Abstract

A right of access to health care services is among the economic and social rights guaranteed by the Constitution of South Africa. Given the jurisprudential novelty of such a right and its dependence on economic resources, however, its realization is likely to be difficult to secure. The article discusses the scope and limitations of the right of access to health care in South Africa. Though the country's courts have yet to develop clear principles for interpreting a right of access to health care services, the more significant obstacles to the full enjoyment of this right are the country's pervasive poverty, gross income disparities, and extremely high burden of disease.

L'accès aux services de santé figure parmi les droits économiques et sociaux garantis par la constitution de l'Afrique du Sud. Étant donné la nouveauté en matière de jurisprudence d'un tel droit et sa dépendance par rapport aux ressources économiques, sa réalisation sera probablement difficile à assurer. L'article parle de la portée et des limites du droit aux soins médicaux en Afrique du Sud. Bien que les tribunaux du pays aient encore à mettre au point des principes clairs pour l'interprétation d'un droit d'accès aux services de santé, les obstacles les plus significatifs à la pleine jouissance de ce droit sont la pauvreté omniprésente dans le pays, les disparités choquantes de revenus et le fardeau extrêmement lourd des maladies.

El contar con acceso a los servicios de salud es uno de los derechos económicos y sociales garantizados por la constitución de Sudáfrica. Sin embargo, llevarlo a la realidad será indudablemente difícil, dada la novedad que en la jurisprudencia tal derecho representa y de los recursos económicos necesarios para su aplicación. En este artículo se estudia el alcance y las limitaciones del derecho de acceso a los servicios de salud en Sudáfrica. A pesar de que las cortes del país tienen que establecer principios claros para la interpretación del derecho de acceso a los servicios de salud, los obstáculos más importantes para gozar del beneficio completo de este derecho lo representan la extrema pobreza, la disparidad en los ingresos brutos y la muy alta carga económica por enfermedad en el país.

Articles

The Recognition of Access to Health Care as a Human Right in South Africa: Is It Enough?

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The broad indication is that the new South Africa is taking a holistic approach to respect for human rights. At a nascent stage of its democracy, it became a signatory to the International Covenant of Economic, Social and Cultural Rights (ICESCR), although it has yet to ratify it.[1] Even more significantly, it has conspicuously recognized socioeconomic rights closely modeled on those found in the ICESCR as justiciable rights in its Constitution.[2] The Human Rights Commission has been charged with monitoring the realization of these rights, which include the right of access to health care.[3] This right is found in a number of provisions, but most elaborately in Section 27 of the Constitution, which provides that:

> (1) Everyone has the right to have access to:
> (a) *health care services, including reproductive health care;*

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(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

(2) *The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.*

(3) *No one may be refused emergency medical treatment* (emphasis added).[4]

The purpose of this article is threefold: first, to explain the significance of a right to health care within the peculiarities of the South African health care system; second, to consider the scope of the right of access to health care; and third, to examine the limits of the realization of such a right in a country at South Africa's level of economic development.

Significance

In one sense, Section 27 vindicates the indivisibility and interdependence of human rights that has been espoused in human rights jurisprudence.[5] It is an affirmation of the confluence between civil/political rights and socioeconomic rights and, thus, challenges the classical liberal assumption that the latter are too polycentric and too politically charged to be amenable to adversarial adjudication.[6] Notwithstanding the doctrine of separation of powers, it is apparent from the language of Section 27(2) in particular that courts are given jurisdiction to adjudicate over matters of policy, including budgetary appropriations. Indeed, in *Ex parte Chairperson of the Constitutional Assembly*, the Constitutional Court, the country's highest court, expressly acknowledged such a jurisdiction.[7]

In a more immediate sense, however, Section 27 is an integral part of the transformation of the social, political, and economic fabric of South African society that began with the election to office of the African National Congress (ANC) in 1994, marking the demise of apartheid.[8] In this sense, Section 27 seeks to redress the past by making a fundamental break with a health care system that had historically been saturated with unfathomable disparities.[9] The lottery of income, geographical location, and race, in partic-

ular, had been for three centuries the primary determinant of the quantity and quality of health care services received by South Africans.[10]

Especially in apartheid South Africa, the health care system was used as one of many political superstructures to shore up white supremacy.[11] Whites disproportionately enjoyed the bulk of public expenditure on health care, receiving four times more per capita than their African counterparts.[12] Coloureds (people of mixed racial parentage) and Indians enjoyed a somewhat intermediate position.[13] Extreme differentials in income distribution and the rural-urban chasm accentuated the racial inequalities and assured that the least-favored population groups—Africans in particular and, to a lesser extent, Coloureds and Indians—had the worst health outcomes. Africans, being disproportionately poor and concentrated in rural areas with little access to effective health care services, ended up with the worst outcomes with respect to infant mortality rates, morbidity rates, life expectancy and so on.[14]

