

A background to health law and human rights in South Africa

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1.1 What do we mean by health?

In the early 20th century, Herbert Dhlomo, a writer from KwaZulu-Natal, wrote a short play called Malaria. In a poem introducing the play, he complained that:

*“In slums and shanty towns the children cry
And die – they die who earth should beautify!
In barracks and shacks grown people sigh
And die – they sleep who
Wrong should rectify!
And superstition, ignorance and fear
Our rural areas stalk
Our efforts mock and balk
Year after crippling year.
Where should be laughter,
We witness slaughter!
Where fruitful toil and health –
Decay, despair and death!”*

Dhlomo’s poem captures how important health and an understanding of health are to human development. This is even truer in the 21st century.

Human beings are complex organisms. Our bodies are made up of many separate but interlinked organs and parts. The proper functioning of each of these parts gives us our health.

However, health does not only mean “being free from disease or incapacity”. It includes a sense of positive well-being because as human beings we depend on being healthy in order to live our lives to the fullest – to work, to have many types of enjoyment, to think, and to have sex and procreate.

World Health Organisation definition of health

The World Health Organisation (WHO) defines health as:

“A state of complete physical, mental and social well-being.”

But unfortunately for the vast majority of people in South Africa and the world, the WHO’s definition of health is as far from reality as it was when Dhlomo wrote his poem:

- Physical well-being is still denied to millions because each part of our bodies is vulnerable to many different types of disease, or other risks such as injury. The causes of disease vary:
 - Diseases that can be transmitted between humans are called communicable diseases. They are usually caused by viruses, such as the Human Immuno-deficiency Virus (HIV), or bacteria such as tuberculosis (TB).
 - Diseases that are not transmitted between humans are known as non-communicable diseases, and include cancers, heart disease and diabetes.
- Communicable diseases are not always infectious. For example, many people have the TB bacterium, but it is latent in their bodies. Similarly, HIV is not infectious through casual contact. It is usually transmitted through sexual intercourse, or when the blood or other bodily fluids (such as semen or vaginal fluids) of a person with HIV are directly exposed to the blood or other bodily fluids of another person.
- Mental well-being is denied to people with mental illnesses, or people who live in poverty, or in fear of crime, sexual abuse or victimisation.
 - Social well-being is denied to people who do not have access to health care services, water, sufficient food or jobs.

Examples: Global differences in health

According to the WHO *World Health Report, 2004*:

- While 100% of people in Austria have sustainable access to an improved water source, only 19% of urban dwellers in Afghanistan have similar access.
- While the maternal mortality ratio in Canada is 5 for every 100 000 live births, in India it is 540.

Each of the parts in the WHO's definition of health is linked. People's risk from diseases such as HIV or TB is influenced by the environment in which they live. Our mental health strongly influences our physical health. Our social well-being has an impact on both our mental and physical health.

Living with dignity, with the right to make choices and the ability to control our own bodies, can have a big effect on our health.

Health is also influenced by the choices we make about how we live our lives, such as whether to smoke tobacco or drink alcohol. These choices are often influenced by whether people have access to education or information. Similarly, if we live in an environment that is clean, and where everyone has access to clean water and nutrition, it is likely that we will be healthier.

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Example: Health and living conditions

In England during the 19th century, the greatest advances in health and reductions in diseases such as TB came alongside improvements in people's living conditions.

Thus we can see why dignity, a clean environment and food security are important for human health.

A wider responsibility for health care

The right to health care is about more than the right of access to medicines and doctors – although this is very important. It is also about the duty of governments to ensure that people live in conditions that do not harm their health, but instead promote and fulfil this right. This duty to respect the right to health does not lie only with governments.

People suffer poor health and disease when they live or work in situations where their human rights are not respected.

Examples: Social and environmental factors

- In South Africa during the 20th century, tens of thousands of mine workers lost their lives and health because of conditions on the gold mines.
- Today, people are most at risk of cholera when they live without access to clean water or flushing toilets.
- The risk of infection with HIV is much greater among people who do not have access to information, who are poor, and who as women do not have full control over their own bodies.

