rights as it indeed has direct and continuous knowledge of its society, its needs, resources, economic and political situation, legal practices, and the fine balance that need to be struck between the competing and sometimes conflicting forces that shape its society.
52. Both doctrines establish the primary competence and duty of the Respondent State to promote and protect human and peoples' rights within its domestic order. That is why, for instance, the African Charter, among others, requires Complainants to exhaust local remedies under its Article 56. It also gives Member States the required latitude under specific Articles in allowing them to introduce limitations. The African Commission is aware of the fact that it is a regional body and cannot, in all fairness, claim to be better situated than local courts in advancing human and peoples' rights in Member States."
[49] Para 52.
[50] *Oppelt v Department of Health, Western Cape* 2016 (1) SA 325 (CC).

*'The purpose of the [s 27(3)] right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate medical attention, such as the injured person in Paschim Banga Khet Mazdoor Samity v State of West Bengal [an Indian Supreme Court case], **should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital** which is able to provide the necessary treatment. What the section requires is that remedial treatment that is necessary and available be given immediately to avert that harm.' [Footnote omitted.]*

*[56] Proficient healthcare entails providing urgent and appropriate emergency treatment whenever a medical condition requires it. **As Sachs J noted in Soobramoney, the right to emergency care provides reassurance to all members of society that emergency departments will be available to deal with the unforeseeable catastrophes that could befall any person, anywhere and at any time**. Section 25(2)(m) of the National Health Act 38 outlines some of the duties of the provincial health services and general functions of provincial departments. It provides:*

'(2) The head of a provincial department must, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province —

... (m) provide and coordinate emergency . . . provision of medico-legal mortuaries and medico-legal services.' [Emphasis added.]"

92. In the *Law Society*[51] case, the Constitutional Court also noted that "*[65] The Minister, correctly so, **draws our attention to other statutory provisions which ensure that the security of the person of motor accident victims is protected**. **A ready example would***

[51] *Law Society of South Africa v Minister of Transport* 2011 (1) SA 400 (CC).

be the constitutional and statutory requirement that no person may be refused emergency medical treatment. Although the right is written in negative terms, at the very least, victims of motor accidents would be entitled not to be denied emergency health care by a health care provider, health worker or health establishment."

93. As indicated by the Constitutional Court, the general obligation found in the Constitution in section 27(3), is now given statutory effect by the National Health Act[52]. In particular section 5 (which evidently was intended to give effect to section 27(3) of the Constitution) provides that, "*[a] health care provider, health worker or health establishment may not refuse a person emergency medical treatment.*" By definition, "*health establishment,*" includes both public and private institutions.

94. However, as Jason Brickhill and Nick Ferreira explain, in the latest Bill of Rights Handbook, "*[t]he [section 27(3)] right does not extend to routine medical treatment and it does not guarantee free service. Emergency treatment may not be refused because of lack of funds, but payment for treatment may be sought after the treatment has been provided.*"[53]

VI. THE STATE'S OBLIGATION TO REASONABLY AND PROGRESSIVELY REALISE THE RIGHT OF ACCESS TO HEALTHCARE SERVICES WITHIN ITS AVAILABLE RESOURCES

95. The Constitution makes clear that it is the State that bears the obligation to ensure the realisation, progressively, and within the State's available resources, of the right everyone has to access to health care services. This has been confirmed by the

[52] The National Health Act 61 of 2003.
[53] "*Socio-Economic Rights*" (updated by Jason Brickhill and Nick Ferreira) in Iain Currie and Johan De Waal, *The Bill of Rights Handbook*, (6th ed, 2013), pg 593.

Constitutional Court in the cases discussed above.

96. The State's positive obligation to ensure access to health care services, and the public's right to such services where provided, are informed by the requirements of section 27(2).

97. The Courts have interpreted the limits and ambit of the State's powers and obligations, in terms of section 27(2) (and the similarly framed section 26(2)). The key obligations and constraints may be summarised as follows:

97.1 The measures (including legislation) or programmes must ensure that "*the appropriate financial and human resources are available*".[54]

97.2 The measures or programmes "*must clearly allocate responsibilities and tasks to the different spheres of government*".[55]

97.3 The measures or programme "*must be capable of facilitating the realisation of the right*".[56]

97.4 The measures or programmes must be "*reasonable both in their conception and their implementation*".[57] "*An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the State's obligations*".[58]

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[54] *Grootboom* para 39.
[55] *Grootboom* para 39.
[56] *Residents of Joe Slovo Community, Western Cape v Thubelisha Homes and Others* 2010 (3) SA 454 (CC*)* para 115; *Grootboom* para 39;
[57] *TAC* para 100, quoting from *Grootboom* para 42.
[58] Ibid.

97.5 In general, measures and programmes must be balanced and flexible.[59]

97.6 Such measures or programme should have due regard to short, medium and long-term needs.[60]

97.7 A programme that excludes a significant segment of society cannot be said to be reasonable.[61]

97.8 If the measures or programmes chosen to give effect to the State's obligation under section 27 limits other constitutional rights (for instance the right to equality), that too must be taken into account in determining the reasonableness thereof.[62] In this regard, in *Khosa* the Constitutional Court found that a failure to ensure that the relevant legislation provided for social assistance for permanent residents, in addition to citizens, was held to be unconstitutional, on the basis that:

97.8.1 Denial of access to social grants to permanent residents who, but for their citizenship, would qualify for such assistance, does not constitute a reasonable legislative measure as contemplated by section 27(2);[63] and

97.8.2 It amounted to unfair discrimination in violation of section 9.[64]

97.9 The measures or programmes adopted by the State must ensure progressive realisation of the right.[65] As held by the Constitutional Court, "*the requirement of*

[59] *TAC* para 68; *Grootboom* 43
[60] *TAC* para 68; *Grootboom* 43
[61] *TAC* para 68; *Grootboom* 43
[62] *Khosa* para 45.
[63] Para 82.
[64] Para 79-80, read with paras 68-75.
[65] TAC para 94.

progressive realisation means that the State must take steps to achieve this goal. It means that accessibility should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and, where possible, lowered over time."[66] The Court also made clear that progressive realisation meant that any deliberately retrogressive measures would need to be fully justified.[67]

97.10 The State is only obliged to provide the services within the State's available resources.[68] In *Grootboom*, the Constitutional Court held as follows in relation to the meaning of available resources:

> "*[46]* ***The third defining aspect of the obligation to take the requisite measures is that the obligation does not require the State to do more than its available resources permit***. *This means that both the content of the obligation in relation to the rate at which it is achieved as well as the reasonableness of the measures employed to achieve the result are governed by the availability of resources. Section 26 does not expect more of the State than is achievable within its available resources. As Chaskalson P said in Soobramoney:*
>
> *'What is apparent from these provisions is that the obligations imposed on the State by ss 26 and 27 in regard to access to housing, health care, food, water, and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are* ***limited by reason of the lack of resources****. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled.'*
>
> *There is a balance between goal and means. The measures must be*

[66] *Grootboom* para 45.
[67] Ibid.
[68] *TAC* para 94; *Soobramoney* para 31.

> *calculated to attain the goal expeditiously and effectively but the availability of resources is an important factor in determining what is reasonable*." (Emphasis added)

98. The *TAC* case demonstrates how section 27(2) both limits and shapes the State's policy. In that case, the Constitutional Court found that the State's HIV/Aids programme was unreasonable because it only provided access for a very limited number of persons (importantly, it was accepted that in general an expansion of the programme was within the State's available resources[69] – indeed, an international pharmaceutical company had offered to make the relevant drugs available for free at least for five years).[70]

99. It is most instructive to consider the order made in the case, since it highlights both how Government's programme fell short of sections 27(1) and (2) and how the Government was required to remedy that failure (we note once again the emphasis on the State's available resources):

> "*(a) Sections 27(1) and (2) of the Constitution require the government to devise and implement* ***within its available resources*** *a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV.*
>
> *(b) The programme to be realised progressively within available resources must include reasonable measures for counselling and testing pregnant women for HIV, counselling HIV-positive pregnant women on the options open to them to reduce the risk of mother-to-child transmission of HIV, and making appropriate treatment*

[69] *TAC* para 73.
[70] *TAC* para 48.

available to them for such purposes.

(c) The policy for reducing the risk of mother-to-child transmission of HIV as formulated and implemented by government fell short of compliance with the requirements in subparas (a) and (b) in that:

(i) Doctors at public hospitals and clinics other than the research and training sites were not enabled to prescribe Nevirapine to reduce the risk of mother-to-child transmission of HIV even where it was medically indicated and adequate facilities existed for the testing and counselling of the pregnant women concerned.

(ii) The policy failed to make provision for counsellors at hospitals and clinics other than at research and training sites to be trained in counselling for the use of Nevirapine as a means of reducing the risk of mother-to-child transmission of HIV.

3. Government is ordered without delay to:

(a) Remove the restrictions that prevent Nevirapine from being made available for the purpose of reducing the risk of mother-to-child transmission of HIV at public hospitals and clinics that are not research and training sites.

(b) Permit and facilitate the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV and to make it available for this purpose at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendent of the facility concerned this is medically indicated, which shall if necessary include that the mother concerned has been appropriately tested and counselled.

(c) Make provision if necessary for counsellors based at public hospitals and clinics other than the research and training sites to be trained for the counselling necessary for the use of Nevirapine to reduce the

risk of mother-to-child transmission of HIV.