Section 27 is egalitarian in orientation and complements Section 9 of the Constitution, known as the equality clause.[15] Section 27 seeks to secure not only formal equality, so that extraneous factors such as race, gender, or HIV status cease to be a barrier to services, but also substantive equality, so that other social disadvantages, including income and geographical location, are eliminated or ameliorated. It confers not only a negative right, under which the state or individuals should refrain from adversely and unjustifiably interfering with an individual's right to secure health care services. Even more significantly, it confers a positive right to receive health care from the state. It represents a realization that securing health for everyone is an integral part of securing equality of opportunity in a democracy. The provision of health is a collective interest that entails distributive justice and necessitates going beyond the Aristotelian minimal principle of justice. Thus, given the history of entrenched structural inequality, it would not be enough simply to treat everyone the same way. To achieve meaningful equality, it is necessary to take into account factors such as income and geographical location

that may constitute impediments to equal access to health care services.

Scope

Though Section 27 has both vertical and horizontal applications, in that it is enforceable against the state as well as individuals, its importance lies in the former, not least because the state had historically played a dominant role in maintaining an inequitable and iniquitous health care system. Moreover, the state has a legitimate interest in, and monopoly over, the provision of social goods. The private sector, with its emphasis on profit, is ill-suited to assuage social needs. Indeed, in South Africa's case, private health care is inaccessible to all but a minority—it provides coverage for only 20% of the population—but, at the same time, it consumes a disproportionate share of national wealth, commanding 60% of the resources that are spent on health care.[16] The medical schemes that finance private health care have historically been biased against the chronically sick, elderly, and poorly remunerated sections of the population in favor of the younger, healthier, and better remunerated. Because of repeated waves of privatization of health care during the apartheid era, the state eventually assumed the responsibility of providing care for the 80% of the population that the private sector deems uninsurable.[17]

But is Section 27 robust enough to impose tangible obligations against the state? Does it not allow the state an inordinate margin of discretion, thus unduly circumscribing or even nullifying the content of the right? Is it not yet another paper lion, worthy of skepticism from proponents of the rights to health and health care?[18] The answer is both yes and no.

Yes, in the sense that Section 27 is susceptible to the same criticisms of vagueness and imprecision that have been directed at Article 2.1 of the ICESCR, to which it bears a strong resemblance.[19] Its language is that of compromise and flexibility. It does not define the quantity or quality of health care services to be accessed. Though, like the ICESCR, it imposes a mandatory injunction, it adopts a gradualist or incremental approach by requiring only *pro-*

gressive rather than immediate realization. It can even be argued that Section 27 is weaker than the ICESCR in that it requires recourse only to "available" rather than "the maximum of its available" resources, and thus insufficiently impresses upon the state the importance of deploying optimally all feasible resources, including international assistance.

But the answer is also no, in the sense that Section 27 is a realistic formulation. The concept of health care is inherently relative and acutely sensitive to the quantity of resources that a state can realistically marshal. To attempt to define the quantity or quality of health care to be received in rigid or precise terms would raise false expectations. In any event, the quasi-legal interpretation by the United Nations Committee on Economic, Social and Cultural Rights (CESCR) of obligations imposed by the ICESCR, for example, suggests that it is open to courts to develop principles to ensure that the state diligently adheres to the spirit and intent of the Constitution.[20] It is commonly accepted that provisions of the South African Bill of Rights must be interpreted generously.[21] The obligations imposed by Section 27 are neither open-ended nor without time constraints. The state should, at the very least, begin by meeting minimal or basic needs as proclaimed, for example, in the Alma-Ata Declaration.[22] A right of access to health care means being able to access health care that is affordable, available, and effective. It means prioritizing primary health care so as to prevent and control local endemic diseases, immunize against major infectious diseases, treat common diseases and injuries, and provide essential medicines. It also means prioritizing care to vulnerable groups, with particular emphasis on women and children. In short, the state must, as a starting point, seek to deliver a package of essential health services according to universal standards within a scheduled period of time.

The efficacy of Section 27 as a justiciable instrument for creating an equitable and egalitarian health care system will in part depend on the capacity and willingness of the judiciary to inquire robustly into alleged breaches of state socio-economic obligations. It is incumbent upon the Constitutional Court especially to go beyond the traditional approach

to judicial review when reviewing the constitutionality of administrative action or inaction in respect of the obligations in Section 27. That is to say, it is not sufficient merely to inquire whether the administrative action or inaction satisfies the requirements of legality, jurisdiction, and rationality in the traditional sense of judicial review.[23] Courts must develop new and appropriate tests, similar to those developed under international human rights jurisprudence, for determining whether there has been a failure to marshal and deploy available resources to progressively realize a specific right and, if so, whether the failure can be justified.[24] Inquiring into state budgetary decisions and appropriations is a concomitant part of the court's jurisdiction in this regard.

