

Realising the right to health in South Africa

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1. Introduction	2
2. Health care in South Africa	3
3. Impact of apartheid on access to health	5
4. Legal, policy and functional frameworks	6
4.1 The protection of the right to health under international human rights law	6
4.2 Protection of the right of access under South Africa's constitutional and legislative framework	8
4.2.1 The South African Constitution	8
4.2.2 Normative content on the right to health	9
4.2.2.1 Availability	9
4.2.2.2 Accessibility	9
4.2.2.3 Acceptability	10
4.2.2.4 Quality	10
4.2.3 Legislation	10
4.2.3.1 National Health Act	10
4.2.3.2 The Mental Health Care Act	11
4.2.3.3 The Sterilisation Act	11
4.2.3.4 The Choice on Termination of Pregnancy Act	11
4.2.3.5 The Tobacco Products Control Amendment Act	11
4.2.3.6 The Medical Schemes Act	12
4.2.3.7 The Medicines and Related Substances Control Amendment Act	12
4.2.3.8 The Correctional Services Act	12
4.2.3.9 The Children's Act	12
4.2.3.10 Other health-related legislation	12
4.2.3.11 White Paper for the Transformation of the Health System (1997)	13
4.2.3.12 National Patients' Rights Charter	13

4.2.3.13 National Drug Policy	14
4.2.3.14 National Department of Health Strategic Plan 2010/11–2012/13	14
4.2.3.15 National Core Standards	15
4.2.3.16 National Health System (NHS) Priorities For 2009–2014 (The Ten Point Plan)	15
4.2.3.17 National Health Insurance	16
4.3 Jurisprudence on the right to health	18
4.3.1 Soobramoney v Minister of Health (Kwazulu-Natal)	18
4.3.2 Minister of Health and Other v Treatment Action Campaign	19
4.3.3 Pharmaceutical Manufacturers’ Association v President of the Republic of South Africa	21
4.3.4 New Clicks South Africa v Minister of Health and Another	21
4.3.5 Minister of Health and Another v New Clicks South Africa	22
4.3.6 Hospital Association of SA Ltd v Minister of Health and Another	23
4.3.7 Van Biljon and Others v Minister of Correctional Services	23
4.3.8 Lee v Minister of Correctional Services	24
4.3.9 Cipla Medpro (Pty) Ltd v Aventis Pharma SA	24
4.3.10 EN and Others v The Government of South Africa and Others	25
4.4 Barriers to health care provision	25
4.4.1 Cost of services	26
4.4.2 Personnel disparity between public and private health providers	27
4.4.3 Quality of health care services and poor management	27
4.4.4 Lack of implementation of policies	28
4.4.5 The burden of disease	28
4.4.6 Inequalities in access to health services	28
4.4.7 Primary health care or tertiary health care?	30
4.4.8 No clear allocation of responsibilities and tasks to the different spheres of government	30
4.4.9 Social determinants and access to health	31
5. Conclusion	32
Bibliography	33
Treaties	35
Legislation	36
Cases	36
Glossary	36
Notes	39

1. Introduction

The movement towards defining health as a social issue led to the founding of the World Health Organisation (WHO) in 1946.² With the emergence of health as a public issue, the conception of health changed. WHO developed and promulgated the understanding of health as ‘a state

of complete physical, mental and social well being and not merely the absence of disease or infirmity.’³ It defined an integrated approach linking together all the factors related to human well being, including physical and social surroundings conducive to good health.

The preamble to South Africa’s 1996 Constitution explicitly provides for the constitutional imperative to

improve the quality of life for all citizens and to free the potential of each person.⁴ The preamble to the Constitution specifically stipulates that it seeks to 'heal the divisions of the past', 'establish a society based on democratic values, social justice and fundamental human rights' and 'improve the quality of life for all citizens and free the potential of each person.'⁵

Section 7(1) of the Constitution affirms that it is 'a cornerstone of democracy in South Africa and emphasises the democratic values of human dignity, equality and freedom.' The Constitution places an overarching set of obligations on the State to 'respect, protect, promote and fulfil the rights in the Bill of Rights'.⁶ Furthermore, section 39(2) enjoins every court, tribunal or forum to 'promote the spirit, purport and objects of the Bill of Rights' when developing the common law or customary law. The Constitution thus creates various mechanisms for holding the State and private actors accountable for violations of socio-economic rights. An example is the South African Human Rights Commission which has a specific constitutional mandate to monitor socio-economic rights. In that regard, section 184(3) of the Constitution provides that:

Each year, the South African Human Rights Commission must require relevant organs of State to provide the Commission with information on the measures that they have taken towards the realisation of the rights in the Bill of Rights concerning housing, health care, food, water, social security, education and the environment.⁷

Section 27 of the Constitution affirms the right of everyone to have access to health care services, including reproductive health care. Section 27, as will be fully discussed below, places an obligation on the State to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of this right.⁸ In 2004, the National Health Act⁹ was promulgated to provide a framework for a structured and uniform health system that took into account the obligations imposed on the State by the Constitution. The National Health Act, in its preamble, acknowledges the socio-economic injustices and inequities of health ser-

vices of the past, the need to establish a society based on social justice and fundamental human rights, and the need to improve the quality of life for all in the country as the background context for its enactment.¹⁰

In this chapter, I discuss the right of access to health care services binding on South Africa with particular focus on select international law provisions, the relevant constitutional provisions, and the relevant laws, regulations and policies adopted to operationalise the right. I also discuss the various spheres of government responsible for the implementation of the right at all levels and analyse the systemic fault lines across all of the human rights dimensions that affect the realisation of the right of access to health care services.

The chapter is divided into three parts. The first part gives an overview of the health care system in South Africa, including a discussion of the impact of apartheid on access to health care services in the country. The second part analyses the legal and policy framework relating to the right of access to health care services as well as a discussion, select jurisprudence emanating from the courts relating to the right. The final part discusses the systemic fault lines across all human rights dimensions that affect the realisation of the right of access to health care services in South Africa. It is not, however, a comprehensive technical analysis of the efficacy of the laws, regulations and policies or programmes that have been adopted to operationalise the right of access to health care services. Nor is it an exhaustive discussion of the entire international legal framework, laws, policies, regulations and jurisprudence germane to the right of access to health in South Africa.

2. Health care in South Africa

Access to health care services in South Africa has historically been skewed in terms of race, gender, socio-economic status and a number of other arbitrary grounds. This division reflects the socio-economic fragmentation in the health delivery system where a relatively wealthy minority, usually covered by private health insurance, has access to private health care facilities. On the other hand, the majority of the population is mostly dependent

on overburdened, under-resourced and tax-funded public health facilities for hospital-based and inpatient care.¹¹ The result is that despite increased budgetary allocations in the health sector and improved social policies, South Africa has not adequately addressed health disparities in the country.¹² This is because of a health-care system ill-prepared to address the changing trend of burden of disease, poor management, inadequate human-resource capacity and a poor surveillance system.¹³ Kahn has pointed out that South Africa has a complex burden of disease, with a well-documented coexistence of infectious diseases/nutritional deficiencies, and chronic degenerative diseases.¹⁴ The country has experienced a complex health transition in the past two decades.¹⁵ Mortality worsened between 1990 and 2005, in all age groups, largely because of HIV and AIDS prevalence.¹⁶ South Africa's disease burden is characterised by both communicable and non-communicable diseases and, according to Chopra et al, the latter contributes substantially to rural and urban ill health.¹⁷

However, in the past few years, significant strides have been made mainly by the government to tackle these formidable health challenges at policy and health system levels.¹⁸ Commentators and health observers have noted that the government response to the HIV and tuberculosis epidemics has changed greatly since 2009.¹⁹ This has resulted in government increasing budgetary allocations over the years for the expansion of antiretroviral therapy, increased impetus on the prevention of mother-to-child transmission programmes, promotion of HIV and tuberculosis treatment integration, and increased investments in HIV prevention.²⁰ Mayosi et al have pointed out that the change in the leadership at the Department of Health has seen some advances in addressing the historical injustices in the health sector.²¹ It is particularly noteworthy that 'policy and programme changes are evident for all four of the so-called colliding epidemics: HIV and tuberculosis; chronic illness and mental health; injury and violence; and maternal, neonatal, and child health.'²²

A range of successes have been recorded in the past couple of years and the most important have been the increase in life expectancy and the decreases in child mortality from 56 to 40 per 1000 children and in infant

mortality from 40 to 30 per 1000 infants.²³ South Africa now has the world's largest programme of antiretroviral therapy, and some advances have been made in implementation of new tuberculosis diagnostics and treatment. Expansion of access to treatment has started to affect AIDS mortality, with the proportion of overall deaths that are related to AIDS decreasing between 2006 and 2011.²⁴ Significantly, HIV prevention has received increased attention and child mortality has benefited from progress in addressing HIV.²⁵ South Africa has adopted a strategy which aims to eliminate malaria in the country by 2018.²⁶ Malaria, a major cause of morbidity and mortality in southern Africa, has largely been contained and restricted in South Africa to the areas bordering Mozambique.²⁷

Mayosi et al have, however, pointed out that the new momentum is inhibited by stasis within the health management bureaucracy.²⁸ It must be noted that although progress has been made in access to basic education, electricity, potable water, and social protection, large racial inequities still exist in the social determinants of health, especially housing and sanitation for the poor and inequity between men and women.²⁹ It has also been pointed out that the integration of the private and public sectors, and of services for HIV, tuberculosis, and non-communicable diseases needs to improve so as to improve the health delivery system.³⁰

The significance of socio-economic determinants of health such as poverty, lack of access to basic social goods such as potable water, adequate sanitation and shelter, and social exclusion and marginalisation as drivers of an inequitable society have been extensively highlighted in South Africa, where for decades state-engineered social inequities were and continue to be systemic.³¹ The inequities in access to health care are worsening. In the past decade, private hospital and specialist costs have increased to more than the consumer price index, and distribution of specific skilled human resources is skewed to the advantage of the private sector.³² The private sector is run largely on commercial lines and caters for middle and high-income earners who tend to be members of medical schemes. Significantly, there has been a migration of health practitioners from the public sector to the private sector. This has heralded a two-

tiered system which is inequitable and inaccessible to a large portion of the population. While access to health care has generally improved in South Africa, the quality of health care has plummeted. Public health institutions in the public sector have suffered poor management, underfunding and deteriorating infrastructure.³³ The situation is compounded by public health challenges, including the burden of diseases such as HIV and tuberculosis, and a shortage of key medical personnel.³⁴ On the other hand, in the past decade, private hospital and specialist costs have increased faster than the consumer price index, and distribution of specific skilled human resources is skewed to the advantage of the private sector.³⁵ Over the past decade, private hospital costs have increased by 121 per cent whilst over the same period specialist costs have increased by 120 per cent.³⁶ Contribution rates per medical scheme beneficiary have doubled over a seven-year period. This has not been proportionate with increased access to services because of the limited access to needed health service coverage due to the design of the medical scheme benefit options, or the early exhaustion of benefits.³⁷

3. Impact of apartheid on access to health

South Africa is regarded as a middle-income country with a Gross Domestic Product (GDP) of \$277 billion.³⁸ However, it is worth noting that access to health care services in South Africa has historically been skewed in terms of race, gender, socio-economic status and a number of other arbitrary grounds. As noted by Coovadia et al, 'the history of South Africa has had a pronounced effect on the health of its people and the health policy and services of the present day.'³⁹ Coovadia et al have comprehensively chronicled the historical roots of the determinants of health in South Africa and the development of the health system through colonialism and apartheid to the current post-apartheid period.⁴⁰ The institutional mechanisms established to deliver health care services have historically reflected and continue to reflect a disproportionate bias in favour of dominant groupings in society. There are marked differences in rates of disease and mortality between races in South Africa and these

reflect racial differences in the access to basic household living conditions and other determinants of health.⁴¹ For example, the national prevalence estimates for HIV or rates of infant mortality are higher in black populations than in white populations.⁴²

At the advent of democracy in 1994, the health system was extremely fragmented and reflected broader societal inequalities. Health policy in the apartheid era, like all government action, was dominated by the objective of maintaining economic and political power, and a higher quality of life for the white population with scant regard to the plight of the black majority.⁴³ Prior to 1994, the health system was fragmented and designed along racial lines. On the one hand was a highly resourced system that benefited the white minority. The other was systematically under-resourced and reserved for the black majority.⁴⁴ This resulted in rigid segregation of health facilities and grossly disproportionate spending on the health of whites as compared to blacks, with the latter relegated to overcrowded and filthy facilities characterised by inadequate staff, funds and other resources.⁴⁵ The result were public health policies that ignored diseases primarily affecting black people and the denial of basic sanitation, clean water supply and other components of public health to homelands and townships.⁴⁶ Attempts to deal with these disparities and to integrate the fragmented services that resulted from fourteen health departments (serving the four race groups and various bantustans) did not fully address the inequities. Problems linked to health financing that are biased towards the privileged few have also not been adequately addressed.⁴⁷

Another key feature of the health sector by 1994 was that it was very biased towards hospital-based, curative care. South Africa had considerable hospital capacity, but this was heavily concentrated in urban areas and at the higher levels of care. Its district hospital capacity was poor and primary care services had been systematically neglected. The adoption of the 1996 Constitution resulted in the creation of nine provinces which integrated the former provinces and 'homelands'. A quasi-federal structure was adopted whereby considerable responsibility was given to each province. The public health system was streamlined into a single Department

of Health at the national level and one in each of the nine provinces. Some local governments also had health departments, but for many years their role in the overall health system was legislatively unclear.