(d) Take reasonable measures to extend the testing and counselling facilities at hospitals and clinics throughout the public health sector to facilitate and expedite the use of Nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV."

(Emphasis added)

100. Importantly, the Court in *TAC*, while recognising that the private healthcare sector was in a position to provide HIV/Aids treatment to those who could afford to access it, made clear that it was the State which was required under section 27, within the bounds of section 27(2), to ensure progressive realisation of the right to access HIV/Aids treatment for those who lacked the necessary resources to use private healthcare services. In particular, the Court noted that:

> "*The crux of the problem, however, lies elsewhere: what is to happen to those mothers and their babies who cannot afford access to private healthcare and do not have access to the research and training sites [the limited public sites at which the State had made HIV/Aids treatment available]?*"[71]
>
> and
>
> "*Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means. They and their children are in the main dependent upon the State to make health care services available to them.*"[72]

101. Notably, in *TAC* the Constitutional Court when referring to section 27, indicated that it

[71] *TAC* para 17.
[72] *TAC* para 79.

gave effect to the right of access to "*public health care services.*"[73] (Emphasis added)

102. The challenge that the State faces in realising socio-economic rights is large, and the Court has been alive to this, but it has repeatedly made clear that it is indeed the State, a no one else (i.e. private parties do not bear a positive horizontal obligation to ensure the realisation of these rights), which bears the responsibility to realise these rights. In particular, in *TAC* the Constitutional Court held that: "*the State faces huge demands in relation to access to education, land, housing, health care, food, water and social security.* ***These are the socio-economic rights entrenched in the Constitution, and the State is obliged to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of them. In the light of our history, this is an extraordinarily difficult task. Nonetheless it is an obligation imposed on the State by the Constitution.***"[74] (Emphasis added)

103. In the *New Clicks* matter, Sachs J in emphasising the role of the State in ensuring access health care for the poor, put the challenge clearly:

> "*Though illness strikes the rich and the poor alike, its impact on the poor is aggravated by harsh living conditions and what is frequently the extreme difficulty of getting access to health care and medication.* ***Hence the duty on the state to take special measures to assist those who are the most vulnerable to disease and, simultaneously the most lacking in resources. The question, however, is not simply whether the objective of the regulation is worthy, which it clearly is, but whether it is reasonable. Put another way, the mere fact that it serves a rational purpose in pursuing a legitimate government aim, would not in itself be enough. It would have to pass the test of being reasonable.***"[75]

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[73] *TAC* para 4, emphasis added.
[74] *TAC* para 92, emphasis added.
[75] *Minister of Health and Another NO v New Clicks South Africa (Pty) Ltd and Others (Treatment*

(Emphasis added)

VII. THE PRIVATE HEALTH CARE SYSTEM WITHIN THE FRAMEWORK OF THE STATE'S OBLIGATIONS UNDER SECTION 27

A. Negative obligations and private entities

104. The Constitutional Court's decision in *TAC* indicates that the negative aspect of the right of access to healthcare services may in principle place an obligation on private bodies (in addition to the State) to desist from *"preventing or impairing"* the right of access in certain specific circumstances – obviously, the Constitutional Court has affirmed in *TAC*, that under section 27(2) only the State bears a positive obligation to ensure access to healthcare services.

105. This approach is in line with section 8(2) of the Constitution, which indicates that "*[a] provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right.*"

106. The Constitutional Court has not had occasion to consider the scope of the negative aspect of the section 27 right of access to health care, particularly in relation whether, and to what extent, it might apply to private entities.

107. That being said Currie and De Waal note that "*s 8(2) states that a 'provision' may apply to private conduct. It does not say that a 'right' may apply to private conduct. It is therefore possible, and quite reasonable, that some provisions of the Bill of Rights may apply to conduct of a private person or juristic persons while other provisions in the*

Action Campaign and Another as Amici Curiae) 2006 (2) SA 311 (CC) para 651, per Sachs J, emphasis added.

same section (and pertaining to the same right) will not apply to such conduct. ***For example, <u>the right of access to health care services (s 27(1) and (2)) probably does not apply directly horizontally</u>. However, the right not to be refused emergency medical treatment (s 27(3) probably does apply horizontally***."[76] (Emphasis added)

1. <u>*Juma Musjid*</u>

108. In understanding the ambit of the negative obligation and its implication for private bodies, useful instruction may be drawn from probably the leading case on the horizontal application of socio-economic rights, being *Juma Musjid.*[77]

109. The matter involved the right of access to basic education, and a decision by a Trust to evict a public school from land that the Trust owned, on the basis that the relevant provincial MEC had failed to enter into an agreement for the use of the land (in terms of section 14 of the Schools Act, which allows a public school to be located on private land by agreement)[78] and make payment in respect thereof.

110. The Constitutional Court, in considering whether the negative aspect of the right to a basic education (in section 29(1)) placed any obligation on the Trust in relation to the question of eviction, held as follows:

110.1 "*It is clear that there is no primary positive obligation on the Trust to provide basic*

[76] See Iain Currie and Johan De Waal, *The Bill of Rights Handbook*, 6th Edition, 2013 pp 48-49, emphasis added.
[77] *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others* 2011 (8) BCLR 761 (CC) at para 5406.
[78] Section 14(1) of the South African Schools Act 84 of 1996 provides that "*a public school may be provided on private property only in terms of an agreement between the MEC and the owner of the private property*".

education to the learners. That primary positive obligation rests on the MEC." [79]

110.2 "*<u>There was also no obligation on the Trust to make its property available to the MEC for use as a public school</u>. A private landowner may do so, however, in accordance with section 14(1) of the Act which provides that a public school may be provided on private property only in terms of an agreement between the MEC and the owner of the property.*"[80] (Emphasis added)

110.3 "*It needs to be stressed however that the purpose of section 8(2) of the Constitution* ***<u>is not to obstruct private autonomy or to impose on a private party the duties of the state in protecting the Bill of Rights</u>***. *It is rather to require private parties not to interfere with or diminish the enjoyment of a right.*"[81] (Emphasis added)

110.4 "*[Section 8(2)'s] application also depends on the 'intensity of the constitutional right in question, coupled with the potential invasion of that right which could be occasioned by persons other than the State or organs of State'.*"[82]

111. Importantly, the Court made clear that the primary obligation in respect to the learners' right rested on the State. The only reason why the Trust was found to bear a "*secondary*" obligation not to impair the right to basic education of the learners in that case was that it had decided to allow its land to be used as a **<u>public school</u>**, which was regulated by section 14 of the Schools Act. However, even though the Trust had made its property available for use as a public school, the Court emphasised that this did not mean that it had given up its rights of ownership – rather, the high watermark of the

[79] Para 57.
[80] Para 57.
[81] Para 58.
[82] At para 58 relying on *Khumalo and Others v Holomisa* 2002 (5) SA 401 (CC) at para 33.

Trust's obligation was a duty to try to minimise the impairment to the rights of the learners, when seeking an eviction.

112. In particular, the Court held that,

> "*In order to assess whether the Trustees acted reasonably in seeking an order for eviction, one has to be mindful that the primary obligation in respect of the learners' right to a basic education is that of the state. The Trust's obligation is secondary and, important to remember,* ***arises only from its willingness to allow the property to be used as a public school and to enter into a section 14 agreement.*** *It did not give up its rights of ownership of the property.* ***At most, the Trust's constitutional obligation, once it had allowed the school to be conducted on its property, was to minimise the potential impairment of the learners' right to a basic education.*****"** (Emphasis added)

113. In the context of the right of access to healthcare services, similar considerations would significantly impact upon whether any court would hold that private parties bear any negative obligation in relation to the right of access to healthcare services.

114. Evidently, such a secondary negative obligation (of minimising the potential impairment of a person's rights to access to healthcare) may only arise if private entities allow their facilities to be used for the provision of public healthcare. In those circumstances, private entities may need to act reasonably, by having regard to the possible effect on persons' rights of access to healthcare services, when seeking to terminate any agreement in relation to the use of facilities. Even then, these negative obligations would not cast a financial burden on the private entity to realise the right of access (nor would it limit their property rights) – the financial burden rests firmly on the State. The Constitution is clear in its assertion that it is the State that must realise

the right of access to healthcare services within the State's available resources.

115. Notably, unlike the right to basic education, the right of access to healthcare services is limited by the State's obligation to progressively realise that right within the State's available resources. As the Constitutional Court held in *Juma Musjid* "*[i]t is important, for the purpose of this judgment, to understand the nature of the right to a basic education under s 29(1)(a). Unlike some of the other socio-economic rights, this right is immediately realisable. There is no internal limitation requiring that the right be progressively realised within available resources subject to reasonable legislative measures. The right to basic education in s 29(1)(a) may be limited only in terms of a law of general application which is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.*"[83] (Emphasis added)

116. This distinction is important in the current context, when one is seeking to understand whether section 27(1) places any negative obligations on private entities. Since section 27(1) is limited by section 27(2) (the State's obligation to progressively realise), there could only ever be a very limited indirect negative obligation on private parties not to impair access that already exists, where this has been created by the State (and not privately). This is so since the Constitutional Court has made plain that the right in section 27(1) is not a general right to any minimum core of healthcare service. For instance, it is not, without more, a right to whatever healthcare is or could be made available in the private sector, particularly where persons cannot afford such healthcare), but rather it is only a right to access those services that the State is able to

[83] Para 37, emphasis added.

make available, and then only those that are made available within its available resources on a progressive basis.