The recent case of *Soobramoney v Minister of Health (Kwa-Zulu Natal)*, the first in which the Constitutional Court was asked to interpret the enforcement of a quintessentially socioeconomic right against the state, casts doubt on whether there is sufficient judicial enthusiasm to depart from the traditional mould of judicial review.[25] The appellant, 41 years old, was in the final stages of chronic renal failure. He had been receiving renal dialysis through private care, but he had exhausted his funds. Without dialysis, he would die. He sought dialysis from a state renal unit, but his request was declined on account of limited resources. The unit's budget allocation from the provincial health authority did not allow for sufficient dialysis machines, bed space, or health care personnel to meet the demand for dialysis. It had, in consequence, devised criteria for rationing dialysis that essentially excluded any patient who had a poor prognosis or would require long-term or life-long dialysis. The appellant was not only diabetic; he also suffered from heart and vascular disease. This meant that he was not a candidate for kidney transplant and would require permanent dialysis. For these reasons he was turned down. He approached the courts contending that he had a constitutional right to receive renal dialysis.

The appellant based his claim on the right to not be refused emergency care in Section 27(3) and the right to life in Section 11 of the South African Constitution, rather than

on Section 27(1). He failed in the High Court and then in the Constitutional Court. The Constitutional Court was not persuaded that lifelong renal dialysis following chronic renal failure constituted emergency care. According to the Constitutional Court, Section 27(3) envisaged sudden illness or unexpected trauma, not ongoing treatment to relieve a condition which had been extant for many years and would eventually end the life of the sufferer. Moreover, even if Section 27(3) could be interpreted more broadly to include treatment for chronic conditions, this would not be done in a vacuum, but within the context of limited resources. In this case, cost was a limiting factor. The unit could only meet 30% of the demand for dialysis. Rationing as the unit had done was therefore both inevitable and reasonable.

The Constitutional Court also found that the right-to-life argument was unnecessary, as the Constitution contained specific provisions dealing with access to health care. Indeed it was the Court's opinion that the appellant's claim *should* have been based on Section 27(1) rather than on Sections 27(3) or 11. The Court opined, nonetheless, that the applicant would not have succeeded on Section 27(1) because the resources at the command of the unit, as allocated by the provincial health authority, did not allow for meeting the appellant's need. It was proper for health authorities to balance their priorities and ensure that their resources would also be used for preventative health care and medical treatment for persons suffering from illnesses that were not life-threatening.

The *Soobramoney* decision highlights the availability of resources as the crucial consideration when determining the enforcement of a socioeconomic right against the state. While the Court reached the correct decision on the lack of affordability of lifelong renal dialysis under Sections 27(2) and (3), it was also unduly deferential to executive assertions about budgetary constraints. While the Court was prudent to be slow to interfere with rational decisions made in good faith by the political organs and medical authorities on whom rests the primary responsibility for setting the health care budget, it should not have shied away from its implicit constitutional obligation to inquire sufficiently into budget-

ary appropriations when dealing with enforcement of socioeconomic rights.[26] In this regard, the Court failed to inquire whether priorities within the provincial and national governments' health-care budgets were in consonance with its constitutional obligations.[27] In South Africa, the national and provincial governments have concurrent jurisdiction over the provision of services.[28] Moreover, provincial governments derive the bulk of their health budget from appropriations from national coffers. It seems imperative, therefore, when interpreting Section 27 to carry out as broad an inquiry as possible to ensure that all possible resources at the disposal of the state or its organs are taken into account. It is true that, in the *Soobramoney* case, such an exhaustive inquiry would not have altered the outcome of the case; lifelong renal dialysis is prohibitively expensive for a country at South Africa's level of economic development. It would, however, have allowed for the development of more appropriate judicial standards for measuring the state's compliance with its duties under Section 27 and other socioeconomic provisions.