Private companies, and in particular the big transnational corporations, must also respect the right to health. Today we live in a global economy where the actions of foreign governments or companies can have a direct impact on health and the environment. For example, the exploitation of cheap labour in poor countries can rob people of their physical health. Similarly, pollution has an impact on the environment globally, altering the weather in a way that negatively affects people's livelihoods and health.

In 2003, the United Nations Commission on Human Rights passed a resolution setting out *Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights*.

See Chapter 5 for a fuller explanation of international law in relation to health.

Key Points: Different health services

Because there are many causes of ill health, there are also many different aspects of health services. These include:

- Physical health.
- Mental health.
- Sexual and reproductive health.
- Occupational health.
- Environmental health.

As a result, divisions of medicine – and of health services – specialise in each of these areas.

1.2 What are health rights?

The history of medicine can be traced back to at least 2600 BC when a scientist in 3rd dynasty Egypt wrote texts describing the diagnosis and treatment of at least 200 diseases. However, for many centuries diseases and their cures were understood through religious and cultural beliefs.

Most of the breakthroughs in medicine were made in the 19th and 20th centuries through chemistry and bacteriology. It was also at around this time that governments of the world began to accept that they had a duty to provide services to protect and improve the health of their citizens. Today most governments, including South Africa's, use part of the taxes they raise to pay for health services.

The 19th century witnessed the formation of the modern nation state together with political movements that began to campaign for better conditions for the poor and working classes. In Europe and Asia, for example, trade unionists and socialist political parties championed the idea that health is a human right, rather than a privilege or a commodity to be bought or sold. Friedrich Engels, the 19th century Marxist, for example, drew attention to the way that factory work destroyed the health of the working class. He complained about *“a pretty list of diseases engendered purely by the hateful greed of the manufacturers”*.

Universal Declaration of Human Rights

In 1948, the recognition of health as a human right took a great step forward when the newly formed United Nations adopted the *Universal Declaration of Human Rights (UDHR)*. The UDHR states that everyone:

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“has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.”

The history of the idea of human beings having “rights” is a long one, and there have been many different approaches to and theories about human rights. Even though the international human rights machinery is stronger now than ever in history and the United Nations has many declarations about human rights, there are governments, religions and cultures that dispute or deny people some or many human rights.

In this book, we do not dispute the idea of human rights. We believe that human beings are born equal and should – as a right – be treated with dignity and have access to health care services.

International Covenant on Economic, Social and Cultural Rights

In 1966, nearly 20 years after the adoption of the UDHR, the responsibility of governments in respect of the right to health was made even more specific in the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*.

The ICESCR mandated governments ratifying the agreement to undertake these steps:

- a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.*
- b) The improvement of all aspects of environmental and industrial hygiene.*
- c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases.*
- d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.”*

See Chapter 5 for a fuller explanation of international law in relation to health.

Key Points: Need for support from more governments

- Some powerful governments, including the United States, have refused to ratify the ICESCR.
- The principle that health is a human right is still not accepted by many governments, and many governments still support policies, religions or cultural practices that have a very negative impact on health.

In the past, the idea of health as a human right was not accepted in South Africa either. Under the colonial government of Britain, the 19th century governments of the Boer republics and the apartheid government, people's access to health care services was determined by their race or class. Black people and poor people suffered a great deal of ill health, and were denied medical services or information about health.

The South African Constitution

Since democratic elections in 1994, our Constitution has included a Bill of Rights. South Africa's final Constitution (Constitution of the Republic of South Africa, 1996):

“enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom”.

The rights to human dignity, life, freedom from slavery, privacy, housing, education and access to information are all important for good health. So are the rights to equality and non-discrimination. As a result today:

- People can no longer be denied health services because of factors like their race, gender or religion.
- People cannot be discriminated against because they have an illness, which is what used to happen to people living with HIV/AIDS.