117. Put differently, section 27(1) is limited by section 27(2), which is the State's obligation to realise the right within its available resources. Whatever the intensity of the right in section 27(1), its intensity is for the State to ensure as a matter of positive obligation, and then only programmatically. As to its negative component, it is also not a right that private entities would generally have the potential to invade, since the right means no more, and no less, than a right to those services which the State is able to provide – and hence there will be limited if any occasion for private hospital groups of "*minimising the potential impairment*" of a person's rights to access to healthcare.

118. Thus, section 8(2) is less likely to be interpreted as creating binding horizontal obligations upon private healthcare providers when read with section 27(1), certainly as compared with the right to basic education (which is not programmatic but immediately realisable).

119. If the right has any application to private parties it would be for them to ensure, in certain circumstances, that their actions do not impair or limit the right to access those services which the State has already made available through its available resources or is attempting to provide through the adoption of a reasonable programme aimed at progressively achieving the right's realisation. This may for instance be relevant if private parties enter into agreements with the State to make their resources available to the State as part of the public health care services offered by the State.

120. *Juma Musjid* also shows that the obligation on private parties, even if engaged, is limited, and distinct in kind and extent, from the obligation cast on the State:

120.1 It is not an obligation to realise the right (only the State bears that obligation);

120.2 It is not an obligation to incur expense or endure invasion of one's private property rights;

120.3 It is not an obligation that obstructs private autonomy;

120.4 At best it is an obligation to act in a consultative manner with the State, the primary obligation bearer, to seek to minimize any negative impacts on the rights holders, particularly in circumstances when the private entity has made its private property or facilities available (by agreement) to the State for the State's use in fulfilling the right in question.

121. *Juma Musjid* further makes clear that whether any negative obligation would be created on a private entity in relation to socio-economic rights, would depend on the facts. It would not arise in every instance. It would appear to mainly arise where the private entity has taken some positive step (for instance agreeing to make its property available for the public's use) that would draw down some negative obligation on the private entity not to impede the access that it has already permitted.

122. Ultimately, in *Juma Musjid*, the Constitutional Court held that in view of its long engagement with the MEC, the Trust had acted reasonably in seeking the eviction of the school from its property, and that in view of the fact that the MEC had made investigations to ensure that the learners would be accommodated at alternative schools, the granting of an eviction order was warranted. This finding further highlights the limited nature of the negative obligation, which socio-economic rights – through the courts – may place on private entities.

2. *Maphango*

123. A further case that emphasises the points drawn from *Juma Musjid*, is *Maphango and Others v Aengus Lifestyle Properties (Pty) Ltd* 2012 (3) SA 531 (CC).

124. In this matter, the residents of an apartment block had sought to challenge the cancellation of their leases by their landlord before the Gauteng Rental Housing Tribunal, a body established under the Rental Housing Act 50 of 1999. Ultimately, the tenants withdrew their complaint when the landlord brought eviction proceedings against them in the High Court. The High Court granted an eviction order. An appeal to the Supreme Court of Appeal ("**SCA**") was dismissed.

125. On appeal to the Constitutional Court, the majority found that it was appropriate to postpone the appeal to allow the residents an opportunity to refer a complaint to the Housing Tribunal for it to consider whether the cancellation of the leases had constituted an unfair practice under the Rental Housing Act (in the event that this was not done in 15 days, then the appeal would be dismissed. If it was, then the parties were given leave to approach the Court for further directions after the Tribunal's ruling).

126. In reaching this conclusion, Cameron J writing for the majority, reiterated the Court's view on the nature of the negative obligation created by socio-economic rights (in that case section 26 of the Constitution).

127. He held that:

> "*[T]he inclusion in the Constitution of social and economic rights created a*

right of access to social goods. Amongst these is the right now afforded to everyone to have access to adequate housing. ***It is true, as the landlord emphasised, that the main burden of fulfilling this right falls upon the state, which s 26(2) obliges to take reasonable measures within available resources to achieve its progressive realisation.***

[32] But the impact of the right is not solely on the state. ***It goes wider in two ways****. First, the right of access to adequate housing imports* ***an inhibitory duty not to impede or impair access to housing****. This rests not only on public bodies but also on private parties. ....*

[33] Later decisions of this court have shown how the progressive realisation of the right of access to housing may impinge on private parties. Thus, debt recovery is subjected to judicial consideration of the right before creditors may levy execution on a debtor's home. ***And while a private landowner cannot be expected to house unlawful occupiers indefinitely, its right not to be arbitrarily deprived of property must be interpreted in conjunction with the constitutional requirement that every eviction be made by court order after considering all the relevant circumstances.***

[34] ***The second way in which the right of access to adequate housing ripples out to private rights is when the state itself takes measures to fulfil the right. These may affect private relationships.*** *The Act is a prime instance. It originated in a government White Paper in December 1994 that envisioned a policy framework aiming to create market certainty while enabling provincial and local governments to fulfil their constitutional obligations in relation to housing.*

[35] The statute's heading states that it is enacted 'to define the responsibility of Government in respect of rental housing property' and 'to promote access to adequate housing through creating mechanisms to ensure the proper functioning of the rental housing market'. ***The Preamble expressly couches the statute's enactment and its objectives within the right of access to adequate housing, and the state's duty to fulfil it****. It*

goes on to note that 'rental housing is a key component of the housing sector', and that there is 'a need to promote the provision of rental housing'. It also notes 'a need to balance the rights of tenants and landlords and to create mechanisms to protect both tenants and landlords against unfair practices and exploitation', and to 'introduce mechanisms through which conflicts between tenants and landlords can be resolved speedily at minimum cost to the parties.'

[36] Rent control was a focus of major public debate before the Act was passed. It was recognised that rent control inhibited market mechanisms that provide an incentive for investors to contribute to the available stock of rental housing. After extensive public consultation, the statute's provisions were finalised, placing responsibility on government to 'promote a stable and growing market' in rental housing that 'progressively meets the latent demand for affordable rental housing among persons historically disadvantaged by unfair discrimination and poor persons'. This is to be done 'by the introduction of incentives, mechanisms and other measures' that improve conditions in the rental housing market, encourage investment and correct distorted patterns of residential settlement.

….

[49] The Act abolished rent control legislation, but in its stead, it enacted a more complex, nuanced and potentially powerful system for managing B disputes between landlords and tenants. That system expressly takes account of market forces as well as the need to protect both tenants and landlords. Even-handedly, it imposes obligations on both. ***It is in particular sensitive to the need to afford investors in rental housing a realistic return on their capital. The statutory scheme is therefore acutely sensitive to the need to balance the social cost of managing and expanding rental housing stock without imposing it solely on landlords. Far from ignoring the interests of investors like Lowliebenhof's landlord, the Act seeks to create a framework for resolving disputes with tenants that accommodates landlords'***

requirements."

(Emphasis added)

128. This is in line with the Court's jurisprudence in *Juma Musjid*, and it demonstrates that:

128.1 The primary and positive obligation for the realisation of socio-economic rights is on the State;

128.2 However, private individuals may be implicated in two ways:

128.2.1 They are required to not impede or impair access (a negative obligation) – this may be a relevant consideration when a private body seeks to exercise its private rights; and

128.2.2 The State's regulatory steps to fulfil the right of access may affect private relationships.

128.3 Where the State does choose to regulate in order to ensure access to social goods, it involves careful consideration of complex polycentric issues and extensive public consultation. For instance, in relation to rental housing, it was clear that the State when drafting the Rental Housing Act, after much debate chose to remove rent (price) control, because "*rent control inhibited market mechanisms that provide an incentive for investors to contribute to the available stock of rental housing*" – in other words, rental control would, in fact, have had a negative impact on access to rental housing.

129. We now turn to consider the State's regulatory function and its implications for private parties.

B. The State's regulatory function

130. It is evident from the Constitutional Court authority discussed above that section 27 does not create any direct positive obligation on private individuals or entities to fulfil the right of access to healthcare services, rather that obligation falls on the State. This is consistent with the purpose and wording of section 27(2). This is made evident by the fact that the Constitutional Court has definitively determined in a series of cases that section 27(1) has no independent content and creates no independent positive obligations: its content is animated and conscribed by what the State can reasonably provide within its available resources. This is in line with the weight of academic opinion, which has consistently suggested over many years that section 27 of the Constitution does not place any so-called "*horizontal*" obligation on the private sector to positively realise the right of access to healthcare services.[84]

131. Importantly, the Constitutional Court has recognised that in our society there will often be situations where persons may be unable to afford private healthcare, yet in those circumstances the Constitution does not place obligations on private institutions, but rather, consistent with section 27(2), it requires the State with its available resources to ensure access to public health care services.[85] This is clear from a reading of the *TAC* case in particular where the Court summarised the problem confronting it as follows:

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[84] See Iain Currie and Johan De Waal, *The Bill of Rights Handbook* 6th ed (2013), pg 49, Halton Cheadle and Dennis Davis '*The Application of the 1996 Constitution in the Private Sphere* (1997) 13 *SAJHR* 44, 59-60; Alfred Cockrell 'Private Law and The Bill of Rights: A Threshold Issue of "Horizontality" in Butterworths Bill of Rights Compendium (RS13 Oct 2003) ch3A, 33; Johan van der Walt 'Blixen's *Difference: Horizontal Application of Fundamental Rights and the Resistance to Neo-Colonialism* (2003) TSAR 311-331; and Stu Woolman and Dennis Davis '*The Last Laugh: Du Plessis v De Klerk, Classic Liberalism, Creole Liberalism and the Application of Fundamental Rights under the Interim and Final Constitutions*' (1996) 12 SAJHR 361, 399-401.