The national level is largely responsible for providing overall strategic direction for the health system, ensuring that health policy is translated into legislation, monitoring the implementation of national policy. The national department is also responsible for developing norms and standards to ensure that all South Africans, irrespective of the province within which they live, enjoy access to comparable health services.⁴⁸ The provincial level is directly responsible for certain services, such as specialist hospital services and ambulance services and for overseeing all health services within that province. The local government level is only directly responsible for 'municipal' health services, which largely relate to environmental health services.⁴⁹

4. Legal, policy and functional frameworks

4.1 The protection of the right to health under international human rights law

A significant number of international and regional human rights instruments provide for the right to health. The content of the obligations imposed by the right to health have been elaborated by the United Nations (UN) and regional treaty monitoring bodies. With the establishment of WHO, for the first time the right to health was recognised internationally. The WHO Constitution affirms the enjoyment of the highest attainable standard of health 'as one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'⁵⁰ Significantly, this recognition was reiterated in a wide range of international and regional human rights instruments, which include the Universal Declaration of Human Rights (UDHR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW); the Convention on the Rights of the Child (CRC); the American Declaration on the Rights and Duties of Man; the European Social Charter (ESC);

the African Charter on Human and Peoples' Rights (African Charter); the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and the African Charter on the Rights and Welfare of the Child, among others.

Universal recognition of the right to health was further buttressed in the 1978 Declaration of Alma-Ata on Primary Health Care (Alma-Ata Declaration), in which states pledged to progressively develop comprehensive health care systems to ensure effective and equitable distribution of resources for maintaining health.⁵¹ The Alma-Ata Declaration proclaims that the attainment of the highest possible level of health is a 'most important worldwide social goal.'⁵² Signatory states undertook to provide adequate health care and social measures for their populations.⁵³ The Alma-Ata Declaration develops the bases for implementing primary health care systems, which have implications for the observance of the right to health. Although the Alma-Ata Declaration is not binding, it represents a further commitment on the part of states to respect the right to health, and establishes the framework for an integrated policy aimed at securing its enjoyment. The following section discusses the protection of the right to health under international human rights law in detail.

The UDHR provides for the right of everyone to the adequate standard of health.⁵⁴ As a General Assembly resolution, the UDHR is not binding as such.⁵⁵ However, its most fundamental provisions are generally thought either to have crystallised into customary international law or to constitute an authoritative interpretation of the UN Charter obligations.⁵⁶ Significantly, the broad human rights provisions contained in the UDHR have since been incorporated in legally binding form in many international human rights instruments.⁵⁷

The ICESCR provides for the right to health in article 12 by enjoining states to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.⁵⁸ The steps to be taken by the states to achieve the full realisation of the right to health should include those necessary for the reduction of the stillbirth rate, of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention,

treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which would assure to all medical service and medical attention in the event of sickness.⁵⁹

CEDAW also provides for the right to health. Article 12 of CEDAW enjoins states parties to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Additionally, states are compelled to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. The CEDAW also provides for the particular problems faced by rural women. Article 4(2)(b) provides that states parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right to have access to adequate health care facilities, including information, counselling and services in family planning.⁶⁰

The CRC also contains a comprehensive provision on the right to health.⁶⁰ The CRC enjoins states parties to strive to ensure that no child is deprived of his or her right of access to such health care services. Article 24 of the CRC emphasises that state parties should pursue full implementation of the right and to take measures to diminish infant and child mortality, and to ensure the provision of necessary medical assistance and health care to all children, with emphasis on the development of primary health care. Additionally, states parties are enjoined to combat disease and malnutrition, including within the framework of primary health care, through the application of readily available technology and the provision of adequate nutritious foods and clean drinking water; appropriate pre-natal and post-natal health care for mothers; and to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children.

The African Charter recognises that individuals within the states' respective jurisdictions have the right

to enjoy the best attainable state of physical and mental health. Consequently states must undertake to adopt measures necessary to protect such individuals' health by ensuring 'that they receive medical attention when they are sick.'⁶¹ The fulfilment of the right to health is, furthermore, linked to the protection and implementation of other provisions in the African Charter which may have direct or indirect implications on a person's enjoyment of the right to health.

In the case of *Purohit and Moore v The Gambia (Purohit)*, the African Commission on Human and Peoples' Rights (African Commission), the monitoring organ under the African Charter, has held that states have an obligation to ensure that health care facilities and commodities, including medicines, are made available to citizens.⁶² The African Commission further stated that the enjoyment of the right to health is crucial to the realisation of other fundamental rights and freedoms and includes the right of all to health facilities, as well as access to goods and services, without discrimination of any kind.⁶³ The African Commission reiterated that mental health patients should be accorded special treatment to enable them to attain and sustain their optimum level of independence and performance.⁶⁴

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women Protocol)⁶⁵ became the first international treaty to provide for binding obligations on the right to health, which specifically mentions HIV and AIDS. Article 14(1) of the African Women Protocol provides that states parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. In that regard states are enjoined to respect and promote the right of women to control their fertility; to decide whether to have children, the number of children and the spacing of children; to choose any method of contraception; the right to self-protection and to be protected against sexually transmitted infections, including HIV and AIDS; family planning education as well as adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas.

The African Charter on the Rights and Welfare of the Child (African Children's Charter) provides for the right of every child to enjoy the best attainable state of physical, mental and spiritual health.⁶⁶ The African Children's Charter enjoins states to reduce infant and child mortality rate; ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; ensure the provision of adequate nutrition and safe drinking water; combat disease and malnutrition within the framework of primary health care through the application of appropriate technology; and ensure appropriate health care for expectant and nursing mothers. It further imposes obligations on states to develop preventative health care and family life education and provision of service; integrate basic health service programmes in national development plans; ensure that all sectors of the society, in particular parents, children, community leaders and community workers, are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents.⁶⁷

Article XI of the American Declaration on the Rights and Duties of Man establishes the right to the preservation of health through sanitary and social measures (food, clothing, housing and medical care), while it conditions its implementation on the availability of public and community resources. Significantly, article 34 of the Organisation of American States' Charter stipulates, as among the goals for contributing to the integral development of the person, access to knowledge of modern medical science and to adequate urban conditions. The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights provides for the right to health for all individuals in article 10 and the right to a healthy environment in article 11.

The European Social Charter (ESC) complements the European Convention on Human Rights in the field of economic and social rights. Article 11 of the ESC provides for the right to health, the attainment of which it enjoins states to engage in promotion, education and disease prevention activities. The ESC has several provisions which guarantee, expressly or implicitly, the right to

health. Article 11 covers numerous issues relating to public health, such as food safety, protection of the environment, vaccination programmes and alcoholism. Article 3 concerns health and safety at work. The health and wellbeing of children and young persons are protected in articles 7 and 17. The health of pregnant women is guaranteed under articles 8 and 17. The health of elderly persons is protected under article 23 of the ESC.

In addition to human rights instruments, there are soft law mechanisms such as the MDGs which have helped to put the issue of access to health care on the global agenda.⁶⁸ The MDGs, derived from the Millennium Declaration of 2000, consist of eight goals which all member states of the UN have pledged to achieve by 2015.⁶⁹ Of the MDGs, four are directly related to health, namely (i) to reduce child mortality; (ii) to improve maternal health; (iii) to combat HIV and AIDS, malaria and other diseases; and (iv) to eradicate poverty. Each of the MDGs has time-bound and quantifiable targets measurable by specific indicators and such targets and indicators are designed to assess country progress towards realisation of the goals highlighted above.

4.2 Protection of the right of access under South Africa's constitutional and legislative framework

4.2.1 *The South African Constitution*

The right of access to health care is provided for in three sections of the Constitution. These provide for access to health care services, including reproductive health, basic health care for children, and emergency services and medical services for detained persons and prisoners.⁷⁰ Universal access is provided for in section 27 (1)(a) which states that 'Everyone has the right to have access to health care services, including reproductive health care.' Section 27 (1)(b) provides for the state to 'take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of the right.' Section 27(3) states that no one can be denied emergency medical treatment. Section 28(1)(c) provides for the right to basic health care services for children, whereas section 35(2)(e) protects the right to adequate medical treatment at state expense for detained persons. Other health-related con-

stitutional provisions include section 24(a), which protects the right to an environment that is not harmful to one's health or well being. Section 12(2) protects the right to bodily and psychological integrity, including the right to make decisions on reproduction; to security in and control over one's body; and the right not to be subjected to medical or scientific experiments without one's informed consent.

4.2.2 Normative content on the right to health

The Committee on Economic, Social and Cultural Rights (CESCR), in its General Comment No. 14, has elaborated on the normative content of the right to health, stating that the right to health facilities, goods and services should be understood as:

The creation of conditions which would assure to all medical service and medical attention in the event of sickness ... both physical and mental, includes the provision of equal and timely access to basic preventative, curative, rehabilitative health services, and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventative and curative health services, such as the organisation of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.⁷¹

The CESCR, in its General Comment No. 14, has elaborated on the normative content of the right to health by recognising the right to health to include equal access for all, on the principle of non-discrimination, to health care facilities, goods and services. These have to be available in sufficient quantity; must be physically and economically accessible to everyone; must be ethically and culturally acceptable; and must be of a medically appropri-

ate quality. These four principles are discussed in more detail below.

4.2.2.1 Availability

Functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity.⁷² These include the underlying determinants of health, such as safe and potable drinking water and sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by WHO's Action Programme on Essential Drugs.⁷³

4.2.2.2 Accessibility

Health facilities, goods and services have to be accessible to everyone within the jurisdiction of a state without discrimination.⁷⁴ Accessibility has four overlapping dimensions. These include non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised, in law and in fact, without discrimination on any of the prohibited grounds. Physical accessibility entails that health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups.⁷⁵ Accessibility further includes adequate access to buildings for persons with disabilities. Among such groups it includes ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons living with HIV and AIDS.

Economic accessibility (affordability) entails that health facilities, goods and services must be affordable for all.⁷⁶ It expressly stipulates that payment for health care services must be based on the principle of equity, ensuring that these services, whether publicly or privately provided, are affordable for all, including socially disadvantaged groups. Payment for health care services must be based on the principle of equity. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility includes the right to seek, receive and impart information and ideas concerning

health issues.⁷⁷ However, accessibility of information should not impair the right to have personal health data treated with confidentiality. Access is therefore the opportunity and freedom to use services, and encompasses the circumstances that allow for appropriate service utilisation, plus a sufficiently informed individual or household (demand-side) empowered to exercise choice within the health system (supply-side). The 'degree of fit' between demand- and supply-sides, rather than each in isolation, determines the degree of access achieved.⁷⁸

4.2.2.3 Acceptability

Acceptability is a poorly conceptualised dimension of access to health care. Studies have shown that if a health system cannot be trusted to guarantee a threshold level of quality, it will remain under-utilised.⁷⁹ Gibson has pointed out that perceptions of whether patients are treated respectfully and with dignity are also important for understanding the acceptability of health care and its representation.⁸⁰ In relation to general views on the public sector, just over half of respondents in a South African Costs and Benefit Incidence Analysis study by McIntyre et al showed that patients at public hospitals are rarely treated with respect and dignity.⁸¹

The CESCR has elaborated in General Comment 14 that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.⁸² It is therefore significant to take into account the various perceptions as to the acceptability of health care services that people hold of public and private hospitals and to understand these in light of contemporary health system reforms in South Africa.⁸³

4.2.2.4 Quality

In the South African Costs and Benefit Incidence Analysis study by McIntyre et al highlighted above, the findings of the study provided insights into the dissatisfaction among health care users in South Africa with both the private and the public health care providers.⁸⁴ Concerns about public sector health care providers primarily related to patient-provider engagements, cleanliness of

facilities and drug availability.⁸⁵ Concerns with private health care providers related to the high cost of medical schemes and the underlying profit motive.⁸⁶

The CESCR has explained in General Comment 14 that health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.⁸⁷

In addition to these four principles, General Comment No. 3 of the CESCR enjoins states parties to ensure the satisfaction of minimum essential levels of all the rights enunciated in the ICESCR. For example, a state in which any significant number of individuals is deprived of essential primary health care is failing to discharge its obligations under the ICESCR⁸⁸ and constitutes a violation of the right. In the CESCR's view, the minimum core standards for the right to health include at least the following, and are non-derogable.⁸⁹ The state is obliged to:

- ensure essential primary health care;
- to ensure the right of access to health care facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalised groups;
- ensure equitable distribution of all health facilities, goods and services;⁹⁰
- provide essential drugs as defined by WHO's Programme on Essential Drugs;⁹¹ and
- adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population which shall be devised and periodically reviewed.

4.2.3 Legislation

4.2.3.1 National Health Act

The National Health Act 61 of 2003 (National Health Act) came into force in May 2005 and is the most important piece of legislation implementing the constitutional rights on health. Although other laws deal with specific aspects of health rights, the National Health Act is the main law that gives overall direction on health rights in South Africa. The National Health Act provides a framework for a single health system for South Africa. Fur-

thermore, it provides for a number of basic health care rights, including the right to emergency treatment⁹² and the right to participate in decisions regarding one's health.⁹³ Some of the aims of the National Health Act are to make effective health services available to the population equitably and efficiently; to protect, promote, respect and fulfil the rights of South Africans to progressively realise the constitutional right to health; and to establish a national health system that will provide people with the best possible health services that available resources can afford.⁹⁴ The National Health Act also gives special protection to people needing emergency medical treatment by stipulating that a public or private health care provider, health worker or health establishment may not refuse anyone emergency medical treatment.⁹⁵

The National Health Act similarly calls for 'a spirit of co-operation and shared responsibility among public and private health professionals and providers.'⁹⁶ However, no framework is provided on how interaction between the public and private health sectors will occur. Developing a framework for both the public and private health sectors on their interactions is important. Additionally, the National Health Act pays particular attention to the need to 'provide uniformity in respect of health services across the nation.'⁹⁷ This concern has arisen since the establishment of a quasi-federal constitutional structure in 1996, where provincial governments, which have the main responsibility for health care provision, have considerable autonomy in funding, planning and implementing health and other social services. Consequently, the National Department of Health has an important role to play in ensuring the provision of essential services, which all public sector health departments must equitably provide, within the limits of available resources.⁹⁸

4.2.3.2 The Mental Health Care Act

The Mental Health Care Act 17 of 2002 (Mental Health Act) recognises that health is a state of physical, mental and social wellbeing, and that mental health care services must be provided at all levels of the health system. The Mental Health Act aims to regulate the mental health care environment in a way that allows the best possible

mental health care, treatment and rehabilitation that available resources can afford;⁹⁹ sets out the rights and duties of the mental health care user, and the duties of mental health care providers;¹⁰⁰ and respect for the human dignity and privacy of every mental health care user.¹⁰¹ This means that mental health care users must receive treatment and rehabilitation services that would enable their mental capacity to develop to their full potential and to facilitate their integration into community life.