The *Soobramoney* case is, however, not the only one in which the enforcement of a constitutional socioeconomic right has been at issue before a South African court. There are two other cases: *B v Minister of Correctional Services* and *Grootboom and Others v Oostenberg Municipality and Others*.[29] In the *B* case, a High Court ordered state prison authorities to provide expensive antiretroviral combination therapy to two HIV-infected prisoners on the ground that the state had failed to provide satisfactory evidence of lack of financial resources. The prisoners had relied on Section 35(2)(e) of the Constitution, which, *inter alia*, provides persons in state incarceration with a right to "adequate medical treatment" at state expense. The *B* case is, however, distinguishable from the *Soobramoney* case for three main reasons. First, in *B*, the court was dealing with a right that is intended for immediate realization in the same manner as civil and political rights. Section 35(2)(e) rights are not qualified by a progressive realization clause, as is the case for Section 27(2) rights. The only qualification to Section 35(2)(e) is Section 36, the general limitation clause that

applies to all provisions of the Bill of Rights.[30] Thus the court lacked the opportunity present in *Soobramoney* to interpret and apply the duty to achieve the progressive realization of a socioeconomic right. Second, in *B* there was manifest failure on the part of the respondent state organ to provide cogent evidence of lack of resources. It is not clear how far the court would have inquired into budgetary appropriations had the state organ provided such evidence. Third, in *B* the right in question was intended to benefit a person incarcerated by the state, whereas this was not the case in *Soobramoney*. It is perhaps understandable for persons incarcerated by the state, by virtue of being a captive population, to be regarded as more vulnerable and disadvantaged than their counterparts outside, and thus to require more immediate guarantees of state-funded access to medical treatment.

The *Grootboom* case, in contrast, provides some parallels with *Soobramoney* in that the applicants' arguments were based in part on a constitutional right subject to progressive realization. The applicants in *Grootboom*, who were homeless, sought to enforce before the High Court the right to have access to adequate housing (Section 26) and the right of every child to basic shelter (Section 28). They succeeded in respect to Section 28 but not Section 26. The applicants succeeded on their Section 28 argument mainly because the section provides for rights intended for *immediate* rather than progressive realization. According to the court, the right to basic shelter was an unqualified constitutional right, and it was therefore not appropriate to consider whether the state had the requisite resources. The right had to be satisfied by the state without delay. To this extent, Section 28 is not directly analogous to Section 27(2). The case, however, does demonstrate a willingness on the part of the judiciary to enforce a socioeconomic right even in the face of a plea of budgetary constraints on the part of the executive.

On the other hand, the Section 26 argument in the *Grootboom* case provides an analogy with Section 27. Section 26(2) requires the state to take reasonable legislative and other measures within its available resources to achieve

the progressive realization of the right of everyone to have access to adequate housing. The court found that the respondents had not failed in discharging their duty under Section 26(2). They were faced with a massive shortage in available housing and an extremely constrained budget. Moreover, against the backdrop of pressing demands and scarce resources, the respondents had implemented a housing program in an attempt to maximize available resources to redress the housing shortage.

Although the applicants did not succeed on the Section 26 argument, the approach of the court in this case does hold a promise for the enforcement of socioeconomic rights intended for progressive realization. Unlike the Constitutional Court in *Soobramoney*, the High Court in the *Grootboom* case attempted to adjudicate the issue of progressive realization of a socioeconomic right with reference to, *inter alia*, approaches that have been developed in international human rights jurisprudence. For example, the court alluded to the General Comment No. 3 of the Committee on Economic, Social and Cultural Rights (CESCR) on the nature of the State's obligation with respect to Article 2.1 of the ICESCR.[31] The court also drew from the Limburg Principles.[32] In the absence of precedent, such an approach is more suited to the interpretation of socioeconomic provisions than the traditional judicial review approach that prevailed in *Soobramoney*.

Other Constraints

Of course, the Constitution is not the only instrument for facilitating a right of access to health care services. Indeed, the overall importance of the Constitution lies in its being an enabling instrument, which must necessarily be underpinned by other legal instruments and policies. So much has been done in this regard by the current government that law and policy are no longer the main impediments to universal access to health care services.[33] Rather, South Africa's high burden of disease and trauma, extreme disparities in income, and general poverty are now the main constraints.

Like much of the developing world, South Africa has a disproportionate burden of disease, especially preventable

disease. The incidence of HIV/AIDS and TB is alarming. Sub-Saharan Africa has the highest burden of HIV/AIDS globally, and the epidemic has become concentrated in Southern Africa.[34] Although South Africa has lagged behind its neighbors in both the timing and the intensity of the epidemic, it now has the fastest-growing epidemic in the world.[35] HIV has also aggravated the incidence of tuberculosis, and the country is experiencing the worst global incidence of TB.[36] There are also peculiarly high rates of road traffic accidents and physical violence.[37] The strain that such negative factors places on the health care system and the economy as a whole cannot be overemphasized.[38]

It is now generally accepted that health is less an outcome of health care services consumed than of general socioeconomic development.[39] South Africa has done poorly on securing economic well-being and equitable distribution of wealth. Poverty and unemployment are high. Despite having been called the continent's "economic powerhouse," South Africa's profile of poverty is paradigmatic of that of Africa in general.[40] More than half of the population is classified as poor, with women, children, and the rural population disproportionately affected.[41] Rural women and children are thus doubly vulnerable. Malnourishment and illiteracy are high. Securing clean drinking water, sanitation, and housing remains a formidable challenge for the government.