[85] See e.g. *TAC* para 94; *Soobramoney* para 31; *Grootboom* para 46.

> "*[W]hat is to happen to those mothers and their babies who cannot afford access to private health care and do not have access to the research and training sites?*"[86]

The answer provided by the Court was to require the State to expand its programme to accommodate mothers and their babies who could not afford access to private health care.

132. Section 27(2) of the Constitution envisages that it is the State that will need to realise the right of access to healthcare, in a progressive manner, by adopting reasonable legislative and other measures. Primarily its efforts will be focused on expanding the provisions and quality of services in the public health sector – which is why the Constitutional Court in *TAC* referred to section 27 enshrining a right to <u>public</u> healthcare services.

133. However, the Government, as with other sectors of the economy, has a regulatory role to play in relation to the private healthcare sector. In line with section 27(2) of the Constitution, the State should ensure reasonable regulation of the private healthcare sector that is not retrogressive, and which complies with the requirements of section 22 of the Constitution, and, in respect of regulations, that also complies with PAJA. Furthermore, the State is always constrained by the principle of legality when it operates in this regulatory space.[87]

134. The State has already taken regulatory steps in the context of the private healthcare sector. Examples include, in particular, the National Health Act, the Medical Schemes

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[86] *TAC* para 17.

[87] See *Pharmaceutical Manufacturers Association of South Africa & another: In re Ex Parte President of the RSA & others* 2000 (2) SA 674 (CC).

Act[88], and the Medicines and Related Substances Act, and the regulations thereunder.

135. Through this legislation the State has placed a number of obligations on the private healthcare sector, including for instance in relation to emergency medical care for members of the general public,[89] and the requirement that prescribed minimum benefits ("**PMBs**") must be provided to members of medical schemes.[90]

136. As the National Health Act makes plain in its preamble, these obligations are imposed in view of the State's obligations to ensure the progressive realisation of healthcare services. The National Health Act preamble states that:

> "*The State must, in compliance with section 7 (2) of the Constitution, respect, protect, promote and fulfil the rights enshrined in the Bill of Rights, which is a cornerstone of democracy in South Africa;*
>
> * *in terms of section 27 (2) of the Constitution the State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of South Africa to have access to health care services, including reproductive health care;*
>
> * *section 27 (3) of the Constitution provides that no one may be refused emergency medical treatment;*
>
> * *in terms of section 28 (1) (c) of the Constitution every child has the right to basic health care services;*"

137. As discussed above, the Constitutional Court has recognised that the National Health

[88] The Medical Schemes Act 131 of 1998.
[89] See section 5 of the National Health Act (which gives effect to section 27(3) of the Constitution) provides as follows:
"*A health care provider, health worker or health establishment may not refuse a person emergency medical treatment.*"
[90] In terms of the Medical Schemes Act.

Act gives effect to the right in section 27(3) to emergency medical treatment.

138. In relation to the Medicines and Related Substances Act, the Constitutional Court recognised in *New Clicks* that:

> "*The Medicines [and Related Substances] Act was first enacted in 1965. It has been amended on no less than 15 different occasions since then. From 1965 until 1997 the main focus of the Medicines [and Related Substances] Act was quality control.* ***In 1997, measures were introduced into the legislation directed towards making medicines more affordable. This, to give effect to the State's constitutional obligation to provide everyone with access to health care services***."[91] (Emphasis added)

139. The SCA has recently had occasion to consider the PMB scheme under the Medical Schemes Act and held that "*[o]ne of the underlying purposes of the PMB provisions in the Act and the regulations is to ease the demand upon public resources, which provide hospital and medical services at little or no cost, while at the same time ensuring that members of the medical scheme suffering from PMB conditions are able to obtain treatment at a satisfactory level.*"[92]

140. Returning to the National Health Act, one sees that the Act currently provides a framework, which the State (through the Minister of Health) may utilise to ensure proper regulation of the private healthcare sector, and co-ordination with the public sector, in the interests of ensuring the progressive realisation of the right of access to healthcare services. For instance:

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[91] Ne*w Clicks* para 1.
[92] *Council for Medical Aid Schemes and Another v Genesis Medical Scheme and Others* 2016 (1) SA 429 (SCA) at para 37.

140.1 Section 45 provides a framework to allow for co-ordinated relationships between private and public health establishments, by providing, *inter alia*, that:

> "*(1) The Minister must prescribe mechanisms to enable a co-ordinated relationship between private and public health establishments in the delivery of health services.*
>
> *(2) The national department, any provincial department or any municipality may enter into an agreement with any private practitioner, private health establishment or nongovernmental organisation in order to achieve any object of this Act.*"

140.2 Section 90(1)(v) provides that

> "*The Minister, after consultation with the National Health Council or the Office, as the case may be, may make regulations regarding…* ***the processes of determination and publication by the Director-General of one or more reference price lists for services rendered, procedures performed and consumable and disposable items utilised by categories of health establishments, health care providers or health workers in the private health sector*** *which may be used-*
>
> *(i) by a medical scheme as a reference to determine its own benefits; and*
>
> *(ii) by health establishments, health care providers or health workers in the private health sector as a reference to determine their own fees,*
>
> ***but which are not mandatory***". (Emphasis added)

140.3 Sections 35 to 40, which have not yet come into force,[93] will also require (subject

[93] See *President of the Republic of South Africa and Others v South African Dental Association and Another* CCT 201/14 of 27 January 2015, a case in which the Constitutional Court dealt with the date of commencement of ss. 36-40 of the Act. The Court declared the proclamation bringing the sections into effect invalid and set it aside (government made clear that the President had erroneously and *bona*

to regulations to be enacted),[94] parties in the private (and public) sector to have certificates of need when offering health services and operating health establishments[95] issued by the Director General, which certificate would be issued after consideration of,[96] and with conditions in relation to,[97] *inter alia*, numerous

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fide brought the sections into operation).

[94] See section 39.

[95] Section 36 provides that "*(1) A person may not-*

(a) establish, construct, modify or acquire a health establishment or health agency;

(b) increase the number of beds in, or acquire prescribed health technology at, a health establishment or health agency;

(c) provide prescribed health services; or

(d) continue to operate a health establishment or health agency after the expiration of 24 months from the date this Act took effect,

without being in possession of a certificate of need.

[96] *See section 36(3) which provides that "(3) Before the Director-General issues or renews a certificate of need, he or she must take into account-*

(a) the need to ensure consistency of health services development in terms of national, provincial and municipal planning;

(b) the need to promote an equitable distribution and rationalisation of health services and health care resources, and the need to correct inequities based on racial, gender, economic and geographical factors;

(c) the need to promote an appropriate mix of public and private health services;

(d) the demographics and epidemiological characteristics of the population to be served;

(e) the potential advantages and disadvantages for existing public and private health services and for any affected communities;

(f) the need to protect or advance persons or categories of persons designated in terms of the Employment Equity Act, 1998 (Act 55 of 1998), within the emerging small, medium and micro-enterprise sector;

(g) the potential benefits of research and development with respect to the improvement of health service delivery;

(h) the need to ensure that ownership of facilities does not create perverse incentives for health service providers and health workers;

(i) if applicable, the quality of health services rendered by the applicant in the past;

(j) the probability of the financial sustainability of the health establishment or health agency;

(k) the need to ensure the availability and appropriate utilisation of human resources and health technology;

(l) whether the private health establishment is for profit or not; and

(m) if applicable, compliance with the requirements of a certificate of non-compliance".

[97] *Section 36(5) provides that "The Director-General may issue or renew a certificate of need subject to-*

(a) compliance by the holder with national operational norms and standards for health establishments and health agencies, as the case may be; and

(b) any condition regarding-

(i) the nature, type or quantum of services to be provided by the health establishment or health agency;

(ii) human resources and diagnostic and therapeutic equipment and the deployment of human resources or the use of such equipment;

(iii) public private partnerships;

social goals related to access to healthcare services.

141. Obviously, much as with the Rental Housing Act, considered by the Constitutional Court in *Maphango*, this legislation has clearly been carefully crafted by the State in order to facilitate and realise access to healthcare services. For instance, in as much as the Legislature in seeking to ensure access to housing, while carefully balancing competing rights and interests, and the economic realities of the market, chose to abolish rental controls by means of the Rental Housing Act, so too in section 90 of the National Health Act, the Legislature has struck an appropriate balance by allowing the Minister to prescribe non-mandatory reference price lists. No doubt, the non-mandatory route was favoured for precisely the same reasons that articulated the Legislature's considered choice in the Rental Housing Act. As recognised by the Constitutional Court, "***rent control inhibited market mechanisms that provide an incentive for investors to contribute to the available stock of rental housing***."[98]

142. Of course, to emphasise the point we made in the introduction, it is *this* type of legislation (which is not focused solely on competition, but on the right of access to health care directly and more broadly), and the public participation processes that accompanied its adoption (and will accompany its amendment), that provide the proper subject of, and forum for, any inquiry into any broader question of whether, in general, the State has adequately fulfilled its constitutional mandate to progressively realise the right of access to healthcare services. If it is alleged that the State has failed in its constitutional obligations (including by failing to regulate private parties in a particular

(iv) types of training to be provided by the health establishment or health agency; and
(v) any criterion contemplated in subsection (3)."