4.2.3.3 The Sterilisation Act

The Sterilisation Act 12 of 1998 (Sterilisation Act) provides for a right to sterilisation and sets out the circumstances when a sterilisation can be performed. Sterilisation is a surgical operation to make a woman incapable of falling pregnant. The Sterilisation Act also deals with the sterilisation of people with severe mental disabilities. The Sterilisation Act elaborates what 'severe mental disability' means and who needs to consent when a person has a severe mental disability, and wants or needs to be sterilised.

4.2.3.4 The Choice on Termination of Pregnancy Act

The Choice on Termination of Pregnancy Act 92 of 1996 gives every woman the freedom to choose whether to have an early, safe and legal termination of pregnancy, according to her beliefs. The Choice on Termination of Pregnancy Act provides for a pregnant woman to choose to have her pregnancy terminated on request during the first twelve weeks of pregnancy. All that the law requires is informed consent.

4.2.3.5 The Tobacco Products Control Amendment Act

The Tobacco Products Control Amendment Act 12 of 1999 was introduced to deal with the harmful effects of tobacco on the health of people. It prohibits the advertising and promotion of tobacco, the free distribution of tobacco products and the smoking of tobacco products, in any public place or workplace. Additionally, the [Tobacco Products Control Amendment Act 23 of 2007] prohibits smoking in public places, creates public awareness of the health risks of tobacco by requiring certain information on packaging, and prohibits the sale of

tobacco products to any person under the age of eighteen.

4.2.3.6 The Medical Schemes Act

The Medical Schemes Act 131 of 1998 (Medical Schemes Act) attempts to enable access to affordable health care services by setting out guidelines on the terms and conditions for membership to medical schemes. The Medical Schemes Act requires that contributions to medical schemes be made only on the basis of income or number of dependants, or both income and dependants. The Medical Schemes Act explicitly prohibits contributions being determined on the basis of past or present state of health or the frequency of using health care services.¹⁰² By limiting the basis on which contributions are made, the Medical Schemes Act effectively disallows the 'loading' of premiums on the basis of health status. This in turn makes health care services more affordable to those who need them. The Medical Schemes Act also limits cancellation or suspension of membership to instances of failure to comply with the rules, fraudulent activities and non-disclosure of material information.¹⁰³

4.2.3.7 The Medicines and Related Substances Control Amendment Act

The Medicines and Related Substances Control Amendment Act 90 of 1997 controls the manufacture, sale and distribution of medicines. One of its important functions is to set out steps to ensure the supply of affordable medicines. Section 15(c) of the Act allows the Minister of Health to lay down conditions for the supply of more affordable medicines in some circumstances to protect public health. This includes provisions that enable the lowering of the cost of prescription drugs purchased at pharmacies. Additionally, the Medicines and Related Substances Amendment Act 59 of 2002 aims to make drugs more affordable and provides for transparency in the pricing of medicines.

4.2.3.8 The Correctional Services Act

The Correctional Services Act 111 of 1998 (Correctional Services Act) places a duty on the Department of Correctional Services to provide all prisoners with adequate health care services. Adequate health care is based on the

principles of primary health care in order to allow every prisoner to lead a healthy life. The Correctional Services Act explicitly provides that every prisoner has the right to adequate medical treatment, but that no prisoner has a right to cosmetic medical treatment, such as the removal of tattoos or implants of breasts at state expense. The Correctional Services Act further provides that every prisoner has the right, at his/her own expense, to be visited and examined by a medical practitioner of his/her choice and may be treated by this practitioner as long as the Head of Prison has given permission. The Correctional Services Act prohibits anyone from forcing a prisoner to undergo medical examination, intervention or treatment without informed consent, unless this will be a threat to the health of other prisoners. However, consent to surgery is not needed if a medical doctor decides that it is in the interests of the prisoner's health, and the prisoner is unable to give consent because he/she is unconscious.

4.2.3.9 The Children's Act

The Children's Act¹⁰⁴ aims to protect children living with disabilities or chronic illnesses. Section 11(3) of the Children's Act provides that a child with a disability or chronic illness has the right not to be subjected to medical, social, cultural or religious practices that are detrimental to his/her health, wellbeing or dignity. The Children's Act also restricts virginity testing and outlaws female genital mutilation or circumcision. Section 12(8) of the Children's Act prohibits circumcision of male children under the age of sixteen, except when circumcision is performed for religious purposes in accordance with the practices of a specific religion, or where circumcision is performed for medical reasons on the recommendation of a medical practitioner. The Children's Act further restricts the circumcision of male children older than sixteen in that the child must give consent after proper counselling. This entails that any male child has the right to refuse circumcision, taking into account the child's age, maturity and stage of development.

4.2.3.10 Other health-related legislation

Other important pieces of legislation include the Nursing Act 33 of 2005, which provides for the introduction of

mandatory community service for nurses. The Pharmacy Amendment Act 1 of 2000 permits non-pharmacists to own pharmacies, with the aim of improving access to medicines. The Health Professions Act 56 of 1974 provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions. The Foodstuffs, Cosmetics and Disinfectants Act 54 of 1972 and the Foodstuffs, Cosmetics and Disinfectants Amendment Act 39 of 2007 provide for the regulation of foodstuffs, cosmetics and disinfectants, in particular, by setting quality and safety standards for the sale, manufacturing and importation of such commodities. This legislation also places restrictions on the manufacture, importation and marketing of articles that are harmful or injurious to human health or that contain a prohibited substance. The legislation also prohibits the false description and labelling of foodstuffs; defines the liability of an importer, a manufacturer or a packer; and provides for the analysis of foodstuffs and the examination, control and disposal of certain imported articles, among others. The Occupational Diseases in Mines and Works Act 78 of 1973 provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases; and the Academic Health Centres Act 86 of 1993 provides for the establishment, management and operation of academic health centres. The Human Tissue Act 65 of 1983 provides for the administration of matters pertaining to human tissue.

4.2.3.11 White Paper for the Transformation of the Health System (1997)

The White Paper for the Transformation of the Health System (White Paper),¹⁰⁵ released in 1997, sets out key health policy issues. The White Paper aimed to unify the national health system to address the effects of apartheid on health, reorganise the health service to give priority to primary health care through the district health system, where certain aspects of health service delivery take place at district (instead of national or provincial) level.¹⁰⁶ Additionally, the White Paper emphasised the need to decentralise management of health services, establish the District Health System to facilitate implementation of

primary health care, increase access to services for citizens, and ensure the availability of good quality essential drugs in health facilities.¹⁰⁷ The White Paper also emphasised the need to strengthen disease prevention and health promotion in areas such as HIV and AIDS, and maternal, child and women's health; implement the Integrated Nutrition Programme to focus more on sustainable food security for the needy; and rationalise health financing through budget reprioritisation.¹⁰⁸ The White Paper further gave special attention to health services reaching people most in need of these services – the poor, the underserved, the elderly, women and children – and the need to promote the participation of community structures in health care delivery.¹⁰⁹ The White Paper also sought to unite the public and private health sectors to promote common goals, providing that: "The activities of the public and private health sectors should be integrated in a manner that makes optimal use of all available health care resources."¹¹⁰

4.2.3.12 National Patients' Rights Charter

The South African Patients' Rights Charter (Charter), launched in 1997, provides in its preamble that it seeks a common standard for achieving the right to health services guaranteed in the Constitution, in contrast to the denial or violation of human rights experienced by the vast majority for many decades. The Charter was developed by the Department of Health in consultation with various other bodies. The Charter aims to improve the quality of health care by defining twelve core health rights for those who use health care facilities. Although the success of the Charter is largely dependent on the extent to which users have knowledge of it and are willing to assert their rights, the adoption of the Charter nevertheless represents a commitment to ensuring the provision of appropriate, good quality and human-rights sensitive health care services. However, a significant problem is that the Charter refers to 'consumer rights', which accordingly offers little recourse to people who are unable to gain access to health care services in the first place. A further concern is that the Charter is heavily weighted in favour of curative care with little attention to promotive or preventative care.¹¹¹

The Charter provides that every patient has the right to a healthy and safe environment; access to safe health care; emergency care in life-threatening situations; confidentiality and privacy; to be treated with courtesy and consideration by all staff and to be informed about his/her illness/condition and treatment, so as to be in a position to give informed consent. The Charter also provides for every patient's right to exercise choice in health care services, to participate in decision-making that affects his/her health; to be referred for a second opinion; to continuity of care; to complain about health services; to be treated by a named healthcare provider; and to refuse treatment or information about his/her illness.¹¹² Significantly, the Charter recognises that patients have certain responsibilities. These are the responsibility to advise the health care provider on his or her wishes with regard to his or her death; to comply with the prescribed treatment or rehabilitation procedures; to enquire about the related costs of treatment and/or rehabilitation and to arrange for payment. It also enjoins a patient to take care of health records in his or her possession; to take care of his or her health; to care for and protect the environment; to respect the rights of other patients and health providers; to utilise the health care system properly and not abuse it; to know his or her local health services and what they offer; and to provide health care providers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.¹¹³

4.2.3.13 National Drug Policy

The National Drug Policy (NDP) was launched in 1996, and heralded great changes in the area of drug management in South Africa.¹¹⁴ The cost of drugs is a critical element in determining access to health care services. In South Africa, drug costs are second only to personnel costs in the health sector. The goal of the NDP is to ensure an adequate and reliable supply of safe, cost-effective drugs of acceptable quality to all citizens of South Africa and the rational use of drugs by prescribers, dispensers and consumers.¹¹⁵ According to the NDP, the pharmaceutical sector, as a component of the health sector, reflected its deficiencies, most notably the lack of equity in access to essential drugs, with a consequent impact on quality of health care. Furthermore, rising

drug prices, already extremely high in international terms, gave increasing cause for concern, as did evidence of irrational use of drugs, losses through malpractice and poor security, and cost-ineffective procurement and logistic practices.¹¹⁶

Among the priority issues it outlined were strengthening the Medicines Control Council, rationalising drug registration, controlling the registration of health practitioners and the licensing of premises, enhancing the inspectorate and laboratory functions and promoting other quality assurance measures. With regard to ensuring the availability of safe and effective drugs at the lowest possible cost, the NDP established a pricing committee, promoted the use of generic drugs and suggested the possibility of engaging in parallel importing and international tendering.

4.2.3.14 National Department of Health Strategic Plan 2010/11–2012/13

The Strategic Plan for 2010/11–2012/13 (Strategic Plan) states that the department's vision is to ensure 'an accessible, caring and high quality health system.'¹¹⁷ Its mission is 'to improve health status through the prevention of illnesses and the promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability.'¹¹⁸ The Strategic Plan provides that the health sector must produce twenty deliverables over the next five years. These are increased life expectancy at birth; reduced child mortality; decreased maternal mortality ratio; managing HIV prevalence; reduced HIV incidence; expanded access to the Prevention of Mother to Child Transmission (PMTCT) programme; improved TB case finding; improved TB outcomes; improved access to antiretroviral treatment for HIV-TB co-infected patients; decreased prevalence of drug resistant TB; and revitalisation of primary health care. Other key deliverables include improved physical infrastructure for health care delivery; improved patient care and satisfaction; accreditation of health facilities for quality; enhanced operational management of health facilities; improved access to human resources for health; improved health care financing; strengthened health information systems; improved health services for the youth, and expanded

access to home-based care and community health workers.¹¹⁹

4.2.3.15 National Core Standards

In recent years there has been increasing public sector attention on improving quality of care and on the setting of standards of health care. The National Health Act provides that health care services must have due regard to the principles laid down in the Constitution, particularly sections 27 and 195 with regard to quality, effectiveness and efficiency. In 2008, the Office of Standards Compliance (OSC) within the National Department of Health developed and piloted a set of National Core Standards (NCS) which form the basic requirements for quality and safe health care.¹²⁰ The NCS set the benchmark for quality improvement in public health establishments' standards, defined as 'an expected level of performance'. The main purposes of the NCS are to develop a common definition of quality of care which should be found in all South African health establishments as a guide to the public and to managers and staff at all levels; establish a benchmark against which public health establishments can be assessed, gaps identified and strengths appraised; and provide a framework for national certification of public health establishments.¹²¹

The NCS are structured in seven cross-cutting domains, and defined as areas where quality or safety might be at risk. These include patient rights, safety, clinical governance and care. Clinical support services represent the core business of the health system of delivering quality health care to users. The other focus areas are public health, leadership and corporate governance, operational management, and facilities and infrastructure support systems for health care delivery.¹²²