South Africa (along with Brazil) has the worst income differentials in the world.[42] The poorest 40% of households earn less than 6% of the total income, while the richest 10% earn more than 50%. The strong emphasis on fiscal restraint within the country's current macroeconomic policy may further exacerbate the poverty gap, as it entails reductions in public expenditure.[43] Although the country has put in place a bold program for reforming the economy and the health care system, including provision of universal primary health care, it is hostage in the short term to the constraining factors of historical neglect, extreme income differentials, and general poverty.[44] Current health outcomes reveal a nation within a nation, a First-World oasis within a broader Third-World nation.[45] For example, enor-

mous differentials in infant mortality rate per 1000 births for the various population groups still prevail: 54 for Africans, 36 for Coloureds, 9.9 for Indians and 7.3 for whites.[46]

Conclusion

Perhaps on account of its peculiar history, South Africa is one of the few countries in modern times not only to demonstrate an understanding of the holistic nature of human rights, but also to underscore this understanding in its Bill of Rights. Rather than merely issuing directive principles in respect of socioeconomic rights, it has created explicit, concrete provisions. The courts, however, need to develop new techniques for adjudicating the enforcement of these rights. Further, courts alone cannot ensure the full realization of socioeconomic rights. The onus is ultimately upon the state. A right of access to health care assumes a capacity on the part of the state to substantially ameliorate, if not eradicate, poverty. It assumes more equitable distribution of wealth and a general rise in living standards. South Africa's burden of disease and, more significantly, its poverty and extreme income differentials detract from a meaningful realization of the right to health care. Economic emancipation should be the next stage of South Africa's transformation. Nevertheless, South Africa cannot succeed on its own. Equitable trade relations with, and economic assistance from, the industrialized world are essential. Otherwise, the country will have succeeded in ameliorating only one of the historical impediments to access to health care—race—while leaving others, income or economic class in particular, untouched. Democracy alone is insufficient.

References

1. International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966), United Nations General Assembly Resolution 2200A (XXI) of 16 December 1966. It was entered into force on 3 January 1976. On 3 October 1994, following the new political dispensation with the election of the African National Congress (ANC) to office in May of that year, South Africa became signatory to the ICESCR, although it has yet to ratify the Covenant.

2. Constitution of the Republic of South Africa, Act No. 108 of 1996 (also known as the Final Constitution), which superseded the Constitution of the Republic of South Africa, Act No. 200 of 1993 (also known as the Interim Constitution). In the Interim Constitution, socioeconomic rights were accommodated rather cursorily in a half-hearted approach that has been attributed to a political stalemate between egalitarians and their classic-libertarian opponents at the negotiations for the transition from an apartheid state to a constitutional democracy. See L. Du Plessis and H. Corder, *Understanding South Africa's Transitional Bill of Rights* (Kenwyn: Juta & Co. Ltd, 1994), pp. 23–35. When drafting socioeconomic rights for the Final Constitution, the Constitutional Assembly took the ICESCR as a model so as to ensure rapport between domestic law and international obligations, as well as to point courts towards a legitimate international source when interpreting socioeconomic rights. See P. De Vos, "Pious Wishes or Enforceable Human Rights? Social and Economic Rights in South Africa's 1996 Constitution," *South African Journal on Human Rights* 1997, 13: 67–101. According to Section 39(1)(b) of the Constitution, courts *must* consider international law when interpreting the Bill of Rights. The obligation of the courts in this regard does not depend on whether South Africa has signed or ratified any pertinent international law instrument.

3. Section 184(3) of the Constitution states: "Each year the 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 rights in the Bill of Rights concerning housing, health care, food, water, social security, education and the environment." See J. Sarkin, "The Development of a Human Rights Culture in South Africa," *Human Rights Quarterly* 1998, 20: 628–65.

4. The other provisions that deal directly with rights of access to health care are Section 28(1)(c), which, *inter alia*, provides every child with the right to basic health care services, and Section 35(2)(e), which, *inter alia*, gives every person who is incarcerated by the state the right to adequate medical treatment at the expense of the state.

5. See, generally, A. Eide, C. Krause, and A. Rosas (eds.), *Economic, Social and Cultural Rights* (Dordrecht: Martinus Nijhoff, 1995). An international consensus on indivisibility and interdependence of human rights was proclaimed, *inter alia*, by the Proclamation of Tehran, UN Doc. A.Conf.32/41, para. 13 (1968), and the Vienna Declaration and Programme of Action, Vienna, June 1993, UN Doc. A.Conf.157/24 (1993).