[98] Para 35.

manner), then our courts can and should be approached to challenge such legislation, or any failures to take other measures toward realising such access, whether under that legislation or more generally. In addition, to the extent that the State wishes to comply with its obligations to ensure access to healthcare, then it is permitted to pursue that goal through reliance on the National Health Act and other applicable legislation that is purposely aimed at securing that social good.

143. When pursuing its regulatory aims, the State's regulatory role is constrained by the Constitution. Its regulation of the private healthcare sector must comply with the prescripts of the Constitution, in particular, section 27(2).

144. Whatever role the State assumes in its efforts to regulate the private sector, it cannot replace, supplant or transpose the obligation which the Constitution places squarely on its shoulders: to ensure progressive realisation of the right to access health services within the State's available resources. This positive and primary obligation cannot be shifted onto private entities, whether through legislative or regulatory measures, and not in the course of, or through reliance on, the HMI.

145. The scope and limits of the State's ability to regulate the private healthcare sector is well illustrated by a number of cases, which we now consider.

C. Relevant cases

1. *New Clicks*

146. In *Minister of Health v New Clicks South Africa (Pty) Ltd*, the Constitutional Court was called upon to consider the constitutionality of regulations, which, *inter alia,* controlled the retail prices of medicine. The Court held that certain of the regulations were

unconstitutional. Primarily the Court (and the judges who wrote separate concurring judgments) based this decision on the fact that the regulations (which five of the judges found to constitute administrative action) violated the requirements in terms of PAJA for lawful, reasonable, and procedurally fair administrative action and/or the principle of legality.[99] However, a number of the judges that wrote separately also made plain that the reasonableness of the regulations were also relevant since the regulations and the Medicines and Related Substances Act purported to give effect to the State's obligations under section 27(2).[100]

147. In striking down certain of the regulations, the Court noted that pharmacies are an essential component of the distribution chain of medicine and, therefore, if pharmacies went out of business, the accessibility of medicines would be impaired. Thus, it was found to be unconstitutional to set a dispensing fee that would cause pharmacies to operate at a loss and destroy the viability of profession, and therefore, the failure by the Pricing Committee to have regard to the representations made in that regard was unconstitutional.[101]

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[99] In relation to the applicability of PAJA the Court summarized the position as follows: "*Does the Promotion of Administrative Justice Act 3 of 2000 (PAJA) apply to the recommendations of the Pricing Committee and the subsequent making of regulations by the Minister? Five members of the Court hold that PAJA is applicable. One member of the Court holds that PAJA is applicable to the fixing of the dispensing fee only; and five other members of the Court hold that it is not necessary to decide whether PAJA is applicable, since on the assumption in favour of the Pharmacies that it is, they find the procedure followed to have been fair*." *New Clicks* para 13.

[100] *New Clicks* para 314 (per Chaskalson CJ); para 514 (per Ngcobo J); para 650 (per Sacks J); para 673 (per Moseneke J).

[101] See *New Clicks* para 19, and in particular Chaskalson CJ's separate judgment: "***[404] 'Accountability, responsiveness and openness' on the part of government are foundational values of our Constitution. An allegation has been made by professional organisations representing pharmacists that the dispensing fee will destroy the viability of pharmacies, and impair access to health care. That allegation is supported by a sufficient body of evidence to show that this is a real possibility. In the circumstances the applicants were under an obligation to explain how they satisfied themselves that this would not be the result of the dispensing fee prescribed in the regulations. They were the only persons who could provide this information. They did not, however, do so. Absent such explanation, there is sufficient evidence on record to show that the dispensing fee is not appropriate***."

148. The Court made clear that while Government *could* adopt a policy that sought to reduce the price of medicine to ensure better access to health care services, it must do so within the bounds of the Constitution and the law more generally. As the Court ruled:

> "*This case is not about the wisdom of government policy. Government is entitled to adopt, as part of its policy to provide access to health care, measures designed to make medicines more affordable than they presently are. That has not been disputed by any of the litigants nor by any of the Courts that have previously dealt with the matter.*
>
> *[33] What Courts are concerned with, and what this case is about, is whether the regulations have been made in accordance with the requirements of the Constitution and the law.*"[102]

149. The case made clear that the State in regulating the private sector must strike a correct and reasonable balance otherwise, despite its good intentions, the State may in fact impede the right of access to health care. As the Court held: "***the conduct of this litigation has made it plain that particular attention needs to be paid to the circumstances at least of rural and courier pharmacies to ensure that the right of access to health care is not prejudiced by driving such pharmacies out of the market.***"[103] (Emphasis added)

150. Furthermore, Chaskalson CJ, in his separate judgment, pointed out that ensuring access to medicine also meant ensuring the economic viability of pharmacies:

> "*[314] The purpose of s 22G of the Medicines Act read in the context of the Medicines Act as a whole is to enhance the accessibility and affordability of medicines. This is an obligation of the State which in terms of s 27 of the Constitution is obliged to take reasonable measures to enhance*

[102] Paras 32-33.
[103] Para 19.

access to health care.

[315] Section 22G requires the measures taken to achieve this end to be 'appropriate'. The cost of medicine is relevant to accessibility, but it is not the only factor. ***The medicine must be available to those who require it. Pharmacies are an essential component of the distribution chain. If pharmacies go out of business the accessibility of medicines will be impaired. An appropriate fee is thus one which at least strikes a balance between these requirements of cost and availability***." (Emphasis added)

151. Sachs J made clear in his judgment that when the State seeks to achieve the worthy aim of improving access to healthcare, it is not enough that its measures bear a rational connection to that objective, its measures must also be reasonable.[104]

152. Furthermore, Sachs J explained that in assessing reasonableness, it was particularly relevant whether Government was embarking on a new regulatory endeavour with significant effects on the private health care sector, and if it was, this created a heightened duty on the State:

> "***This is not a case where a system is in place and government decides on an incremental shift one way or the other.*** ***The state is in fact embarking upon an important new regulatory enterprise. I believe that the principle of accountability imposes on it a special responsibility in the particular circumstances to show that it has taken all reasonable steps to assess, take account of and justify the potential knock-on effects on the pharmacy profession of its new intervention. The more the risk, the greater the precaution.***"[105] (Emphasis added)

[104] *New Clicks* at para 651.
[105] *New Clicks* at para 663, emphasis added.

153. Sachs J provided useful guidance in relation to the requirement assessing reasonableness:

> "***[W]hen the reasonableness of the measure is put in issue by evidence that is more than lightweight, an element of persuasiveness or justification is required from the Ministry. It needs to go beyond reliance on placing itself inside the ordinary parameters within which a court would habitually give the nod to official discretion. There are circumstances, such as in the present case, where the nature of the matter, including its novelty and the uncertainty of its potential impact, requires persuasive evidence to indicate that the measure falls within the bounds of what is reasonable. There will be other more stable and predictable circumstances where the weighing of different elements should be left to the administrative body itself, with the court being obliged on the facts to adopt a far more deferential posture. In the long run the Ministry, the profession and the public will be better served by calculations that are manifestly reasonable, than by assertions that might or might not be true but lack convincing substantiation.***"[106] (Emphasis added)

154. This demonstrates that even legislation or schemes with laudable aims must be fine-tuned to the economic realities of the industry that the Government seeks to regulate. It will be impermissible for legislation or regulations, however noble their purposes, to lead to the impairment of access to health services by, for instance, forcing parties in the private health sector out of business.

155. In conclusion, we note that Sachs J pointed out that where measures that are aimed at achieving access to health care services have an impact on the economic viability of private bodies' activities, this then also brings section 22 of the Constitution into

[106] *New Clicks* para 664, emphasis added.

play.[107] Sachs J referred in that regard to the consideration of section 22 in the *Affordable Medicines Trust* case. We consider that case below.

2. *Affordable Medicines Trust*

156. In *Affordable Medicines Trust v Minister of Health*, the Constitutional Court considered "*a constitutional challenge to certain aspects of a licensing scheme introduced by the government. In terms of this scheme, health care providers, such as medical practitioners and dentists, may not dispense medicines unless they have been issued with a licence to dispense medicines by the Director-General of the Department of Health (Director-General). The scheme also regulates the premises from which medicines are dispensed. The challenge was directed at the powers of the Director-General to prescribe conditions upon which licences may be issued, the linking of a licence to dispense medicines to particular premises and the factors to which the Director-General is required to have regard when considering an application for a licence.*"[108]

157. The challenge was brought, primarily on the basis that the legislative scheme breached the principle of legality, in that relevant sections of the Medicines and Related Substances Act and certain regulations thereunder, were impermissibly vague, and/or exceeded the Minister's powers, and/or violated section 22 of the Constitution.[109]

158. Section 22 of the Constitution provides as follows:

"*Every citizen has the right to choose their trade, occupation or profession*

[107] *New Clicks* para 656-7.
[108] Para 1.
[109] Para 63 and 66.

> *freely. The practice of a trade, occupation or profession may be regulated by law.*"

159. Although, ultimately, the Court found that the challenge to provisions of the Medicines and Related Substances Act should be dismissed, it found that certain of the regulations under the Act were unconstitutional (as they were *ultra vires* the empowering provision) and therefore invalid.