In addition to protecting people's rights to dignity and privacy, our Constitution specifically says that the government has a legal duty to “respect, protect, promote and fulfil” people's rights. In particular, it says that:

“Everyone has the right of access to –

- a) Health care services, including reproductive health care,*
- b) Sufficient food and water, and*
- c) Social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.”*

Key Point: Health and social security

From the wording of the South African Constitution, we can see that its drafters did not view health care in a narrow way as just medicines or clinics. Instead, they linked health to access to food, water and social security. Social assistance refers to the right that very poor people have to income support in order to live. This too is important for health: people need money for food, medicines, light, heat and transport to clinics.

The relationship between human rights, policy and law

In studying health and campaigning for health rights, we need to understand the difference between human rights, policy and law:

■ Human rights:

In many countries human rights are not recognised in laws and are therefore not enforceable by courts. In South Africa, however, our Constitution's Bill of Rights means that the rights that are listed there are justiciable. This means they are legally enforceable if there is a dispute.

■ Policy:

Policy is not law, but can sometimes be based on law. Policy is often a stage that takes place before a law is made or amended. For example, a policy explains how human rights can be protected in a new law.

■ Law:

Laws set out the rules of a country and must be followed by everyone. The highest law of South Africa is the Constitution, including the Bill of Rights. This Constitution says that "the Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state". This means that human rights that are set out in the Constitution must guide every law in South Africa.

A legal framework that tries to respect, protect, promote and fulfil people's human right of access to health care services is developed mainly through policies and the laws that try to implement these policies.

Examples: Policy and law

Laws and policies that deal with health fall into several categories, including those:

- Directly dealing with overall health, such as the National Health Act that explains the way in which the health system should work.
- Dealing with aspects of health, such as laws governing the termination of pregnancy, smoking or the regulation of medicines, or policies on voluntary counselling and testing (VCT), breastfeeding or mental health.
- Not relating directly to health, but having an impact on health, such as laws governing the environment, occupational health and safety, water, housing, education, trade and the protection of intellectual property.

Statutory institutions

The government also passes laws to set up statutory institutions that are given responsibility for overseeing aspects of health. Examples are:

- The Health Professions Council of South Africa (HPCSA) that ensures that doctors respect the individual rights of their patients.
- The South African Nursing Council that oversees the registration and conduct of nurses.
- The South African Pharmacy Council that registers pharmacists and their assistants.
- The Medicines Control Council (MCC) that ensures all registered medicines in South Africa are confirmed to be safe, effective and properly manufactured.

1.3 Health under apartheid

From 1948 to 1994, racial discrimination against all black people affected people's health in many ways. These included:

- Social conditions that caused ill health.
- The segregation of health services.
- Unequal spending on health services.
- The failure of professional medical bodies and civil society to challenge apartheid health.

More than 10 years after our democratic elections in 1994, South Africa is still recovering from the many violations of the human right to health that took place systematically under apartheid laws and policies.

Social conditions that caused ill health

During the years of apartheid and before, the migrant labour system deliberately drew African men to the cities as workers for industry and the mines. But, under the Pass Laws, the very same black men were not allowed to reside in "white" urban residential areas without permission. As a result, millions of people were forced to live in townships where there was less clean water, electricity, or access to health care services such as clinics and hospitals.

The migrant labour system also led to millions of men leaving their homes and families to live in single-sex hostels in urban areas. This affected mental health and contributed to problems such as alcoholism. In addition, it led to epidemics of illnesses such as TB that spread rapidly due to overcrowded living conditions and a lack of ventilation in gold mines and the hostels.

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The dependence of women and men on sex work was due to a combination of migrant labour and poverty. It contributed to epidemics of sexually transmitted infections (STIs) – and later HIV. In 1990, for example, some researchers warned in a medical journal that:

“It appears that the migrant labour system has institutionalised a geographic network of relationships for spreading sexually transmitted diseases. This network suggests that once HIV enters the heterosexual mining community it will spread into the immediate urban area, to surrounding urban areas, from urban to rural areas, within the rural areas and across national boundaries.”