6. D. Felder, *Civil Liberties and Human Rights in England and Wales* (Oxford: Oxford University Press, 1993), p. 902. In a seminal article, "The Forms and Limits of Adjudication," *Harvard Law Review* 1978, 92: 353–409, Lon Fuller adapted the concept of polycentrism to adjudication of legal disputes. Prior to the adoption of a democratic constitution in South Africa, academics debated whether socioeconomic rights should be included in the country's Bill of Rights; see N. Haysom, "Constitutionalism, Majoritarianism Democracy and Socio-economic Rights," *South African Journal on Human Rights* 1992, 8: 451–63; E. Mureinik, "Beyond a Charter of Luxuries: Economic Rights in the Constitution," *South African Journal*

on Human Rights 1992, 8: 464–74; and D. M. Davis, "The Case Against the Inclusion of Socio-economic Demands in a Bill of Rights Except as Directive Principles," *South African Journal on Human Rights* 1992, 8: 475–90.

7. *Ex parte Chairperson of the Constitutional Assembly: in re Certification of the Constitution of the Republic of South Africa 1996* (First Certification judgment), 1996 (4) SA 744 (CC), 1996 (10) BCLR 1253 (CC). In this case, the constitutionality of socioeconomic rights in the Constitution was raised before the Constitutional Court. The applicants argued that inclusion of socioeconomic rights was in conflict with Constitutional Principle VI, which requires a separation of powers between the legislature, executive, and judiciary. The court found: "It is true that the inclusion of socio-economic rights may result in courts making orders which will have direct implications for budgetary matters. However, even when a court enforces civil and political rights such as equality, freedom of speech and the right to a fair trial, the order it makes will often have such implications. . . . In our view it cannot be said that by including socio-economic rights within a bill of rights, a task is conferred upon the court so different from that ordinarily conferred upon them by a bill of rights that it results in a breach of separation of powers."

8. The African National Congress articulated its program for the socioeconomic reconstruction of South African society in African National Congress, *Reconstruction and Development Programme: A Policy Framework* (Johannesburg: Umanyano Publications, 1994).

9. African National Congress, *A National Health Plan for South Africa* (Johannesburg: African National Congress, 1994).

10. H. C. J. Van Rensburg, A. Fourie, and E. Pretorius, *Health Care in South Africa: Structure and Dynamics* (Pretoria: Academica, 1992), pp. 56–94; C. De Beer, *The South African Disease: Apartheid Health and Health Services* (Johannesburg: South African Research Service, 1990); H. C. J. Van Rensburg and A. Fourie, "Inequalities in South African Health Care. Part 1: The Problem–Manifestation and Origins," *South African Medical Law Journal* 1994, 84: 95–103; H. C. J. Van Rensburg and S. R. Benatar, "The Legacy of Apartheid in Health and Health Care," *South African Journal of Sociology* 1993, 24(4): 99–111; and African National Congress, *National Health Plan for South Africa* (Johannesburg: African National Congress, 1994), pp. 27–32.

11. M. Price, "Health Care as an Instrument of Apartheid Policy in South Africa," *Health Policy and Planning*, 1986, 1: 158–70.

12. H. C. J. Van Rensburg, "South African Health Care in Change," *South African Journal of Sociology* 1991, 22(1): 5.

13. The continued need for use of racial or even racist epithets, e.g., African, Coloured, Indian (now called Asian), and white, in classifying the South African population is regrettable but unavoidable. The author's use of these classifications in no way implies condonation of them or a recognition of their legitimacy. They are, however, an essential component of South African history and experience with colonialism and apartheid, in which legislation often specifically required or assumed such classification. Structural inequalities in the socioeconomic matrix of the South African population cannot be comprehended without such racial classification.

14. For example, from 1980 to 1985 the infant mortality rate per 1000 births was 13 for whites, 18.9 for Indians, 56 for Coloureds, and 82 for Africans; see Van Rensburg et al, *Health Care in South Africa* (note 10), p. 187.

15. Section 9 of the Constitution provides that:

> (1) Everyone is equal before the law and has the right to equal protection and benefit of the law.
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> (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
>
> (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture and birth.
>
> (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination. Discrimination on one or more grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

16. Van Rensburg et al., *Health Care in South Africa* (note 10), pp. 79–82.

17. *Ibid.*; H. C. J. Van Rensburg and A. Fourie, "Privatisation of South African Health Care: In Whose Interest?" *Curationis* 1988, 11(3): 1–6.

18. M. Kirby, "The Right to Health Fifty Years On: Still Skeptical?" *Health and Human Rights* 1999, 4(1): 6–25.

19. Article 2.1 states: "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures." For a critical appraisal of the obligations imposed by Section 27 of the South African Constitution and Article 2.1 of the ICESCR, see De Vos (note 2) and P. Alston and G. Quinn, "The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights," *Human Rights Quarterly* 1987, 9: 156–229.