160. In striking down certain regulations, Ngcobo J (as he then was) explained the Court's reasoning as follows:

> "*The purpose of reg 18(5) (a), (c), (d) and (e) is manifestly to protect pharmacies against competition from medical practitioners and nurses. This purpose is not discernible from the Medicines Act. Nothing in the Medicines Act empowers the Minister to develop such a policy through the regulations. It follows therefore that the provisions of reg 18(5)(a), (c), (d) and (e) that develop the policy of denying a licence where there are pharmacies in the neighbourhood are ultra vires the empowering statute.*"[110] (Emphasis added)

161. Nevertheless, it is relevant to have regard, for present purposes, to the Court's interpretation of section 22. Ngcobo J held, in elaborating on the test to be applied under section 22, that "*[t]he standard for determining whether the regulation of the practice of a profession falls within the purview of s 22 can therefore be formulated as follows: if the regulation of the practice of a profession is rationally related to a legitimate government purpose and does not infringe any of the rights in the Bill of Rights, it will fall within the purview of s 22.* ***Where the regulation of a practice, viewed objectively, is likely to impact negatively on the choice of a profession, such***

[110] Para 119.

regulation will limit the right freely to choose a profession guaranteed by s 22, and must therefore meet the test under s 36(1) *[that is it must be reasonable and justifiable].*[111] *Similarly, where the regulation of practice, though falling within the purview of s 22, limits any of the rights in the Bill of Rights, [it] must meet the s 36(1) standard.*"[112] (Emphasis added)

162. Furthermore, in *Affordable Medicines Trust*, Ngcobo J confirmed that the Constitutional Court's "***construction of s 22 accords with the approach of the German Federal Constitutional Court (the German Court) to art 12(1) of the Basic Law, which is almost identical to s 22***" and that "***[t]he leading decision on art 12(1) is the Pharmacy case.***"[113] (Emphasis added)

163. Article 12 provides that: *"All Germans shall have the right freely to choose their occupation or profession, their place of work, and their place of training. The practice of an occupation or profession may be regulated by or pursuant to a law."*

164. The leading German case on the interpretation of the provision is the *Pharmacy Case*[114] in which a provision in the Bavarian Apothecary Act was struck down as being

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[111] Section 36 provides that "*(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including-*
(a) the nature of the right;
(b) the importance of the purpose of the limitation;
(c) the nature and extent of the limitation;
(d) the relation between the limitation and its purpose; and
(e) less restrictive means to achieve the purpose."
[112] Para 80.
[113] *Affordable Medicines Trust and Others v Minister of Health and Others* 2006 (3) SA 247 (CC) at paras 64-5, emphasis added.
[114] 7 BVerfGE 377 (1958).

unconstitutional.[115]

165. The Court held that the fact that Article 12 allows the parliament to "*regulate*" the practise of an occupation by or pursuant to law means that activities infringing upon the freedom secured by Article 12 can be justified if they are based on a law. However, the Court also found that:

> "*…not just any legal basis will do; it has to comply with a test called the Stufentheorie (Gradation Theory), basically demanding that the harmful effects of the law on the freedom granted by Art. 12 … have to be proportionate to the value of the goal the parliament hoped to achieve. In the Pharmacy Case, the Court adjudged the harmful effect as immense. The parliament had made the choice of the person wishing to exercise an occupation dependent upon an objektive Berufswahlregelung (a criterion the person herself is unable to control), namely the commercial viability of the pharmacy. The Court demanded important overriding community interests to justify this harmful effect. The Court saw such an overriding interest in the public health, but could not see how the Bavarian law was necessary for this interest.*"[116]

166. More recent jurisprudence of the German Constitutional Court based on Article 12 is illustrative of the limits on the State's regulatory role in the private healthcare sector, and a similar approach is likely to be applied by the South African Constitutional Court:[117]

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[115] See Hestermeyer, H. P, '*A Chamber of the Federal Constitutional Court Endorses Private Dentists*' Information Service and Directory Within the Framework of the Right to Occupational Freedom.' *German Law Journal* Volume 2 (2001); and Kommers and Miller *The Constitutional Jurisprudence of the Federal Republic of Germany* 3rd ed (2012) Chapter 10.10 (this includes a useful translation of relevant portions of the judgment).

[116] Hestermeyer ibid at para 15.

[117] The summaries of the cases are all drawn from Kommers and Miller, *The Constitutional Jurisprudence of the Federal Republic of Germany: Third edition, Revised and Expanded* (2012), at 676-7.

166.1 In the *Stem Cell Research Case* (2000),[118] doctors challenged a federal law that prohibited the use of stem cells in the production of certain medicines. The issue arose in the context of doctors who were using stem cells from sheep embryos in treating human patients for therapeutic purposes. The Constitutional Court ruled that the federal government had overreached its authority in passing a law that effectively prohibited doctors from administering treatments to their patients, as they deemed medically necessary. Hence, the Constitutional Court found that the doctors' occupational rights under Article 12 (1) had been infringed by the law.

166.2 In the *Medical Specialization Case* (2002),[119] the German Constitutional Court was faced with a federal law that limited the manner in which doctors could advertise their specialities. In particular, the law only allowed doctors to advertise themselves as specialists in one area of medicine. The challenge was brought by a general practitioner who had, in addition, designated himself as a paediatrician on his letterhead and in directories. The Constitutional Court accepted that since it was possible to specialize in more than one area of medicine, the rule in the legislation that only allowed one speciality to be designated, violated the doctor's liberty to practice medicine under Article 12(1).

166.3 In the *Pharmacy Opening Hours Case* (2002),[120] the Constitutional Court had occasion to consider the Shop Closing Act. This Act barred pharmacies from selling goods other than pharmaceuticals and personal hygiene products on Saturdays and Sundays when other shops were required to close. Other shops were

[118] 102 BVerfGE 26 (2000).
[119] 106 BVerfGE 181 (2002).
[120] 104 BVerfGE 357 (2002).

permitted to remain open, within normal business hours, on only four Sundays each year. "*The complainant challenged a Land [equivalent of Provincial] regulation permitting pharmacies to open on Sundays on a rotating basis and obliging them to hang a sign on their door with the address of the nearest pharmacies open for business. The complainant was fined for keeping her pharmacy open on one of the four Sundays during which other businesses and shops were allowed to open even though, according to Land law, her pharmacy was scheduled for a rotating closure on that particular Sunday. She claimed the fine infringed both the equality and occupational freedom clauses of the Basic Law. The Federal Constitutional Court agreed but confined its analysis to Article 12 (1), ruling that the complainant's occupational freedom had been infringed. In applying the principle of proportionality, the Court held that infringements of occupational freedom may not go beyond what is required for the public welfare.*"[121] (Emphasis added)

3. HASA

167. Although, we have focused predominantly on Constitutional Court cases, one High Court authority worth noting is *HASA v Minister of Health.*[122]

168. *HASA* related to the National Health Reference Price List (the "**RPL**") published under the National Health Act. The case arose from an attempt by the Minister of Health and the Director General to impose the RPL (which purported to be a non-binding pricing guideline, that nevertheless had a significant impact on the industry) on the health care

[121] Kommers & Miller ibid at 678, emphasis added.
[122] *Hospital Association of South Africa Ltd v Minister of Health and Another* [2011] 1 All SA 47 (GNP).

industry, *inter alia*, without properly consulting with affected stakeholders.

169. The Court was forthright in its criticism.

> "*[154] The Director-General failed to respond timeously to the proposal submitted by HASA [the Hospital Association of South Africa] in relation to the alternative methodology. In so doing, he effectively barred HASA from making any submission in relation to either the 2009 or 2010 NHRPL. The correspondence reveals a consistent failure on the part of the Director-General to engage meaningfully with, or to listen to submissions from, or thereafter, to provide reasons and rational responses to the proposals submitted by and on behalf of HASA. The process of interaction on the part of the Director-General could best be described as one of disdain for and disregard of the rights of HASA.*
>
> *[155] This conduct on the part of the Director-General, and his subsequent publication of an RPL in the face of these attempts by HASA to be heard, tainted the process and the subsequent publication of an RPL with procedural unfairness such that the entire process and the resultant publication falls to be reviewed and set aside.*
>
> *[156] In addition to the principle of fairness inherent in the obligation of rule of law, the process also falls to be reviewed and set aside under the provisions of section 6(2)(c) of PAJA.*" (Emphasis added)

170. Accordingly, the RPL was set aside by the High Court (which decision was not appealed by the Department of Health).[123]

171. The case illustrates the importance of the Government exercising its regulatory role within constitutional bounds. This includes the requirement of procedurally fair

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123 *The Hospital Association of South Africa Ltd v The Minister of Health* 2010 (10) BCLR 1047 (GNP); [2011] 1 All SA 47 (GNP).

regulation as set out in PAJA. If Government fails in its obligations in this regard, it is evident that the courts will not hesitate to strike down such regulatory efforts that are an affront to established constitutional principles.

D. Impairment of access to healthcare

172. As made clear above, Government bears an obligation when implementing legislative and other measures to ensure the progressive realisation of the right to access healthcare services.

173. In addition to the positive obligation on Government to ensure, through its laws and policies, the progressive realisation of the right of access to healthcare services, it is also clear that its actions or laws must not impede existing access to healthcare services. That is because of the negative obligation imposed by section 27(1).