4.2.3.16 National Health System (NHS) Priorities For 2009–2014 (The Ten Point Plan)

As part of its Medium Term Strategic Framework, the National Department of Health released its priorities for the period 2009 to 2014.¹²³ Also known as the Ten Point Plan, the priorities are intended to assist the country in meeting the MDGs and monitoring improvements in the health delivery system. The Ten Point Plan includes the following priority: provision of strategic leadership and

creation of a social compact for better health outcomes.¹²⁴ The objective of this priority is to ensure unified action across the health sector. The Ten Point Plan provides for a Ministerial Advisory Committee on Health whose responsibility is to oversee various aspects of health sector improvement, including human resources for health, information, medical products, finance, leadership and governance, service delivery, technology and infrastructure.¹²⁵ The Ten Point Plan provides for the implementation of National Health Insurance (NHI). Improving the quality of care delivered at health facilities is an important aspect of the Ten Point Plan.¹²⁶ As part of the programme to escalate good service at facility level, all primary health care facilities will be visited by a supervisor at least once a month and an Ombuds Office will be established, which will receive and investigate all complaints relating to quality of health care services.¹²⁷ The Ten Point Plan also focuses on overhauling the health care system and improving its management and in that regard it envisages the putting in place of robust financial management systems in order to improve audit outcomes.¹²⁸ Additionally, the Ten Point Plan puts emphasis on the planning, management and development of Human Resources for Health (HRH). This includes ensuring that all provinces have developed and begin to implement human resource plans which are consistent with service delivery objectives. As part of a detailed planning and forecasting process for various categories of HRH for the next five years, the re-opening of nursing colleges in order to ensure the accelerated production of nurses will also be given due attention.¹²⁹

The Ten Point Plan also puts emphasis on the revitalisation of infrastructure. In that regard, the plan envisages the establishment of public–private partnerships to facilitate the construction and refurbishment of health to revitalise primary-level care facilities in order to improve quality of service.¹³⁰ A national audit of all primary health care infrastructure and services will be conducted. Accelerated implementation of the HIV and AIDS and STI National Strategic Plan 2007–2011, and increased focus on TB and other communicable diseases is also envisaged.¹³¹ The objective of this target is to ensure the implementation of the various existing treatment guidelines and to strengthen prevention interventions. The

other targets include mass mobilisation for better health for the population through a 'Healthy Lifestyle Strategy' focusing on nutrition, physical activity, tobacco control, alcohol and substance abuse control and safer sexual practices; review of the National Drug Policy; and the need to strengthen research and development of research studies and surveys to generate key reliable information for health planning, service delivery and monitoring.¹³²

4.2.3.17 National Health Insurance

Previous attempts to introduce a health scheme with progressive features in South Africa began with the Commission on Old Age Pension and National Insurance in 1928, which was followed by different committees and commissions, as well as a Ministerial Advisory Committee on national health insurance, which was introduced in 2009.¹³³ While the possibility of introducing mandatory health insurance in South Africa was first raised by academics in the early 1990s, the first time it was incorporated into a formal policy-related document was in the African National Congress's (ANC)'s 1994 National Health Plan.¹³⁴ The ANC National Health Plan recommended the introduction of compulsory contributions by all formal sector employees and their employers, which would be used to cover primary health care services as well as hospital care for contributors and their dependants. The ANC National Health Plan further stated that medical schemes, or other forms of private health insurance, would have a role in offering additional cover for services not included in the benefit package.¹³⁵

In 2001, the government set up a Committee of Inquiry into a Comprehensive System of Social Security for South Africa, chaired by Professor Vivienne Taylor (Taylor Committee). The Taylor Committee was mandated to conduct research and to advise government on a social security policy reform process.¹³⁶ This involved, among other things, examining the poverty problem in South Africa; looking at the current social security system, including existing social grants; and making recommendations for reform. In May 2002, the Taylor Committee released its consolidated report (Taylor Report), in which the critical role of the right of access to social security and assistance for reducing poverty was highlighted. The Taylor Report was the first set of policy proposals on

mandatory health insurance to explicitly call for an NHI, albeit to be achieved only in the long term. The Taylor Committee proposed that a comprehensive package of services be covered and that 'South Africa move ultimately towards an NHI system over time that integrates the public sector and private medical schemes within the context of a universal contributory system'.¹³⁷ The objectives that underlay the Taylor Committee's proposals on NHI included increased risk pooling by instituting mandatory contributions; drawing tax resources into a common pool with insurance contributions and ensuring risk-equalisation within the public and private sectors; and universal cover for a minimum level of essential benefits, whether provided through the public or private sectors.¹³⁸

A Green Paper on the Policy on National Health Insurance in South Africa was released in August 2011 (NHI Policy Paper).¹³⁹ According to the NHI Policy Paper, the NHI, which will be phased over a fourteen-year period, will ensure that everyone has access to appropriate, efficient and quality health services. This will entail major changes in the service delivery structures, administrative and management systems.¹⁴⁰ The NHI Policy Paper points out that a large part of the financial and human resources for health is located in the private health sector serving a minority of the population. On the other hand, the public sector is under-resourced relative to the size of the population that it serves and the burden of disease. The public sector has disproportionately less human resources than the private sector, yet it has to manage significantly higher patient numbers.¹⁴¹

The NHI Policy Paper's emphasis is on improved access to quality health services for all South Africans irrespective of whether they are employed or not, and to pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund. The NHI Policy Paper also emphasises the need to procure services on behalf of the entire population and efficiently mobilise and control key financial resources, as this will obviate the weak purchasing power that has been demonstrated to have been a major limitation of some of the medical schemes, resulting in spiralling costs; and to strengthen the under-resourced and

strained public sector so as to improve health systems performance.¹⁴²

The NHI Policy Paper further provides that in order to successfully implement a health care financing mechanism that covers the whole population, such as the NHI, four key interventions need to be implemented. These include; a complete transformation of health care service provision and delivery; the total overhaul of the entire health care system; the radical change of administration and management; and the provision of a comprehensive package of care underpinned by a re-engineered primary health care system.¹⁴³ This is because a two-tiered system of healthcare does not embrace the principles of equity and access and the current health financing model does not facilitate sustainable access to health.¹⁴⁴ The government's view is that the two-tier healthcare system in South Africa is unsustainable, destructive, very costly and highly curative and hospicentric.

The NHI Policy Paper identifies certain principles that underlie the need for an NHI for South Africa. The first principle is the right to access health care as prescribed under section 27 of the Constitution. Accordingly, the reform of health care is an important step towards the realisation of these rights and the key is that access to health services must be free at the point of use and that people will benefit according to their health profile.¹⁴⁵ The second principle is that of social solidarity. This entails the creation of financial risk protection for the entire population that ensures sufficient cross-subsidisation between the rich and the poor, and the healthy and sick.¹⁴⁶ Such a system allows for the spreading of health costs over a person's lifecycle – paying contributions when one is young and healthy and drawing on them in the event of illness later in life. The third principle is of effectiveness – and this will be achieved through evidence-based interventions, strengthened management systems and better performance of the health care system that will contribute to positive health outcomes and overall improved life expectancy for the entire population.¹⁴⁷ The fourth principle is of appropriateness – and this refers to the adoption of new and innovative health service delivery models that take account of the local context and acceptability and are tailored to respond to local needs.¹⁴⁸ According to the NHI Policy Paper, the

health services delivery model will be based on a properly structured referral system rendered via a re-engineered primary health care model.¹⁴⁹ The fifth principle is equity – the health system must ensure that those with the greatest health need are provided with timely access to health services. It should be free from any barriers and any inequalities in the system should be minimised. Significantly, equity in the health system should lead to expansion of access to quality health services by vulnerable groups and in underserved areas.

The principle of affordability of health services is particularly emphasised in the NHI Policy Paper. Affordability entails that services will be procured at reasonable costs that recognise health as not just an ordinary commodity of trade but as a public good and a human right.¹⁵⁰ The NHI Policy Paper also emphasises the need for efficiency, and this will be ensured through creating administrative structures that minimise or eliminate duplication across the national, provincial and district spheres.¹⁵¹

According to the 2014 Budget Speech by Minister of Finance Pravin Gordhan on 26 February 2014, The Department of Health's White Paper on NHI and a financing paper by the National Treasury have been completed and will be tabled in Cabinet shortly.¹⁵² Additionally, the NHI pilot districts have been established in every province, supported by funding for NHI as a conditional grant. In addition to hospital and clinic building and refurbishment programmes, R1.2 billion has been allocated for piloting general practitioners' contracts. An Office of Health Standards Compliance (OHSC) has been established to ensure that public health care provision meets the required standards. Additionally, a new funding framework for the National Health Laboratory Services and associated research activities has been agreed.¹⁵³ Government spending on health care is expected to exceed R492 billion over the next three years as South Africa strengthens its health care system in preparation for the implementation of an NHI scheme. The roll-out of the NHI is currently being financed by two conditional grants: the nationally managed national health grant, and the national health insurance grant managed by the provinces. More than R221 million will

be made available in the 2014 Budget for the NHI grant in order to strengthen national district health structures.¹⁵⁴

4.3 Jurisprudence on the right to health

Since 1994 there have been several court cases that have served to add to the normative content of the right to health care. These have thrown light on the concepts of ‘available resources’ and ‘reasonable measures’ in terms of section 27(1)(b) of the Constitution. The following section discusses the jurisprudence on the right to health from South African courts.

4.3.1 *Soobramoney v Minister of Health (Kwazulu-Natal)*

The *Soobramoney*¹⁵⁵ case was the first major decision in which the Constitutional Court (Court) adjudicated over the socio-economic rights enshrined in the Constitution. In that case, the Court had to consider health care rationing. The major question which the Court was called upon to decide was whether the health rights in section 27 of the Constitution entitled a chronically ill man in the final stages of renal failure to an order enjoining a public hospital to admit him to the renal dialysis programme of the hospital.

The applicant was denied access to dialysis because he suffered from chronic renal failure and was not a candidate for a kidney transplant because he would need kidney dialysis for the rest of his life as his condition was incurable. The KwaZulu-Natal Department of Health’s policy was to limit access to dialysis to persons suffering from acute renal failure or chronic renal failure patients awaiting a kidney transplant. The policy was predicated on ensuring that those whose kidneys could be completely cured were given the best chance of eventually living without the need for dialysis.

The applicant claimed that the Department’s decision amounted to a breach of his constitutionally protected right under section 27(3) of the Constitution not to be refused emergency medical treatment. The applicant further argued in the alternative that the policy breached his right of access to health care services guaranteed in section 27(1)(a) of the Constitution. The Court rejected the challenge based on section 27(3) because the applicant sought access to treatment of an ongoing, chronic condition. The Court held that section 27(3) was intended

primarily to ensure that ‘a person who suffers a sudden catastrophe which calls for immediate medical attention’ is not denied ambulance services or access to hospitals which are, in principle, able to provide the necessary treatment.¹⁵⁶

It is important to note that what the applicant claimed was, in essence, the lifting of the exclusion from state renal dialysis facilities of persons with chronic renal failure who do not qualify for a transplant in terms of the Department’s policy. The implication was to enjoin the State to re-allocate resources to meet the cost of doing so, or to ration existing resources in a manner which would prejudice those to whom renal dialysis was not merely palliative, but potentially curative. The Court ruled that the decision to limit access to dialysis in these circumstances was rational and that ‘a court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters.’¹⁵⁷ The Court further ruled that the applicant had no cause of action in terms of either section 11 or section 27(3) of the Constitution. The Court, instead, held that the applicant’s claim fell to be determined in terms of sections 27(1) and (2) of the Constitution – the qualified right of access to health care services.¹⁵⁸

The Court had to address two critical issues in determining whether the refusal of Addington Hospital to admit the applicant to the dialysis treatment programme constituted an infringement of these provisions. The first issue to be determined was whether it was necessary to ration access to kidney dialysis treatment to patients such as the applicant. Secondly, if such rationing was necessary, whether the policy adopted by the Department complied with the constitutional injunctions in sections 27(1) and (2) and, if so, whether they were applied ‘fairly and rationally’ to the applicant’s case.

The first issue concerns whether and under what conditions limited resources constitute a valid basis for limiting access to medical treatment for patients in the situation of the applicant. The Court alluded to the budgetary constraints facing provincial health departments. The Court noted that the scarcity of resources meant that the need for access to kidney dialysis treatment greatly exceeded the number of available dialysis machines. The

Court further noted that this was a national problem extending to all renal clinics.¹⁵⁹ According to the Court, the diversion of additional resources to the renal dialysis programme and related tertiary health care interventions from within the health budget would prejudice other important health programmes.¹⁶⁰ Additionally, the Court pointed out that if the overall health budget was to be substantially increased to fund all health care programmes, this would diminish the resources available to the State to meet other socio-economic needs such as housing, food, water, employment opportunities and social security.¹⁶¹

The Court was not persuaded that it was reasonable to require the State to divert additional resources to the renal dialysis programme in order to cater for all patients in his situation. This inevitably implied that it was necessary for health authorities to ration access to certain forms of medical treatments. It is significant to note that the applicant had not suggested that the relevant guidelines established by the hospital were unreasonable. Neither did he argue that the guidelines were not applied 'fairly and rationally' when the decision was taken that he did not qualify for dialysis treatment.¹⁶² Accordingly, the Court held that there was no breach of section 27(1)(a) read with (2).

One of the criticisms of the judgment from the view of developing a substantive interpretation of socio-economic rights is the lack of engagement with the purposes and values protected by the right to access to health services in section 27(1)(a) of the Constitution.¹⁶³ Liebenberg argues that the failure to develop the normative content of health care rights, including its relationship with other rights such as the right to life, results in a disproportionate focus on the State's justificatory arguments. The assessment of such arguments also occurs in the absence of a normative framework which should have been supplied by an analysis of the content and scope of the right to access to health care services.¹⁶⁴ This limited approach has led to the position that legislators, state officials and medical personnel would be hesitant to look at the *Soobramoney* decision as an inspiration.

The principle that emerges from the *Soobramoney* decision, apart from the positive obligation placed on the state to realise access to health services for all South

Africans, is that the state is also obliged to ensure that reasonable policies exist to facilitate access to health services. By means of the application of a reasonable policy, which must be applied universally to all, the state does advance materially its obligation to provide access to health services. In this regard, the Court held that:

The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters.¹⁶⁵

Therefore, the particular combination that is required constitutionally, in respect of the provision of health care services by the State, is rational decisions at a political level balanced with those at a functional level. The 'functionality' of health care services, while not explained by the Court in the *Soobramoney* matter, may refer to those decisions to be taken that are medical decisions or informed by such decisions that must be made in relation to the type, standard and location of the provision of care.