20. Article 2.1 of the ICESCR is subject to interpretation by the United Nations Committee on Economic, Social and Cultural Rights (CESCR), which has primary responsibility for monitoring the implementation of the Covenant. A number of principles have emerged from its deliberations; see, for example, General Comment No. 3 (Fifth Session, 1990, UN Doc. E/1991/23). See also Alston & Quinn (note 19); E. R. Robertson, "Measuring State Compliance with Obligation to Devote Maximum Available Resources to Realising Economic, Social and Cultural Rights," *Human Rights Quarterly* 1994, 16: 692–714; and A. R. Chapman, "A 'Violations Approach' for Monitoring the International Covenant on Economic, Social and Cultural Rights," *Human Rights Quarterly* 1996,

18: 23–66.

21. The "generous" approach that the Constitutional Court has adopted when interpreting provisions of the Bill of Rights was explained, *inter alia*, in *S v Mhlungu* 1995 (3) SA867 (CC), 1995 (7) BCLR 793 (CC). In this case, the court built on Lord Wilberforce's ruling in *Minister of Home Affairs (Bermuda) v Fisher* 1980 AC 319 (PC) on the need for a generous interpretation and to avoid "the austerity of tabulated legalism" so as to give individuals the full measure of fundamental rights and freedoms guaranteed in a supreme constitution. The court found: "A constitution is an organic instrument. Although it is enacted in the form of a statute it is sui generis. It must broadly, liberally and purposively be interpreted as to avoid 'the austerity of tabulated legalism' and so as to continue to play a creative and dynamic role in the expression and achievement of the ideals and aspirations of the nation, in the articulation of the values bonding its people and in disciplining the government."

22. WHO, *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR 6–12 September 1978* (Geneva: WHO, 1978).

23. G. Van Bueren, "Alleviating Poverty through the Constitutional Court," *South African Journal on Human Rights* 1999, 15: 58.

24. See Van Bueren (note 23); Alston & Quinn (note 19); Robertson (note 20); and Chapman (note 20).

25. *Soobramoney v Minister of Health (Kwa-Zulu Natal)* 1997 (12) BCLR 1696 (CC).

26. *Soobramoney* (see note 25), para. 29.

27. D. Moellendorf, "Reasoning about Resources: *Soobramoney* and the Future of Socio-economic Rights Claims," *South African Journal on Human Rights* 1998, 14: 327–33, and F. van Oosten, "Financial Resources and the Patient's Right to Health Care," *De Jure* 1999, 1: 1–18.

28. Constitution of the Republic of South Africa (see note 2), Part A, Schedule 4.

29. *B v Minister of Correctional Services*, 1997 (4) SA 411 (C), 1997 (6) BCLR 789 (C), (1997) 50 BMLR 206 SA HC; *Grootboom and Others v Oostenberg Municipality and Others*, 2000 (3) BCLR 277 (C).

30. Section 36(1) provides that:

> The rights in the Bill of Rights may be limited only in terms of the law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including:
> (a) the nature of the right;
> (b) the importance of the purpose of the limitation;
> (c) the nature and extent of the limitation;
> (d) the relation between the limitation and its purpose; and
> (e) less restrictive means to achieve the purpose.

31. CESCR, General Comment No. 3 (note 20).

32. A group of legal experts under the aegis of the International Commission of Jurists met in Limburg in 1986 to elaborate state obligations with respect to socioeconomic rights under the ICESCR. The meet-

ing resulted in the so-called Limburg Principles, which are generally regarded as the best guide to the interpretation of state socioeconomic obligations under the ICESCR. See the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/CN.4/1987/17. See also the Mastricht Guidelines on Violations of Economic, Social and Cultural Rights, *Human Rights Quarterly* 1998, 20: 591–705.

33. Examples of legislation designed to render health care services universally accessible include the Choice on Termination of Pregnancy Act No. 92 of 1996, which made abortion easier for all women to obtain, irrespective of means; the Medicines and Related Substances Control Amendment Act No. 90 of 1997, which sought to render medicines more affordable by promoting generic substitution, allowing "parallel importation" of medicines, and establishing a pricing committee to introduce single exit prices and other price controls; and the Medical Schemes Act No. 131 of 1998, which, *inter alia*, outlaws unfair discrimination on grounds of age, illness, or disability in medical insurance coverage. Not all such legislation, however, has been an unqualified success. The Choice on Termination of Pregnancy Act, for example, is being undermined by health care workers who are hostile to abortion and by the inadequate provision of services, particularly in rural areas. See S. J. Varkey, "Termination of Pregnancy," in Health Systems Trust (eds.), *South African Health Review 1999* (Durban: Health Systems Trust, 1999). Likewise, the parallel importation provisions of the Medicines and Related Substances Act have been stalled on account of vociferous opposition from the pharmaceutical industry, the U.S. government, and European governments, which view the provisions as a breach of intellectual property rights. See S. Harrison, "Health Legislation," in Health Systems Trust (eds.), *South African Health Review 1999* (Durban: Health Systems Trust, 1999). Policy initiatives include the introduction of free health care for children under six years and pregnant women, as well as the reorganization of health services on a primary health care model accessed at a district level. A National Health Act that will codify the reorganization and restructuring of the health care system is awaited.