174. In *TAC* the Constitutional Court, with reliance on *Grootboom*, made clear that the right of access to healthcare services includes "*a negative obligation placed upon the State and all other entities and persons to desist from preventing or impairing the right of access*" to health care service.[124]

175. In the circumstances, any Government policy or legislation that has the effect of inhibiting the access that persons have secured for themselves to private healthcare, through contractual arrangements with private providers of health care, may violate the negative obligation created by the right of access to healthcare services. Moreover, it

[124] *TAC* para 46, relying on *Grootboom* at para 34, which in turn relied on *Ex parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa, 1996* 1996 (4) SA 744 (CC) at para 78; see further *Jaftha v Schoeman and Others* 2005 (2) SA 140 (CC) paras 33 to 34.

would not constitute a reasonable measure by the State to progressively realise the right of access, but would rather amount to an unreasonable and retrogressive measure, in violation of section 27(2).

176. Whether any impairment to persons' existing access to private healthcare is reasonable and justifiable will depend in large measure on whether the Government's legislative or other measures provided concomitant with any impairment, a viable public alternative which ensures the quality healthcare that at least approximates what was being obtained in the private sector.

177. This is made clear by the Constitutional Court's recent decision in *Law Society of South Africa and Others v Minister for Transport and Another* 2011 (1) SA 400 (CC).

178. In that case, the Court was dealing with sections of the RAF Amendment Act[125] under which the Minister of Transport had prescribed the tariff for claims to be paid by the Fund for hospital and other medical treatment. The Court held as follows in regard to the tariff:

178.1 "*I have no hesitation in finding that the UPFS tariff is a tariff that is wholly inadequate and unsuited for paying compensation for medical treatment of road accident victims* ***in the private health care sector****. The evidence shows that virtually* ***no competent medical practitioner in the private sector with the requisite degree of experience would consistently treat victims at UPFS rates. This simply means that all road accident victims who cannot afford private medical treatment will have no option but to submit to treatment at public health establishments.***"[126]

[125] Road Accident Fund Amendment Act 19 of 2005.
[126] Para 91.

(Emphasis added)

178.2 "*It emerges from the evidence that the UPFS tariff does not cover material services which road accident victims require and which are provided by the private health care sector. …* ***It is clear, that the UPFS tariff is inadequate for paying compensation for medical treatment for road accident victims and in particular in relation to victims rendered quadriplegic or paraplegic.***"[127] (Emphasis added)

178.3 "***Lastly and perhaps more importantly, the evidence shows that in certain material respects the public health institutions are not able to provide adequate services crucial to the rehabilitation of accident victims who are permanently disabled.***"[128] (Emphasis added)

178.4 "*A quadriplegic or paraplegic is constantly at risk in a state hospital as a result of the chronic lack of resources, paucity of staff and inexperience in dealing with spinal cord injuries. … spinal cord injured patients who are wholly dependent on state health care facilities commonly receive substandard care and are at the material risk of untimely death due to untreated complications.*"[129] (Emphasis added)

178.5 "… *there are serious deficiencies within the state health care centres and acknowledges that there are vast disparities between the public and private sector, a matter which remains a key challenge.*"[130] (Emphasis added)

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[127] Para 92.
[128] Para 93.
[129] Para 94.
[130] Para 95.

178.6 "***It is indisputable that imposing public health tariffs on road accident victims amounts to restricting them to treatment at public health institutions, if they cannot fund the healthcare themselves***. *In some instances, that restriction will be perfectly reasonable and adequate. However, the overwhelming and undisputed evidence demonstrates that road accident victims who are rendered quadriplegic or paraplegic require specialised care for life without which there can be life-threatening complications which if unattended lead to their inevitable demise.*"[131] (Emphasis added)

178.7 "*To this charge, the respondents have no effective answer.* ***They acknowledge the vast disparity between private and public healthcare establishments and explain how they propose to improve public healthcare establishments. What they do not do, is to meet head-on the complaint that quadriplegic or paraplegic road accident victims would not easily survive the health care services at public hospitals.***"[132] (Emphasis added)

178.8 "***The respondents do not suggest that there is a historical or present unfairness related to giving serious spinal injury accident victims access to private health care services whilst public health provision is being progressively improved.***"[133] (Emphasis added)

178.9 "*I am satisfied that the UPFS tariff is incapable of achieving the purpose which the Minister was supposed to achieve, namely a tariff which would enable innocent victims of road accidents to obtain the treatment they require. UPFS is not a tariff*

[131] Para 96.
[132] Para 97.
[133] Para 98.

at which private health care services are available; it does not cover all services which road accident victims require with particular reference to spinal cord injuries which lead to paraplegia and quadriplegia. ***The public sector is not able to provide adequate services in a material respect. It must follow that the means selected are not rationally related to the objectives sought to be achieved. That objective is to provide reasonable healthcare to seriously injured victims of motor accidents.***"[134] (Emphasis added)

178.10 "*…even if reg 5(1) were found to be rational,* ***the tariff is in any event under-inclusive in relation to the health care needs of quadriplegic and paraplegic road accident victims and, for that reason, would be unreasonable and thus in breach of s 27(1)(a) read together with s 27(2) of the Constitution.***"[135] (Emphasis added)

179. In light of this decision by the Constitutional Court, it is evident that until such time as there is significant improvement in the public health sector, any Government programme or legislative intervention that would seek to limit or reduce existing access to life-saving and superior private sector healthcare, is unlikely to pass constitutional muster, since it would not be a reasonable measure that would ensure the progressive realisation of access to healthcare services.

180. In this respect, one should also have regard to the Canadian Supreme Court case of *Chaoulli v Quebec*.[136] This case concerned the validity of the Health Insurance Act and the Hospital Insurance Act, under the Quebec Charter and the Canadian Charter.[137]

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[134] Para 99.
[135] Para 100.
[136] *Chaoulli v Quebec (AG)* [2005] 1 SCR 791.
[137] For the purposes of this discussion, the provisions of these Charters relevant to this judgment are substantially the same, and reference will be made to the Canadian Charter in the subsequent discussion

These Acts attempted to shore up the provincial health system by prohibiting Quebecers from taking out medical insurance for services in the private sector that are available under the provincial health system. The rationale of these provisions was the provision of healthcare services on the basis of need, and not on the basis of wealth. The appellants claimed that the waiting times in the public health system, coupled with the prohibition on medical insurance, created an obstacle to medical treatment, resulting in unnecessary suffering. As a result, the appellants argued, section 7 of the Charter, which protects the right to life, liberty and security of the person, was infringed.[138]

181. The majority, per Deschamps J, found that there was an infringement of section 7 of the Charter, since waiting times within the public healthcare system meant that it was "*inevitable that some patients will die if they have to wait for an operation.*"[139] Moreover, this infringement was not justified under the Charter since there was no proportionality between the measure adopted and the objective of the provisions, namely, "*to preserve the integrity of the public healthcare system.*"[140]

182. While Deschamps J found that there was a rational connection, she held that the Attorney-General had not demonstrated that this measure met the minimal impairment test.[141]

183. In coming to this conclusion, Deschamps J relied extensively on <u>comparative evidence</u>

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for ease of comparative reference. It should be noted, however, that the judgment was ultimately decided on the basis of the Quebec Charter, and the finding of the Court was inconclusive with regard to the Canadian Charter, since Deschamps J reserved judgment in this regard – the result being that three judges found a violation of the Canadian Charter, while three did not.

[138] Chaoulli *supra* para 37.

[139] As above, para 40.

[140] As above, para 56.

[141] Para 84.

from other Canadian provinces and OECD countries to show that the integrity of the public healthcare system could be maintained, even with private medical insurance allowed.[142]

184. In her reasoning, Deschamps J made a number of comments on the level of deference required of a court in relation to a Government policy intervention such as the one in issue. Her starting point was that Government must be able to justify any measures it takes which infringe Charter rights.

185. In assessing whether such a limitation is justifiable, courts can consider any evidence they wish and, provided that courts are satisfied that they have all the evidence necessary to make an assessment, they must do so. It is only where the State explains why evidence is too complex to be understood by the court, that a measure of deference is required.[143]

186. Moreover, none of the other reasons justifying deference, such as "*the prospective nature of the decision, the impact on public finances, the multiplicity of competing interests, the difficulty of presenting scientific evidence and the limited time available to the state*" were, according to Deschamps J, applicable in this case.[144] Rather, "*[t]he instant case is a good example of a case in which the courts have all the necessary tools to evaluate government's measure.*"[145]

187. Thus, Deschamps J emphasised the institutional capacity of the courts to decide

[142] Paras 70-84.
[143] Paras 85-92.
[144] Para 95.
[145] Para 96.

complex social matters, provided they have the appropriate evidence before them.

188. The concurring judgment of McLachlin CJ and Major J (with Bastarache J), similarly found that the purpose of the legislation was to protect the public health system and that there was an infringement of section 7 as the provisions in question restricted access to private healthcare, while "*failing to provide public healthcare of a reasonable standard within a reasonable time.*"[146] Such an infringement, they concluded, failed to meet the rational connection requirement, and characterised the provisions as "*arbitrary.*"[147] Moreover, they were of the view that the provisions failed to meet the minimal impairment test as "*the prohibition goes further than necessary to protect the public system.*"[148] The majority and concurring judgments therefore characterise the question before the court as being whether the prohibition on private medical insurance is justifiable given the waiting times within the public health system, and the legislative objective of protecting the public health system.