4.3.2 *Minister of Health and Other v Treatment Action Campaign*

The case of *Minister of Health and Other v Treatment Action Campaign (Treatment Action Campaign)*¹⁶⁶ arose from a constitutional challenge to restrictions on the provision of antiretroviral drugs to HIV-positive pregnant women, resulting in tens of thousands of unnecessary infections and deaths. The case alleged violation of the right to health care services protected under sections 27(1) and 28(1)(c) of the Constitution.

The State's policy towards the prevention of mother-to-child transmission was confusing and uncertain. The policy established eighteen 'research sites' – two in each

province – where the antiretroviral drug, Nevirapine, would be provided to HIV-positive pregnant mothers at childbirth.¹⁶⁷ Further, the policy placed a ban on health care professionals in state health care facilities other than the eighteen pilot sites from administering Nevirapine to HIV positive pregnant mothers.¹⁶⁸ This meant that mothers and their babies who could not afford private health care and did not have access to one of the pilot sites, could not access antiretroviral treatment.¹⁶⁹ The Court was therefore asked to consider the reasonableness of government policy in facilitating access to antiretroviral treatment to prevent mother-to-child transmission of HIV. The applicants argued that the state unreasonably prohibited the administration of Nevirapine at public hospitals and clinics outside a limited number of research and training sites.¹⁷⁰ This drug was of proven efficacy in reducing mother-to-child transmission of HIV. The applicants further argued that the state had failed to produce and implement a comprehensive national programme for the prevention of mother-to-child transmission of HIV. According to the applicants, the aforementioned conduct and omissions of the state constituted violations of the right of everyone to have access to health care services protected under section 27 of the Constitution, as well as children's right to have access to basic health care services protected under section 28(1)(c).

The Court found the policy of confining Nevirapine to research and training sites to be unconstitutional and stated that the policy failed to address the needs of mothers and their newborn children who do not have access to these sites. The policy failed to distinguish between the evaluation of programmes for reducing mother-to-child transmission and the need to provide access to health care services required by those who do not have access to the sites.¹⁷¹ The Court found government policy on the provision of mother-to-child transmission unreasonable and unconstitutional because it excluded a significant segment of society.¹⁷² The programme had failed to address the needs of mothers.¹⁷³ Hence, impeding access to other essential health services like sexual and reproductive services, which are key to women's health in the context of HIV and AIDS, would amount to a violation.

The Court also found the policy to be unreasonable because the cost of administering Nevirapine was negligible, its safety and efficacy was proven beyond question, the procedure for administering it was simple, and funds to expand its provision outside designated sites were available.¹⁷⁴ The Court ordered the state to make Nevirapine available, to provide counsellors, and to take reasonable measures to extend the testing and counselling facilities throughout the public health sector.¹⁷⁵ The Court rejected the argument advanced by one of the amici for a distinction between a minimum core content of the right to health care and the obligations imposed on the state in section 27(2) that are subject to progressive realisation and available resources.¹⁷⁶

The decision establishes a conceptual and remedial framework for judicial review and enforcement of the obligation to ensure access to health care, and provides a model for integrating political and legal action.¹⁷⁷ Importantly, the case brought to the fore some of the major health issues confronting South Africans: access to HIV and AIDS-related treatment. Therefore, the Court's approach in this case was proactive to the degree that it compelled the state to provide treatment that enables women affected by HIV and AIDS to have healthy babies.

The case remains instructive in influencing government action through the judicial system. Liebenberg has pointed out that the *Treatment Action Campaign* judgment placed it beyond doubt that the courts are not confined to making general declaratory orders relating to the state's non-compliance with the constitutional duties imposed by socio-economic rights.¹⁷⁸ However, there are concerns around declaratory orders requiring benefits to particular groups. These concerns relate to the institutional capacity and legitimacy of the courts to make decisions with policy direct implications. However, the decision in *Treatment Action Campaign* represents a transformative step in the direction of improving the health of the South African masses. The important principles enunciated by the Court in the *Treatment Action Campaign* case are that with regard to the fulfilment of the constitutionally protected right to health, there must be a comprehensive programme, which may include national framework legislation that can facilitate the right of access to health care services; and there must be a coher-

ent health programme directed at the progressive realisation of the right within its available resources. The essential elements of the definition of health care services must be considered in assessing whether the programme constitutes a coherent one. Significantly, the legislative measures must be supported by appropriate, well-directed policies and programmes, and the programme must respond to the needs of the most desperate.

4.3.3 *Pharmaceutical Manufacturers' Association v President of the Republic of South Africa*

In February 1998, the South African Pharmaceutical Manufacturers Association and 40 Others (later 39, as a result of a merger),¹⁷⁹ mostly multinational pharmaceutical manufacturers, brought a claim against the Government of South Africa, alleging that the Medicines and Related Substances Control Amendment Act No. 90 of 1997 (Amended Medicines Act) violated TRIPS and the South African Constitution.

South Africa had in place the Medicines and Related Substances Control Act (Medicines Act). In 1997, Parliament passed the Amended Medicines Act. The Amended Medicines Act, among other things, gives the government a legal framework to compel pharmacists to prescribe cheaper generic substitutes of medicines no longer under patent (generic substitution). The amendment allowed for cheaper importation of brand-name medicines from countries where the product is sold for less (parallel importing). Furthermore, it allowed for the issuance of compulsory licences, under certain conditions, to local companies to produce generics of patented medicines (compulsory licensing). The law also allowed for a transparent pricing mechanism to make pharmaceutical companies justify the prices they charge. It therefore allowed the government to manufacture generic medicines and make medicines more affordable and accessible.

The Pharmaceuticals Manufacturers Association (PMA) challenged the provisions of the Medicines Act in the case *Pharmaceutical Manufacturers' Association v President of the Republic of South Africa* (PMA case).¹⁸⁰ Initially the PMA suit contended that the Medicines Act authorising parallel imports or compulsory licensing to obtain affordable generic drugs violated the sanctity of patent

rights inscribed in the TRIPS Agreement. The PMA instituted litigation, claiming that the relevant provisions violated the rights of its members to intellectual property under the Constitution, to freedom of trade, occupation and profession and to freedom of expression (in that it compelled pharmacists to inform customers of cheaper generic alternatives to prescribed medicines). Due to a global outcry from humanitarian NGOs such as MSF and Oxfam, PMA dropped the claim. The case, however, demonstrated the government and civil society's vigilance against private actors seeking to diminish access to essential medicines. Hence, this was a commendable step to improve access to affordable medicines by the South African government and all the stakeholders who were involved. The case also highlights the impact of intellectual property rights and the State drug policies' impact on access to health.

4.3.4 *New Clicks South Africa v Minister of Health and Another*

Retail pharmacy chains and the South African Pharmaceutical Society were to later challenge price control regulations that were promulgated pursuant to section 22G of the Medicines Act, in terms of which limits are set on the profit margins of retail pharmacists in relation to prescribed medicines in *Pharmaceutical Society of South Africa v Tshabalala-Msimang and Another NNO; New Clicks South Africa (Pty) Ltd v Minister of Health and Another* (*New Clicks South Africa v Minister of Health*).¹⁸¹ The applicants applied for leave to appeal. At issue was the validity of the 'Regulations relating to a Transparent Pricing System for Medicines and Scheduled Substances'. The regulations were promulgated on 30 April 2004 by the Minister of Health in terms of section 22G of the Medicines Act. The regulations under attack provided for a pricing system that defines and controls the single exit price for manufacturers and importers and for a dispensing fee, which, for pharmacists, amounted to either 16 per cent of the exit price (if it is less than R100) or R16 (if more than R100) without a medical prescription. In the case of a prescription, the figures are 26 per cent (if it is less than R100) and R26 (if more than R100). The major issues were whether these fees were 'appropriate' and whether the regulation of the single exit price was legal.

There were two applications. In one, the first applicant was the Pharmaceutical Society of South Africa, joined by six other entities that own pharmacies. The other was by New Clicks SA (Pty) Ltd, the owner of 86 pharmacies (at the time). In dismissing a variety of the challenges to the validity of the regulations, the Cape High Court affirmed the legitimacy of the purpose of the regulations, which it regarded as being aimed at complying with the state's obligations to increase access to medicines through assuring their affordability in terms of section 27(2). The regulations were subsequently invalidated by the Supreme Court of Appeal (SCA) for not having adhered to the legality principle and for not having prescribed an 'appropriate' fee for pharmaceutical products. The SCA remarked:¹⁸²

The Act must be read in the light of section 27(1) of the Bill of Rights, which provides that everyone has the right to have access to health care services, including reproductive health care and that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right. One has to agree that the right of access to health care includes the right of access to medicines although this right is not without limitations... It is also correct that the prohibitive pricing of medicines may be tantamount to a denial of the right of access to health care. All that is really common cause. What is not, is how parliament has sought to achieve the progressive realisation of this right through the provisions of the Act.

The SCA further held that in determining what is appropriate one must consider the conflicting interests of all those involved and affected. On the one hand there is the public, which is entitled to access to health care including affordable medicines.¹⁸³ On the other hand, and within the context of access to medicines, the advocates for a proper balance between public health and profit-making for pharmaceutical businesses.

4.3.5 *Minister of Health and Another v New Clicks South Africa*

In the case of *Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others*,¹⁸⁴ the Constitutional Court was faced with a dispute between pharmacists and the Department of Health concerning the reasonableness of dispensing fees introduced as part of the single exit price legislation for medicines pursuant to section 22G of the Medicines Act. In its decision, the Court examined the nature of the services provided by pharmacists to the public in both the public and private health care sectors. The imposition of price control over medicines and the provision of pharmacy services was fundamentally endorsed by the Court as a process that complies with the provisions of the Constitution. Therefore, the Court did not oppose the creation of a single exit pricing system for medicines or controlling the dispensing fees of pharmacists, but was concerned with how these processes are conducted. Therefore, the imposition of price control as such on health care is not necessarily out of step with the constitutional prerogatives ensuring access to health care services. In this regard, the Court held that:

The scheme is criticised by the Pharmacies on the ground that regulation of prices is less effective than market forces. The choice of price regulation, if not consistent with the Medicines Act, was a policy decision within the domain of the legislature and the executive with which this Court will not interfere. This Court is concerned with whether the scheme meets the requirements of the Medicines Act and was adopted in accordance with the provisions of the Constitution and PAJA, and not with whether there may be better ways of achieving the same purpose.¹⁸⁵

In relation to the application of a dispensing fee for pharmacists, the Court accepted that the imposition of a particular fee on a particular health care profession, in this instance pharmacies, must be sufficient to enable that profession to operate viably and to make a reasonable profit. Therefore, the imposition of any capped or fixed fee in respect of the provision of health care services

must allow for health care professionals to operate reasonably and to make a living from their profession.

The manner in which the Pricing Committee set about determining the single exit pricing for medicines was criticised by the Court. The Court set out the process that would need to be followed in order for such a pricing system to be implemented lawfully. The *Clicks* decision provides a clear indication that additional economic controls over any aspect of the delivery of health care services constitutes an important part of the assessment of the manner in which access is exercised by members of the public to such a system, and the participation in providing such access by health care providers. The government is required to balance carefully the interests of those providing medical or health care service with the interests of the public and access by members of the public to such health care services. Unreasonable or irrational control of pricing systems in respect of healthcare services is not permitted in terms of South African law, insofar as the rights of health care providers to ensure that they are regulated reasonably and transparently in terms of the Constitution are unfairly limited.

The Court's approach in *Minister of Health and Another v New Clicks South Africa* provides a fair balance between profit-making for pharmacies and the affordability of medicines. The Court's reference to section 27 of the Constitution affirmed the importance of the right of access to health within the context of access to affordable medicines. In this way, the Court endorsed an interpretation that would not leave the marginalised vulnerable. Hence, the decision provides a position that enables poor people to access life-saving drugs. This is mostly illustrious under administrative law as it highlighted the applicability of administrative justice principles to the making of subordinate legislation, or administrative rule making, and its wide ranging analysis of the state of administrative law in South Africa.

4.3.6 *Hospital Association of SA Ltd v Minister of Health and Another*

The case of *Hospital Association of SA Ltd v Minister of Health and Another*¹⁸⁶ concerned the imposition of a proposed national health reference pricelist on health care providers. In this decision, the North Gauteng High

Court (High Court) was required to consider the reasonableness of the imposition of a proposed national health reference pricelist for the provision of health care services in terms of provisions of the National Health Act No. 61 of 2003. Extensive representations had been made by the stakeholders to the Department of Health that the introduction of a national health reference pricelist, on the basis proposed by the Department, would severely compromise the ability of the medical fraternity, in various disciplines, to provide health care services to members of the public.

The High Court found that the imposition of such a national health reference pricelist, as an administrative system, was compromised and overturned the system. The court argued that regulating the pricing of health care services in the manner proposed by the Health Department might lead to a decline in the availability of health care providers and the quality of service they provide. The High Court stated that 'there was the real risk that the effect of the RPL Decision would play out on patients who may face the burden of a declining number of doctors within the country, and who may be confronted with general and specialist practitioners who, in an attempt to make ends meet, would be forced to focus on high volume turnover of patients at the expense of quality provision of medical services.'¹⁸⁷ The court was in favour of the introduction of regulated pricing, provided that the pricing in question could be rationally connected to the purposes to be achieved by such pricing.