34. At a global level, sub-Saharan Africa accounts for over two-thirds of the HIV incidence. In 16 sub-Saharan countries more than one-tenth of the adult population aged between 15 and 49 is HIV-positive. In Southern Africa, the HIV epidemic is more intense, with at least one adult in five HIV-positive; see UNAIDS, *Report on the Global HIV/AIDS Epidemic* (Geneva: UNAIDS, 2000).

35. With an estimated 4.2 million people that are HIV-positive, South Africa has the largest number of people living with HIV/AIDS in the world; see UNAIDS (note 34).

36. WHO, *Fighting Disease, Fostering Development* (Geneva: WHO, 1996).

37. From 1987 to 1997, politically-related violence claimed 21,438 lives; see South African Institute of Race Relations, *South Africa Survey 1997/98* (Johannesburg: South African Institute of Race Relations, 1998). Safety on the roads is relatively poor. In 1996, there were 9790 deaths related to road traffic accidents; see D. Bradshaw, "The Broad Picture:

Health Status and Determinants," in Health Systems Trust (eds.), *South African Health Review 1998* (Durban: Health Systems Trust, 1998).

38. It is estimated, for example, that the HIV/AIDS burden alone could consume one-third to three-quarters of the health budget within the next decade; see H. C. J. Van Rensburg, E. Kruger, and P. Barron, "Health and Development," in Health Care Systems Trust (eds.), *South African Health Review* (Durban: Health Systems Trust), pp. 18–27.

39. P. Townsend and N. Davidson (eds.), *The Black Report* (London: Penguin, 1988) and M. Whitehead, *The Health Divide* (London: Penguin, 1988).

40. L. A. Deng, "Poverty Reduction: Lessons and Experiences from Sub-Saharan Africa," in L. A. Deng and E. N. Tjønneland (eds.), *South Africa: Wealth, Poverty and Reconstruction* (Chr. Michelsen Institute/Centre for South African Studies, 1996), pp. 170–203.

41. Van Rensburg et al. (see note 38).

42. Van Rensburg et al. (see note 38); P. Pillay, "Poverty in South Africa," in Deng and Tjønneland (eds.), *South Africa: Wealth, Poverty and Reconstruction* (Chr. Michelsen Institute/Centre for South African Studies, 1996), pp. 14–16.

43. The current government's macroeconomic policy is known as Growth, Employment and Redistribution (GEAR). Though GEAR is committed to social development—especially education, health, welfare services, housing, and land reform—economic growth is a prerequisite. GEAR is built on fiscal discipline and requires reduction of the budget deficit and curbing of public expenditure, with consequent adverse effects on social expenditure. It has been argued that GEAR will exacerbate the inequities and poverty inherited from colonialism and apartheid, while the "trickle-down" effects of foreign investments and free markets will take a long time to materialize. GEAR has been likened to the structural adjustment programs that have been imposed on much of the developing world by the Bretton Woods institutions, except that GEAR is self-imposed; see Van Rensburg et al. (note 38).

44. African National Congress (see notes 8 and 9).

45. South Africa ranked 95th in the 1995 global Human Development Index (HDI). If *white* South Africa had been considered as a separate country, however, it would have ranked 24th, well into the high category, while a *black* South Africa would have ranked 128th, in the low category; see Van Rensburg et al. (note 38). Historical inequalities among the country's racial groups persist. A survey conducted in 1996 (two years after the beginning of democracy) showed stark differentials in employment opportunities and general economic well-being among Africans, Coloureds, Indians and whites. Fifty percent of African women and 29% of African men were unemployed. The respective figures for Coloureds were 28% of women and 18% of men; for Indians, 20% of women and 10% of men; and for whites, 8% of women and 4% of men; see *Sunday Times, Business Times* (Johannesburg), "Democracy Fails to Wipe out History's Inequalities," 1 December 1996.

46. J. Calitz, *Population of South Africa: Updated Estimates, Scenarios and Projections, 1990–2020* (Midrand: Centre for Policy and Information, 1996).