189. The *Chaoulli* case highlights that poorly crafted legislative or other measures, or ones which are not properly substantiated by evidence, stand to be struck down as unreasonable by the courts and, despite the usual deference that judges are expected to show towards the State's achievement of its policy goals. That is either because of a breach of section 27(2) or because of a more direct breach of rights such as the right to life (section 11), the right to dignity (section 10), or the right to bodily integrity (section 12(2)).

190. This makes clear that any Government policy or programme is unlikely to withstand

[146] Para 105.
[147] Para 155.
[148] Para 156.

constitutional scrutiny if it infringes in any way the public's current ability to access healthcare, in particular if its effect is to force the public to use substandard public healthcare when they are willing and able to make use of private healthcare.

191. Indeed, as the Constitutional Court found in *Law Society of South Africa v Minister for Transport* the "*public sector is not able to provide adequate services in a material respect. It must follow that the means selected [of imposing a tariff which would only allow access the public healthcare sector] are not rationally related to the objectives sought to be achieved. That objective is to provide reasonable healthcare*…."[149]

192. This same unassailable logic would apply to any attempt by the State to try to force the public to make use of a health care system which the government, and indeed the courts, accept is currently failing – particularly where a viable and competitive private healthcare sector is available to service the needs of paying customers. This would be irrational and unreasonable, and would constitute an unconstitutional impairment of the right to access healthcare, alternatively an unreasonable and retrogressive legislative measure in violation of section 27(2).

VIII. THE RIGHT OF ACCESS TO INFORMATION AND ITS RELEVANCE FOR THE HMI

193. The right of access to information, enshrined in section 32 of the Constitution, is not referred to as a relevant contextual consideration or issue in the Terms of Reference of the HMI.

194. Nevertheless, in the list of issues that the Evidence Leaders indicated *might* be relevant

[149] At para 99.

in relation to the broad issue of access to healthcare services, was the role of the private healthcare sector in fulfilling section 32 of the Constitution.

195. Therefore, to the extent that section 32 might be relevant, we, for the assistance of the Panel, consider in particular how the right has been interpreted by our courts.

196. Section 32 of the Constitution provides that:

> "*(1) Everyone has the right of access to-*
>
> *(a) any information held by the state; and*
>
> *(b) any information that is held by another person and that is required for the exercise or protection of any rights.*
>
> *(2) National legislation must be enacted to give effect to this right, and may provide for reasonable measures to alleviate the administrative and financial burden on the state.*"

197. The Constitutional Court has recently affirmed in *My Vote Counts*,[150] relying on its earlier jurisprudence, that PAIA is the legislation enacted in terms of section 32(2) that gives effect to the right in section 32(1) – that is the right both to information in the State's hands and in private hands when that information is required for the exercise or protection of rights.[151]

198. As Moseneke DCJ held in *Independent Newspapers*, "*[t]hat right of access to information is given effect to and regulated through legislation in the form of*

[150] *My Vote Counts NPC v Speaker of the National Assembly and* Others 2016 (1) SA 132 (CC).
[151] *My Vote Counts* paras 138-149.

[PAIA]."[152]

199. *My Vote Counts* makes clear that section 32(1) may not be relied on directly, but rather that parties must access the relevant right in terms of PAIA. Consequently, section 32(1) places no direct obligation on private parties or the State – the only relevant obligations are those in PAIA.

200. If any party were to argue that PAIA insufficiently gave effect to the rights enshrined in section 32, then that party's only recourse would be to challenge the constitutionality of PAIA.

201. Therefore, private healthcare sector participants' only obligation in relation to section 32 is an indirect obligation: to comply with the legislation (PAIA) enacted by Parliament to give effect to section 32.

202. In the circumstances, to the extent the Panel believes that the right of access to information and the role of private bodies in fulfilling that right is a relevant contextual issue to be considered, the Constitutional Court has confirmed that it must look exclusively to PAIA. That Act sets the four corners of the obligation on private bodies, and the concomitant rights of persons to obtain information from private bodies.

203. Of course, as noted by the Constitutional Court in *My Vote Counts*, there may be other legislation which obligates parties to provide information (that would include, for instance, requirements to provide information requested in terms of the Competition Act). However, that legislation is <u>not</u> the legislation envisaged in section 32(2), and

[152] *Independent Newspapers (Pty) Ltd v Minister for Intelligence Services: In re: Masetlha v President of the Republic of South Africa and Another* [2008] ZACC 6; 2008 (5) SA 31 (CC) at para 23.

that legislation is not giving effect to the constitutional right of access to information as enshrined in section 32(1). The Constitutional Court, in rejecting the view of the minority, make this distinction clear:

> "*[149] The minority judgment makes the point that PAIA is not the only legislation that gives effect to section 32. In this regard, it refers to various other pieces of legislation that make provision for access to information. However, even though those pieces of legislation do make this provision, they are distinguishable from PAIA. The main focus of each is some other subject; not access to information in terms of section 32(1) of the Constitution. That this is so is reinforced by the sparse manner in which the content of each touches on the right of access to information. In each, provision for the right is merely incidental to the legislation's main focus. On the contrary, PAIA's focus is one subject: the provision of information in terms of section 32(1) of the Constitution. In short, that there is out there a plethora of other pieces of legislation providing for access to information does not mean all those pieces of legislation are the legislation envisaged in section 32(2) of the Constitution.*"

204. Evidently, any other legislation that obliges private parties to provide certain information must, as with all legislation, be complied with.

A. The requirements of PAIA

205. Since, PAIA delimits the current scope of the private healthcare sector's obligations in terms of section 32, we consider its requirements briefly.

206. The relevant provisions of PAIA in relation to information held by a private body can be summarised as follows:

206.1 In terms of section 9(e), PAIA is, *inter alia*, intended "*to promote transparency, accountability and effective governance of all public and private bodies.*"

206.2 In terms of section 50, a requester (which can include a public body), must be given access to any records held by a private body, if three criteria are met:

206.2.1 First, the record requested must be "*required for the exercise or protection of any rights;*" (Emphasis added)

206.2.2 Second, there must be compliance with the procedural requirements in the Act; and

206.2.3 Third, the record must not be refused in terms of any of the grounds of refusal provided in PAIA. The possible grounds of refusal recognised by the Act include, *inter alia*:

206.2.3.1 Protecting the private information of a third party;

206.2.3.2 Protecting the commercial information of a third party;

206.2.3.3 Legal privilege; and

206.2.3.4 Protecting certain commercial information of the private body.

206.3 Furthermore, if the record is requested by a public body, other than for the protection or exercise of its own rights, the request must be in the public interest.

207. The threshold obligation is the fact that the record must be "*required*" for the exercise or protection of any rights. The SCA in interpreting the test for when a record is

"*required*", has held that "*[t]he question whether the information sought in a particular case can be said to be 'required' for the purpose of protecting or exercising the right concerned, can be answered only with reference to the facts of that case, having regard to the broad parameters laid down in the judgments of our courts, albeit, for the most part, in a negative form.*"[153] (Emphasis added)

208. With regard to the relevant case law the SCA summarised the established principles in relation to when information would be "*required:*"[154]

208.1 "*[I]t does not mean the subjective attitude of 'want' or 'desire' on the part of the requester.*"

208.2 "*[A]t the one end of the scale, 'useful' or 'relevant' for the exercise or protection of a right is not enough, but that, at the other end of the scale, the requester does not have to establish that the information is 'essential' or 'necessary' for the stated purpose.*"

208.3 "*The threshold requirement of 'assistance' has thus been established. If the requester cannot show that the information will be of assistance for the stated purpose, access to that information will be denied.*"[155]

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[153] *Unitas Hospital v Van Wyk and Another* 2006 (4) SA 436 (SCA) para 18.
[154] Paras 16-17, relying on see e.g. *Khala v Minister of Safety and Security*1994 (4) SA 218 (W) at 224G - 225E; *Shabalala and Another v Attorney-General,* B *Transvaal, and Another; Gumede and Others v Attorney- General, Transvaal*1995 (1) SA 608 (T) at 624C; *Nortje and Another v Attorney-General, Cape, and Another* 1995 (2) SA 460 (C) at 474G.
[155] With reliance on *Cape Metropolitan Council v Metro Inspection Services (Western Cape) CC and Others* 2001 (3) SA 1013 (SCA) where the SCA held that in para 28:
"*Information can only be required for the exercise or protection of a right if it will be of assistance in the exercise or protection of the right. It follows that, in order to make out a case for access to information . . . an applicant has to state what the right is that he wishes to exercise or protect, what the information is which is required and how that information would assist him in exercising or*

208.4 "*[M]ere compliance with the threshold requirement of 'assistance' will not be enough.*"[156]

208.5 It could be formulated as a need to show that the record is "*reasonably required*", where this connotes "*a substantial advantage or an element of need.*"

IX. CONCLUSION

209. At the beginning of this paper we summarised our key submissions. There is no need to repeat that summation in this conclusion.

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CHAMBERS, 25 FEBRUARY 2016

protecting that right."

[156] The SCA referred with approval to the finding in *Clutchco (Pty) Ltd v Davis 2005 (3) SA 486 (SCA)* where the SCA held (at para 13):
"I think that 'reasonably required' in the circumstances is about as precise a formulation as can be achieved, provided that it is understood to connote a substantial advantage or an element of need. It appears to me, with respect, that this interpretation correctly reflects the intention of the Legislature in s 50(1)(a)."