4.3.7 *Van Biljon and Others v Minister of Correctional Services*

In the case of *Van Biljon and Others v Minister of Correctional Services*,¹⁸⁸ the Court ordered the Department of Correctional Services to provide antiretroviral therapy to two prisoners. The Department of Correctional Services had maintained that prisoners did not have greater rights than patients at state hospitals, who were at that stage not receiving this treatment, and that the drugs were far too expensive.¹⁸⁹

The Court held that the Constitution did not give prisoners the right to the best medical treatment, but only to 'adequate' treatment and explained that a prisoner's right to medical treatment depends on an exam-

ination of circumstances, such as prison conditions, to decide what is adequate. Accordingly, the meaning of adequate medical treatment has to be linked to what the state can afford. As a doctor had prescribed the two prisoners ARV treatment, this was considered 'adequate medical treatment' for their condition and circumstances. This decision, however, did not mean that all prisoners with HIV should receive expensive drugs.¹⁹⁰ The Court summarised its approach by stating that:

Even if it is accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the State for patients outside, this principle can, in my view, not apply to HIV-infected prisoners. Since the State is keeping these prisoners in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the State must provide them must be treatment which is better able to improve their immune systems than that which the State provides for HIV patients outside.¹⁹¹

4.3.8 *Lee v Minister of Correctional Services*

The applicant was detained at Pollsmoor Maximum Security Prison from 1999 to 2004.¹⁹² The applicant contracted tuberculosis (TB) while in prison. He sued the Minister for damages on the basis that the poor prison health management resulted in his becoming infected.¹⁹³ The High Court upheld the claim on the basis that the prison authorities had failed to take reasonable steps to prevent the applicant from contracting TB.¹⁹⁴ On appeal, the SCA found that, while the prison authorities were negligent in their failure to maintain reasonably adequate systems to manage the disease, the Minister was not liable. It found that the applicant had not proved that the presence of reasonable, precautionary measures would have completely eliminated his risk of contracting TB.

In the Court, the majority held that the SCA, in applying the test for factual causation, adopted a rigid and deductive logic which necessitated the conclusion that because the applicant did not know the exact source of his infection, his claim had to fail.¹⁹⁵ It held that our law

has always recognised that the test for factual causation should not be applied inflexibly as was done by the SCA. The majority held further that on the approach adopted by the SCA it is unlikely that any inmate will ever be able to overcome the hurdle of causation and further that no effective alternate remedy will be available to a person in the position of the applicant.¹⁹⁶

The majority noted that there is a legal duty on the responsible authorities to provide adequate health care services as part of the constitutional right of all prisoners to conditions of detention that are consistent with human dignity. In upholding the applicant's claim, the majority held that there is a probable chain of causation between the negligent omissions by the responsible authorities and the applicant's infection with TB.¹⁹⁷

4.3.9 *Cipla Medpro (Pty) Ltd v Aventis Pharma SA*

In the case of *Cipla Medpro (Pty) Ltd v Aventis Pharma SA*,¹⁹⁸ the SCA was tasked with adjudicating in appeal proceedings pertaining to a South African patent which was registered in the name of Aventis. Aventis sought an interim interdict to prevent Cipla from infringing its patent, for an oncology product by the brand name of Taxotere (docetaxel), by selling Cipla Docetaxel. Cipla in turn applied for the setting aside of an earlier amendment of the patent. Both applications failed at first instance before the Court of the Commissioner of Patents, and both parties appealed to the SCA. The Treatment Action Campaign, a group lobbying for cheaper medicines, was admitted as *amicus curiae* only at the SCA stage of the matter.

The TAC opposed the interdict sought by Aventis and based its first argument against an interdict on section 27(1) of the Constitution. The TAC argued that the Patents Act must be construed 'through the prism of the Constitution' and in a way that appropriately balances the rights of a patentee against the constitutional rights of others. The Court noted that:

What we are to make of viewing the legislation through the prism of the Constitution was not developed by the TAC. Section 39(2) indeed calls upon a court to 'promote the spirit, purport and objects of the Bill of Rights' when interpreting

legislation, as pointed out by the TAC, but that does not open the door to changing the clear meaning of a statute ... On the assumption that the patent is not revocable for want of an inventive step I cannot see how section 39(2) or the prism of the Constitution comes into play so as to deny Aventis its right to enforce its patent.¹⁹⁹

However, the SCA indicated that TAC was on stronger ground with its further submission that the broader public interest, and not only the interests of the litigating parties, must be placed in the scales when weighing where the balance of convenience lies. The SCA dealt in some detail with a number of cases decided in the US where injunctions against patent infringement have been refused on the ground of public interest.²⁰⁰ The SCA decided in favour of Aventis due to the public interest not being materially affected. One of the reasons for this finding was that Aventis itself intended to launch a significantly cheaper generic version of Taxotere, namely Docetere, which was to be only marginally more expensive than Cipla Docetaxel.²⁰¹ The court held in its judgment that:

Where the public is denied access to a generic during the lifetime of a patent that is the ordinary consequence of patent protection and it applies as much in all cases. To refuse an interdict only so as to frustrate the patentee's lawful monopoly seems to me to be an abuse of the discretionary powers of a court. But in any event there will be no material prejudice of that kind on the facts of this case.²⁰²

The SCA ruled that the broader public interest must be considered when weighing up the commercial interests of companies involved in patent disputes. The decision represents an important element of the transformation of the health sector because it compels the courts to consider patients' access to medicines when pharmaceutical companies battle over patents.²⁰³

4.3.10 *EN and Others v The Government of South Africa and Others*

In *EN and Others v The Government of South Africa and Others*²⁰⁴ case, prisoners living with HIV in the Westville Correctional Centre challenged the slow implementation of the government's plan to provide ARVs to prisoners needing them. The Durban High Court agreed that this was a matter of life and death, and said that the prison officials had not shown an appreciation for the seriousness and urgency of the situation. Relying on the judgment in the *Grootboom* case, the Court held that the Westville Correctional Centre's implementation of the relevant laws and policies in this case was unreasonable because it was inflexible, and characterised by unexplained and unjustified delays and irrationality. The court also hinted that the Government's Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa is faulty itself because it did not properly consider the special vulnerability of prisoners to HIV and AIDS. The Court ordered the Westville Correctional Centre to immediately remove all restrictions that prevented prisoners needing ARVs from accessing them; to immediately provide all the applicants in the court case with access to ARVs; and to submit a plan to the Court to explain how they plan to comply with the orders made by the Court.²⁰⁵

The state appealed against this judgment to a full bench of the KwaZulu-Natal High Court. On 28 August 2006, the full bench dismissed the state's case and found it to be in contempt of the court order. The High Court ordered the state to implement without delay the original court orders unless and until another court sets aside these orders on further appeal.

The following section discusses some barriers and fault-lines impacting on the provision of health care services in light of the constitutional provisions providing for a right of access to health care services.²⁰⁶

4.4 Barriers to health care provision

The South African health system performs poorly when its impact on the health status of the nation is compared to countries with a similar or poorer per capita Gross Domestic Product (GDP).²⁰⁷ Although large budgets are allocated by government towards health care and the

provision of health services, access to health care services in the public health care system and the quality of care provided are of great concern, in spite of existing policy and legislation governing this sector. Although South Africa spends more on health than any other African country, South Africa is one of only twelve countries in which maternal mortality and mortality for children younger than five years have actually increased since 1990.²⁰⁸

The national health system has a myriad challenges, among these being the worsening quadruple burden of disease and shortage of key human resources. Available information points to the lamentable state of many public health facilities in the country, the shortage of trained health care workers, lack of drugs in clinics, long waiting periods for treatment, poor infrastructure, disregard for patients' rights, the shortage of ambulance services and poor hospital management, underfunding, and deteriorating infrastructure.²⁰⁹ The following section discusses in detail some of the challenges confronting the health delivery system despite the plethora of legislative and policy interventions discussed above.

4.4.1 Cost of services

Although the Constitution guarantees freedom and equality for all,²¹⁰ there are still many barriers that people face in getting access to health care services. Health care services are often expensive and most people do not have access to private medical aid to pay for expensive treatment. Poor people face the high costs of transport, buying medicines, and follow-up visits to a doctor. Similarly to the public health system, the private sector also has its own problems, albeit relating to the costs, pricing and utilisation of services. It has been suggested that over-servicing practices in the private sector need to be governed to protect the public.²¹¹ Furthermore, mechanisms will have to be designed and implemented to bind the private provider sector into the national health system without reducing its equally important role in the health delivery system in South Africa.²¹² According to the Department of Health's NHI Policy Paper, the high costs are linked to high service tariffs, provider-induced utilisation of services and the continued over-servicing of patients on a fee-for-service basis.²¹³ Accordingly, the

private health sector may not be sustainable over the medium to long term.²¹⁴

The WHO recommends that countries spend at least five per cent of their GDP on health care. South Africa already spends 8.5 per cent (in 2010) of its GDP on health, way above what WHO recommends. Despite this high expenditure, health outcomes remain poor when compared to similar middle-income countries. This poor performance has been attributed mainly to the inequities between the public and private sector spending on health services.²¹⁵ The 8.5 per cent of GDP spent on health is split as 4.1 per cent in the private sector and 4.2 % in the public sector. The 4.1% spent in the private sector covers 16.2 per cent of the population (8.2 million people), who are largely on medical schemes. The remaining 4.2 per cent is spent on 84 per cent of the population (42 million people), who mainly utilise the public health care sector.²¹⁶

Over the past decade, private hospital costs have increased by 121 per cent whilst over the same period specialist costs have increased by 120 per cent.²¹⁷ Contribution rates per medical scheme beneficiary have doubled over a seven-year period. This has not been proportionate with increased access to services because of the limited access to needed health service coverage due to the design of the medical scheme benefit options, or the early exhaustion of benefits.²¹⁸ According to the NHI Policy Paper, per capita annual expenditure for the medical aid group is estimated at R11 150, in contrast to the public sector dependant population where the per capita annual health expenditure is estimated at R2 766. Accordingly, 'the amount spent in the private health sector relative to the total number of people covered is not justifiable and defeats the principles of social justice and equity...[and therefore] not an efficient way of financing health care.'²¹⁹

While the South African drug policy and the relevant legislation aimed at making access to medication more affordable are welcomed, their effectiveness is questionable. Currently, public sector drug costs are extremely high. Bronwyn Harris et al have pointed out that pharmaceutical profits are substantial in this country and the amount spent on medicine is nearly double to triple that of other major countries.²²⁰

4.4.2 Personnel disparity between public and private health providers

There is a general shortage of doctors in South Africa relative to the country's population, resulting in the available doctors and nurses being overworked. As noted by McIntyre, compared to 1997, the South African health delivery system needs an additional 80 000 staff in the public sector in order to address the increase in population size and the greater burden of disease from HIV and AIDS.²²¹ Some health practitioners have left the country for better salaries overseas. Because of the HIV and AIDS crisis, many hospitals and clinics face a huge increase in patients, but there has not been an increase in the doctors and nurses available to care for all the new patients. There is a serious lack of managerial capacity in the health system.²²² The biggest challenge to efficient management of the health system is training managers to implement effective systems in running clinics and hospitals where many problems have been identified. Problems include insufficient cleaning staff, nurses, doctors, dentists, pharmacists, psychologists and specialists. These problems place an enormous pressure on existing staff.²²³ New staff members are often unhappy with their working conditions, leading to some of them resigning. Many opt for better remuneration and working conditions in the private health care sector or go abroad.²²⁴

Engelbrecht and Crisp have pointed out that 'the private provider sector uses disproportionately more of the available human resources in comparison to the service that it provides.'²²⁵ The private sector has further been accused of 'clinical care practices with costs disproportionate to quality adjusted life years added.'²²⁶ The recent estimates show that the ratio of patients to health professionals (specialists, general practitioners, pharmacists) is lower in the private sector than in the public sector. There are also massive disparities in human resources between the two sectors, with one specialist doctor serving less than 500 people on average in the private sector but nearly 11,000 people in the public sector.²²⁷ The public-private mix is undoubtedly the greatest equity challenge facing the South African health system.²²⁸

4.4.3 Quality of health care services and poor management

Although significant improvements have been recorded in health services coverage and access since 1994, there are still notable quality problems. In many areas access has increased in the public sector, but the quality of health care services has deteriorated or remained poor. Many people do not have access to clean water, sanitation, nutrition and electricity, and this is a catalyst for poor health. Among the commonly cited challenges experienced by the public are cleanliness, safety and security of staff and patients, long waiting times, staff attitudes, poor staff productivity, corruption among senior managers, poor infection control and drug stock-outs.²²⁹ Health care facilities often do not have enough staff or medicines to provide proper health care services. The public health sector will have to be significantly changed so as to shed the image of poor quality services that has been scientifically shown to be a major barrier to access.²³⁰ In the South African Costs and Benefit Incidence Analysis study by McIntyre et al highlighted above, the findings are that there is dissatisfaction among health care users about the quality of health care provision in South Africa – with both private and public health care providers.²³¹ Concerns about public sector health care providers are primarily related to patient-provider engagements, cleanliness of facilities and drug availability.²³² Concerns with private health care providers are related to the high cost of medical schemes and the underlying profit motive.²³³

Harrison has argued that success in South Africa's public health delivery system has been 'hamstrung by the failure to devolve authority fully, and by the erosion of efficiencies through lack of leadership and low staff morale' and 'generally weak health systems management' resulting in poor health outcomes relative to total health expenditure.²³⁴ Engelbrecht and Crisp have also weighed in, pointing out that management capacity of hospital managers has been identified as a major concern, primarily 'due to the size of the budgets managed in hospitals and the complexity of the environment.'²³⁵ Emphasising the importance of management, Sewankambo and Katamba noted that, with reference to policy makers and managers, 'their lack of stewardship and leadership has been evident in the highly variable quality of care deliv-

ered within the public health sector. For example, the Western Cape province had a TB cure rate of around 80% in 2007 whereas, for most of the districts in KwaZulu-Natal, the cure rates were between 40 per cent and 60 per cent.²³⁶ It has been noted, for example, that provincial departments of health collectively overspent their budgets by more than R7.5 billion in 2009/10.²³⁷ Although this might on the face of it signal the urgent need for increased funding, it is, however, clear from the Auditor-General's findings that poor financial management pervades all the provincial departments.²³⁸ Furthermore, initiatives at the national level to develop effective management training programmes for hospital managers have largely failed.²³⁹ In that regard, Engelbrecht and Crisp have suggested the decentralisation of the management of large hospitals and their conversion into semi-autonomous structures with performance-linked funding.²⁴⁰ The two authors have argued that 'management competence is strengthened by giving managers authority, decentralising decision-making and making them accountable.'²⁴¹

4.4.4 Lack of implementation of policies

The government has developed legislative and other measures to comply with its constitutional duties under the Constitution. However, despite national policies and programmes that mostly follow international standards and targets, the health care system has not been able to successfully deliver quality health care on an equitable basis in all the provinces. Provinces do not spend the same amount for each person on health care delivery, with rich provinces like Gauteng and the Western Cape far exceeding the amount spent by poor provinces such as Limpopo, Mpumalanga and the Eastern Cape.²⁴²

Engelbrecht and Crisp have pointed out that health authorities need to ensure that there is appropriate targeting of upstream factors that impact on health status and that intersectoral activities are included in the delivery plans of the responsible sectors, such as housing, sanitation and water quality.²⁴³ Mayosi has pointed out that the incidence of rheumatic heart disease for those aged fourteen years and more in Soweto was 23.5 cases/100 000 per annum, which puts this urban community among the high incidence communities of the world.²⁴⁴

Mayosi attributes the prevalence of such a preventable condition to 'inadequate implementation of the guideline for the prevention of rheumatic fever in South Africa. A recent study showed that very few paediatricians were aware that rheumatic fever is a notifiable condition, and that the national notification system administered by the Department of Health was dysfunctional.'²⁴⁵ Engelbrecht and Crisp have also pointed out that inadequate implementation and policy co-ordination is 'but one indicator of a dysfunctional system that comprises islands of independent services rather than a coherent, co-operative approach to delivering health care services in the country. Improvements are also needed in drug availability, health technology and infrastructure.'²⁴⁶

4.4.5 The burden of disease

South Africa is plagued by four clear health problems described as the quadruple burden of disease.²⁴⁷ These are HIV and AIDS and TB; maternal, infant and child mortality; non-communicable diseases; and injury and violence.²⁴⁸ Despite South Africa only having 0.7 per cent of the world population, it is home to 17 per cent of all HIV-infected people in the world.²⁴⁹ The HIV prevalence is 23 times the global average, while the TB infection rate is among the highest in the world. Moreover, the TB and HIV and AIDS co-infection rate is one of the highest in the world at 73 per cent. As a result life expectancy in South Africa has declined over a number of years. HIV and AIDS has also contributed significantly to high maternal and child mortality rates. According to the NHI Policy Paper, failure to intervene may reverse 50 years of health gains.²⁵⁰

4.4.6 Inequalities in access to health services

In South Africa, health care access for all is constitutionally enshrined yet considerable inequities remain, largely due to distortions in resource allocation.²⁵¹ In spite of increased budgetary allocations in the health sector and improved social policies, South Africa has not adequately addressed health disparities in society.²⁵² This is because of an ill-prepared health care system to address the changing trend of burden of disease, poor leadership and management, inadequate human-resource capacity and a poor surveillance system.²⁵³ Access barriers also include

vast distances and high travel costs, especially in rural areas, high out-of-pocket (OOP) payments for care, long queues, and disempowered patients.²⁵⁴ South Africa's apartheid past still shapes health, service and resource inequities. Racial, socio-economic and rural–urban differentials in health outcomes, and between the public and private health sectors, remain challenging. In 2005, spending per private medical scheme member was nine-fold higher than public sector expenditure, and one specialist doctor served fewer than 500 people in the private sector but around 11 000 in the public sector.²⁵⁵ This burden on the poor bears vivid testimony to the country's distinctive private–public sector split, which severely limits cross-subsidisation from the wealthy to the poor, and from the healthy to the sick.²⁵⁶ Costs of accessing services can be crippling for poor households.²⁵⁷

Transportation costs and travel distance are key access barriers, especially for black Africans, the poor, and rural residents. Although the Clinic Upgrading and Building Programme has improved service availability, the research by Harris et al found that access barriers relate to the geographic inaccessibility of health facilities, particularly in largely rural and poorly resourced provinces.²⁵⁸ However, within the same geographical setting, different households cope differently with illness. This suggests a need for holistic and inter-sectoral approaches to support worse-off households, including mobile services, grants and user fee exemptions.²⁵⁹ The research also found that a considerable portion of the groups exempted from user fees still pay for services. This undermines the equity-objectives of the government's exemption policies and risks undoing this important financial protection for poor households and vulnerable groups. It also illustrates the 'discretionary power' of providers and bureaucrats who determine who ultimately qualifies for exemption.²⁶⁰

The principles underpinning the national health policy, such as those of non-discrimination and equality, serve to facilitate increased access to health care services. Attempts have been made at ensuring physical accessibility through the adoption of the District Health System. However, in spite of certain positive measures, health care services still remain highly inaccessible in some respects. The issue of language barriers in the health sys-

tem and the absence of comprehensive policies in respect of interpreter and translation services is but one example of a health care system that is extremely inaccessible to the majority of its users.²⁶¹ Language barriers between patients and health care workers mean that many people may not be able to fully understand their treatment because the health care worker does not speak the patient's language.

Population growth appears to have outstripped the availability of health facilities in South Africa. For instance, the country's population per clinic is 13 718, which is inconsistent with the WHO norm of 10 000 people per clinic.²⁶² However, this analysis cannot be conclusive without reviewing the utilisation rate of public health facilities. By the end of 2008/09, the primary health care utilisation rate in the country was 2.5 visits per person. The usable bed occupancy rates of hospitals were 65.2 per cent at district hospitals; 77.1 per cent at regional hospitals; 71.5 per cent at tertiary hospitals and 69.2 per cent at central hospitals. Except for regional hospitals, these utilisation rates were inconsistent with national targets.²⁶³

Distribution of Public Health Facilities in South Africa, 2009

	Number of facilities	Population per facility
Clinic	3595	13 718
Community Health Centre	332	148 553
District Hospital	264	186 817
National Central Hospital	9	5 479 966
Provincial Tertiary Hospital	14	3 522 835
Regional Hospital	53	930 560
Specialised Psychiatric Hospital	25	1 972 788
Specialised TB Hospital	41	1 202 919
Grand Total	4333	

Sources: Statistics South Africa (StatsSA), *Statistical Release P0302, Mid-Year Population Estimates, 2009 and District Health Information System (DHIS)*

South Africa is regarded as a middle-income country with a GDP of \$277 billion. However, South Africa's health outcomes are not always commensurate with this ranking. In 2008, South Africa's GDP per capita was five times higher than that of India. However, the average life expectancy in India was much higher (64 years) than that of South Africa (53.5 years for males and 57.2 for females).²⁶⁴

Three important reports from Ministerial Committees relating to health were submitted to the Minister of Health during 2009/10. These were: (i) 'Saving Mothers 2005–2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa', produced by the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD); (ii) the First Report of the Committee on Morbidity and Mortality in Children under 5 Years (CoMMiC); and (iii) the National Perinatal Morbidity and Mortality Committee Report 2008.²⁶⁵

The Saving Mothers Report indicated that the five major causes of maternal death had remained the same during 2005–2007 and 2003–2005, and that these were non-pregnancy related infections – mainly HIV (43.7 per cent), complications of hypertension (15.7 per cent), obstetric haemorrhage (antepartum and postpartum haemorrhage; 12.4 per cent), pregnancy related sepsis (9.0 per cent) and pre-existing maternal disease (6.0 per cent). The Saving Mothers Report also stated that 38.4 per cent of the 4 077 maternal deaths reviewed were avoidable within the health care system. Key administrative weaknesses identified included poor transport facilities, lack of health care facilities and lack of appropriately trained staff. Avoidable factors associated with health care providers included failure to follow standard protocols and poor problem recognition and initial assessment.²⁶⁶

The CoMMiC Report estimated over 60 000 South African children between the ages of one month and five years die each year. This translated into an under-five mortality rate for South Africa of between 57.6 and 94.7 deaths per 1 000 live births and an infant mortality rate of between 42.5 and 59.1 deaths per 1 000 live births. The CoMMiC indicated that these rates were highest in the Eastern Cape, KwaZulu-Natal and Free State provinces, and lowest in the Western Cape, Gauteng and Northern Cape provinces. According to the CoMMiC, the major

causes of childhood deaths were diarrhoeal disease, lower respiratory tract infections and perinatal conditions, with HIV and AIDS and malnutrition contributing as both primary and underlying causes of child mortality.²⁶⁷

Another factor impacting on access to health care services is stigma. There is a lot of prejudice and ignorance in some communities about HIV and AIDS. Some people living with HIV and AIDS fear that the community will reject them if they get tested and people find out that they are HIV positive and are taking ARVs.

4.4.7 Primary health care or tertiary health care?

An issue often facing the delivery of health care services at different levels is the allocation of resources and their impact. For instance, South Africa's tertiary health care services were historically well-funded, but basic, essential health care services were said to be deficient for the poorer two-thirds of the population. South African health policy has accordingly recognised the need to redistribute resources from tertiary level care to primary level care. It recognises the latter to be most effective and most cost-effective as the means to achieve better health.²⁶⁸ However, health policy recognises that such allocation of resources is often contrary to popular demand for high technology hospitals providing curative care. Hence, it should be acknowledged that while there is both national and international consensus on the value of primary level care, in practice different levels of care often compete for limited resources.²⁶⁹

4.4.8 No clear allocation of responsibilities and tasks to the different spheres of government

Certain key provisions of the Constitution inform the roles and functions of different spheres of government. For instance, section 27(2) obliges the state to take measures to realise health care rights. An 'organ of state' is defined in section 239 of the Constitution as including national, provincial and local spheres of government. Schedule 4, Part A of the Constitution enlists health care services as an area of concurrent national and provincial legislative competency, while Part B of the same Schedule enlists municipal health services as a local government competency. Although the National Health Act

attempts to allocate responsibilities and tasks to all spheres of government,²⁷⁰ in practice the issue of which sphere of government is ultimately responsible for the delivery of a particular health service often remains difficult to settle.²⁷¹ For instance, it is still unclear what are 'municipal health services' and what the distinction is between them and 'health care services' as referred to in Part A of Schedule 4. This lack of clarity has impeded the realisation of the right at different levels.²⁷² In its judgment in the *Grootboom* case, the Court explained that a reasonable government programme should 'clearly allocate responsibilities and tasks to different spheres of government and ensure that the appropriate financial and human resources are available'.²⁷³

Some of the challenges confronting the health system include the fragmentation of the health system between the private, public and non-governmental sectors. According to Engelbrecht and Crisp, 'the challenge is that these sectors currently do not share a single set of values, a common vision or a joint strategy for the health of the country as a whole'.²⁷⁴ Engelbrecht and Crisp have further pointed out that '[t]he public sector, comprising nine provinces, a national Department of Health (NDoH) and several municipalities, is also not united. The country, therefore, has a system of fragmented pieces in competition with each other.'

4.4.9 Social determinants and access to health

It has been noted that there has been a surge in attempts to address the social determinants of health (SDH).²⁷⁵ This is a result of a number of factors, including the imperative need to address the entrenched health inequities within the country and inadequate or poorly performing health systems and changing disease profiles.²⁷⁶ SDH have been defined as 'the social and economic factors that influence health, and include income, education, social safety networks, employment and working conditions, unemployment and job security, early childhood development, gender, race, food insecurity, housing, social exclusion, access to health services, and disability'.²⁷⁷

In South Africa, apartheid represented not only the disenfranchisement of the black population, but also an institutionalised system which maintained white domi-

nation and privilege in the political, economic, social and cultural spheres.²⁷⁸ Blacks were denied access to land, subjected to underdevelopment in economically marginal reserves and 'homelands', and were systemically discriminated against in their access to a range of social services and resources.²⁷⁹ The result is that race and class intersected, and racial discrimination deepened the class divisions in South African society. The effect of these deep class divisions was that the attempt at deracialisation of public policy in the post-apartheid era has had a limited impact on inequality.²⁸⁰

The result is that, in South Africa, gender, race and geographical location remain the key markers of social and economic inequities and of poor health outcomes.²⁸¹ These inequities are exacerbated by the challenges of a quadruple burden of disease and the sub-optimal performance of the health system highlighted above.

Indicators show that health and wealth are mutually reinforcing and that pro-poor policies also contribute to health, and improved health outcomes contribute to economic development.²⁸² Poverty, unemployment, and socio-economic inequity are some of the major reasons why South Africa has not achieved social and economic development in the past two decades of democratic rule.²⁸³ Mayosi et al have argued that these factors are the core elements for much of the deprivation and ill health in the country.²⁸⁴ Although substantial progress has been made in access to basic goods such as education, electricity, sanitation and potable water, the socio-economic needs of the poor in South Africa remain largely unmet. These include improving the quality of education, improved sanitation, and access to housing. Although the implementation of the social grant system, such as child-support grants, foster-care grants and care-dependency, has resulted in the reduction of poverty and improvement of health, especially in children, wealth inequalities have been growing, thereby impacting access to health.²⁸⁵

The Minister of Health signed the Negotiated Service Delivery Agreement (NSDA) for the Health Sector in October 2010, thereby signalling the importance of mainstreaming SDH in health policy.²⁸⁶ The NSDA provides for four strategic outputs for the health sector and these are: increasing life expectancy, decreasing maternal

and child mortality, combating HIV and AIDS and decreasing the burden of disease from tuberculosis (TB), and strengthening health system effectiveness.²⁸⁷ It has been pointed out that a more critical SDH discourse that interrogates and addresses the structural determinants of health inequities as well as the unequal power relationships that exacerbate such inequities is needed.²⁸⁸

5. Conclusion

Universal access to health care is provided for in the South African Constitution, which states that everyone has the right of access to health care services, including reproductive health care. South Africa is regarded as a middle-income country with a GDP of \$277 billion and spends considerable amounts on health care – 8.5% of its GDP, way above the WHO recommendation of five per cent of GDP. However, South Africa's health outcomes are not always commensurate with this ranking. Despite this high expenditure, the health outcomes remain poor when compared to similar middle-income countries. Although large budgets are allocated by government towards health care and the provision of health services, access to health care services in both the public and private sectors, and the quality of care provided, especially in the public sector, are of great concern. The national health system has a myriad challenges, among which are the worsening burden of disease, shortage of key human resources and mismanagement and corruption by senior managers. Available information points to the lamentable state of many public health facilities in the country, the shortage of trained health care workers, lack of drugs in clinics, long waiting periods for treatment, poor infrastructure, disregard for patients' rights, the shortage of ambulance services and poor hospital management, underfunding, and deteriorating infrastructure.

South Africa's apartheid past still shapes health, service, and resource inequities. Racial, socio-economic, and rural–urban differentials in health outcomes, and between the public and private health sectors remain challenging. Access barriers also include vast distances and high travel costs, especially in rural areas; high OOP payments for care; long queues; the unacceptability of

health care services, especially in the public sector; and disempowered patients.

The biggest challenge facing the efficient running of the health system is training managers to implement efficient systems in running clinics and hospitals where many problems have been identified. Problems include insufficient cleaning staff, nurses, doctors, dentists, pharmacists, psychologists and specialists. These problems place an enormous pressure on existing staff.

Another related challenge is that a large part of the financial and human resources for health is located in the private health sector serving a minority of the population. On the other hand, the public sector is under-resourced relative to the size of the population that it serves and the burden of disease. The public sector has disproportionately less human resources than the private sector, yet it has to manage significantly higher patient numbers.

Although significant improvements have been recorded in health services coverage and access since 1994, there are still notable quality problems. In many areas access has increased in the public sector, but the quality of health care services has plummeted or remained poor. Many people do not have access to clean water, sanitation, nutrition and electricity, and this is a catalyst for poor health. Among the commonly cited challenges experienced by the public are cleanliness, safety and security of staff and patients, long waiting times, staff attitudes, infection control and drug stock-outs.

A plethora of legislative, policy and administrative frameworks has been adopted to entrench and implement the right of access to health care services. However, despite national policies and programmes that mostly follow international standards and targets, the health care system has not been able to successfully deliver quality health care on an equitable basis in all the provinces. South Africa is plagued by four clear health problems described as the quadruple burden of disease. These are HIV and AIDS and TB; maternal, infant and child mortality; non-communicable diseases; and injury and violence. As a result, life expectancy in South Africa has declined over the years. It is therefore important that major changes in the service delivery structures, admin-

istrative and management systems be adopted and implemented to ensure that everyone has access to appropriate, efficient and quality health services.

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Glossary

ACCESS	Alliance for Children's Entitlement to Social Security
ACHPR	African Charter on Human and Peoples' Rights
ADSL	asymmetric digital subscriber line
ANC	African National Congress
ARV	Anti-retroviral
ASIDI	Accelerated schools infrastructure delivery initiative

BCCSA	Broadcasting Complaints Commission of South Africa	DWAF	Department of Water Affairs and Forestry (now DWA)
BNG	Breaking New Ground	ECA	Electronic Communications Act
CALS	Centre for Applied Legal Studies	ECDoE	Eastern Cape Department of Education
CCC	Complaints and Compliance Committee	ECS	electronic communications service
CCL	Centre for Child Law	ECT	electronic communications and transactions
CDE	Centre for Development and Enterprise	EEA	Employment of Educators Act 76 of 1998
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women	EFF	Economic Freedom Fighters
CESCR	(United Nations) Committee on Economic, Social and Cultural Rights	EHP	Emergency Housing Programme
CFO	chief financial officer	ES	equitable share
CoGTA	Department of Co-operative Governance and Traditional Affairs (previously DPLG)	ESTA	Extension of Security of Tenure Act 62 of 1997
Comtask	Communications Task Group	FBSan	free basic sanitation
COO	chief operating officer	FBW	free basic water
COSATU	Congress of South African Trade Unions	FICA	Financial Intelligence Centre Act 38 of 2001
CRC	Convention on the Rights of the Child	FHR	Foundation for Human Rights
CSIR	Council for Scientific and Industrial Research	FLISP	Finance Linked Individual Subsidy Programme
CSSR	Centre for Social Science Research	FXI	Freedom of Expression Institute
DA	Democratic Alliance	GCEO	group chief executive officer
DBE	National Department of Basic Education	GCIS	Government Communication and Information System
DHS	Department of Human Settlements (previously National Department of Housing or NDoH)	GDE	Gauteng Department of Education
DMA	Disaster Management Act 57 of 2002	GEC	General Education Certificate
DMMA	Digital Media and Marketing Association	GG	Government Gazette
DORA	Division of Revenue Act (renewed annually)	HDA	Housing Development Agency
DPLG	Department of Provincial and Local Government (now CoGTA)	HOD	head of department
DPME	Department of Planning, Monitoring and Evaluation	HSDG	Human Settlements Development Grant
DWA	Department of Water Affairs (previously DWAF)	IBA	Independent Broadcasting Authority
		ICASA	Independent Communications Authority of South Africa
		ICCPR	International Covenant on Civil and Political Rights
		ICERD	International Convention on the Elimination of all forms of Racial Discrimination
		ICESCR	International Covenant on Economic, Social and Cultural Rights

ICTs	information and communications technologies	PAJA	Promotion of Administrative Justice Act 3 of 2000
IDP	Integrated Development Plan	PCSA	Press Council of South Africa
IEC	Independent Electoral Commission	PDMSA	Print and Digital Media South Africa
IP	Internet protocol	PDMTTT	Print and Digital Media Transformation Task Team
IPTV	Internet protocol television		
IRDP	Integrated Residential Development Programme	PED	Provincial Education Department
ISP	Internet service provider	PIE	Prevention of Illegal Eviction from and Unlawful Occupation of Land Act 19 of 1998
ISPA	Internet Service Providers' Association		
LDoE	Limpopo Department of Education	PMSA	Print Media South Africa
LRC	Legal Resources Centre	POCDATARA	Protection of Constitutional Democracy against Terrorist and Related Activities Act 33 of 2004
LSM	Living Standards Measurement		
LTSM	Learning and Teaching Support Materials	R2K	Right to Know Campaign
MAT	Media Appeals Tribunal	RDP	Reconstruction and Development Programme
MDDA	Media Development and Diversity Agency	RGA	Regulation of Gatherings Act 205 of 1993
MEC	Member of the Executive Council (provincial 'cabinet minister')	RHIG	Rural Household Infrastructure Grant
MIG	Municipal Infrastructure Grant	RHLF	Rural Housing Loan Fund
NDoH	National Department of Housing (now called Department of Human Settlements or DHS)	RICA	Regulation of Interception of Communications and Provision of Communications Related Information Act
NDP	National Development Plan		
NERSA	National Energy Regulator of South Africa	SA	South Africa
NGO	non-governmental organisation	Saarf	South African Advertising Research Foundation
NHFC	National Housing Finance Corporation	SABC	South African Broadcasting Corporation
NHSDB	National Housing Subsidy Database	SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
NHSS	National Housing Subsidy Scheme		
NIA	National Intelligence Agency	SADF	South African Defence Force
NPC	National Planning Commission	SADTU	South African Democratic Teachers' Union
NSC	National Senior Certificate		
Nurcha	National Urban Reconstruction and Housing Agency	SAHRC	South African Human Rights Commission
NUSP	National Upgrading Support Programme	SAICE	South African Institution of Civil Engineering
NWSRS	National Water Services Regulation Strategy	SANDU	South African National Defence Union
OBE	Outcomes Based Education	Sanef	South African National Editors' Forum
OECD	Organisation for Economic Co-operation and Development	SAPS	South African Police Service
		SASA	South African Schools Act 84 of 1996

		Notes
SATRA	South African Telecommunications Regulatory Authority	
SCA	Supreme Court of Appeal	
SCOPA	Standing Committee on Public Accounts	1. This paper was produced in July 2014 with the financial support of the Foundation for Human Rights. The contents of this paper are the sole responsibility of the author and can under no circumstances be regarded as reflecting the position of the Foundation for Human Rights.
SERI	Socio-Economic Rights Institute of South Africa	2. The origins of WHO go back to the various international health conferences held in the nineteenth century.
SERs	social and economic rights	3. See Constitution of the World Health Organisation, <i>Basic Documents</i> , Official Document No. 240 (Washington, 1991) available at www.who.int/governance/eb/who_constitution_en.pdf . The Constitution of WHO was adopted at the International Health Conference held in 1946 in New York, where it was signed by the representatives of 61 states.
SGB	school governing body	4. See preamble to the Constitution of the Republic of South Africa, 1996.
SHF	Social Housing Foundation	5. See preamble to the Constitution.
SHI	Social Housing Institution	6. See section 7(2) of the Constitution.
SHP	Social Housing Programme	7. See Section 184(3) of the Constitution.
SHRA	Social Housing Regulatory Authority	8. See section 27 of the Constitution.
SIU	Special Investigating Unit	9. The National Health Act No. 61 of 2003.
SSA	State Security Agency	10. See preamble to the National Health Act.
TIMSS	Trends in International Mathematics and Science Study	11. HM Coovadia et al 'The Health And Health System of South Africa: Historical Roots of Current Public Health Challenges' 2009 (374) <i>The Lancet</i> 817; JE Ataguba and D McIntyre 'Paying for and Receiving Benefits from Health Services in South Africa: Is the Health System Equitable?' (2012) 27 <i>Health Policy and Planning</i> 135–145 and D McIntyre and L Gilson 'Putting Equity in Health Back onto the Social Policy Agenda: Experience from South Africa' (2000) 54 <i>Social Science and Medicine</i> 1637–56.
TRU	temporary residential unit	12. NK Sewenkambo and A Katamba 'Health Systems in Africa: Learning from South Africa' <i>Lancet</i> (2009) <i>Lancet</i> 957.
TV	television	13. NK Sewenkambo and A Katamba 'Health Systems in Africa' 957.
UISP	Upgrading of Informal Settlements Programme	14. K Kahn 'Population Health in South Africa: Dynamics over the Past Two Decades (2011) 32 <i>Journal of Public Health Policy</i> S30–36. Available at www.palgravejournals.com/jphp/j/full/jphp201127a.html .
UKZN	University of KwaZulu-Natal	15. Kahn 'Population Health in South Africa' S30–36.
UN	United Nations	16. Kahn 'Population Health in South Africa' S30–36.
UPM	Unemployed Peoples' Movement	
UPR	Universal Periodic Review	
USAASA	Universal Service and Access Agency of South Africa	
USDG	Urban Settlements Development Grant	
VIP	ventilated improved pit latrine	
Waspa	Wireless Applications Service Providers' Association	
WSA	water services authority	
WSDP	water services development plan	
WSP	water services provider	

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33. See www.southafrica.info/about/health/health.htm.
34. See www.southafrica.info/about/health/health.htm.
35. NHI Policy Paper, para. 1.
36. See Council for Medical Schemes *Annual Report 2008–2009* available at www.link2media.co.za/index.php?option=com_content&task=view&id=5442&Itemid=12.
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38. See Department of Health *National Department of Health Strategic Plan 2010/11–2012/13*, 16.
39. Coovadia et al 'The Health and Health System of South' 817.
40. Coovadia et al 'The Health and Health System of South Africa' 834.
41. Coovadia et al 'The Health and Health System of South Africa' 824.
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44. See National Health Insurance In South Africa: *Policy Paper* (2011) para. 7. www.gov.za/documents/download.php?f=148470.
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50. See para. 3 of the Preamble to the WHO Constitution.
51. The Declaration was adopted at the International Conference on Primary Health Care, held in Alma-Ata, USSR (6–12 September 1978). In September 1978, the World Health Organisation organised an international conference on 'Primary Health Care' in Alma Ata (Kazakhstan, then the USSR). Representatives from almost all UN member states gathered with main international organisations to define a framework for promoting 'Health for all', with special emphasis on poor communities in developing

- countries. The conference resulted in the adoption of the Alma-Ata Declaration, which called for 'a publicly funded, comprehensive system approach to ensure the right of health for all'
52. See para. I. The Declaration was adopted at the International Conference on Primary Health Care, held in Alma-Ata, USSR (6–12 September 1978).
 53. WHO, Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978.
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 65. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2000) CAB/LEG/66.6.
 66. See article 14 of the African Charter on the Rights and Welfare of the Child (1989) UN Doc A/44/49.
 67. See article 14(2)(a)–(j) of the African Children's Charter.
 68. Millennium Development Goal 6 aims to halt and begin reversing 'the spread of HIV/AIDS' by 2015. Although the Millennium Development Goals are not contained in a binding treaty format, it is argued that at least some of them – including goal 6 – have attained the status of customary international law.
 69. See GA Res 55/2, UN GAOR, 55th sess, Agenda Item 60(b), UN Doc A/RES/55/2 (2000).
 70. Sections 27(1)(a), (b) and (c); Section 28(1)(c) and Section 35(2)(e) of the Constitution of the Republic of South Africa, 1996.
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 75. These would include ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV and AIDS, including people living in rural areas.
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95. See section 5 of the National Health Act.
96. See Preamble to the National Health Act.
97. See section 2 of the National Health Act.
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103. Section 29(ii).
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