Therefore the overall effect of apartheid policies was to make black people more at risk of illness, but also less able to get health care.

Examples: Apartheid and health

- In 1971, deaths from diarrhoea were 100 times more common among black children than among white children.
- In 1978, typhoid fever was 48 times more common among black people than among white people.

Key Point: A culture of ill health

For over 40 years, an environment that encouraged disease was created. The lack of health services, or medicine, helped to create a culture of ill health – one where people did not seek early diagnosis or treatment of illness – simply because they could not get it.

Segregation of health services

The apartheid government passed special laws and policies to enforce racial inequality in access to health care services.

South Africa’s health departments were divided into “white”, “coloured”, “Indian” and “black”. In addition, the provinces and the Bantustans (called “homelands”) had separate health departments. This led to great inequalities in access to health services.

Examples: Inequality of access

- In 1987, the number of white dentists for each person in the white population was 1: 2 000, while for black people, it was 1: 2 000 000.
- In 1990, the number of doctors to patients in urban areas was 1: 900, while in rural areas it was 1: 4 100.

Black people were prevented from training as doctors or dentists at white universities, and black doctors and nurses were not allowed to supervise white nurses even if they were more qualified. Apartheid was so petty that in “white” hospitals black doctors were not allowed to wear white doctors’ coats, examine white patients or attend the post-mortems of deceased white people.

Unequal spending on health services

The apartheid government spent less money on black people’s health. This table shows health spending for each person according to race in 1985 and 1987:

	1985	1987
Africans	R115	R137
Coloureds	R245	R340
Indians	R249	R356
Whites	R451	R597

In 1982, the entire health budget for KwaZulu, then a “semi-independent” Bantustan with more than 5 million people under the leadership of Mangosuthu Buthelezi, was equivalent to the entire budget for Johannesburg General Hospital (then a “whites only” hospital).

Lack of significant challenge to apartheid health

Civil society, including health workers, has a major role to play in protecting and promoting health rights. Although some brave individual health workers, such as Dr Nthatho Motlana or Dr Wendy Orr, resisted apartheid health policies, most white health workers either collaborated with the system or did not oppose it.

In some cases, such as the murder of political activists like Steve Biko in 1977, doctors even helped the police to cover up their crimes. In 1998, the Truth and Reconciliation Commission (TRC) found that:

“The health sector, through apathy, acceptance of the status quo and acts of omission, allowed the creation of an environment in which the health of millions of South Africans was neglected, even at times actively compromised, and in which violations of moral and ethical codes of practice were frequent, facilitating violations of human rights.”

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Creating a culture of health-seeking behaviour – instead of tolerating ill health – remains a great challenge for today. That is one of the aims of this book. We believe it can be achieved if more people understand why health is a human right, and how South African law and policy supports or works against this right.

1.4 A vision for health as a human right

During the years of apartheid the African National Congress (ANC) and other progressive organisations developed an alternative framework for providing health care in South Africa. This vision was based on racial equality and human rights.

Freedom Charter

The Freedom Charter, adopted by the Congress of the People in Kliptown, Soweto in 1955, sets out this vision on health:

“A preventive health scheme shall be run by the state.

Free medical care and hospitalisation shall be provided for all, with special care for mothers and young children.

Slums shall be demolished, and new suburbs built where all have transport, roads, lighting, playing fields, crèches and social centres.

The aged, the orphans, the disabled and the sick shall be cared for by the state.”

Primary health care approach

In later years, the ANC embraced the principles of primary health care (PHC) as a way to realise this vision. In particular, the ANC was influenced by the principles of the *Declaration of Alma Ata* that was adopted at an international conference on health care in 1978 and endorsed by many governments around the world.

Key Points: Principles of primary health care

The PHC approach:

- Believes that access to health care is a fundamental human right.
- Puts emphasis on the government’s duty to invest in preventative health services that are close to communities.
- Teaches people how to avoid ill health.
- Focuses on health education as a key aspect, in order to try to save expenditure on hospitals and complex medical services that cater for

people who have already become ill with preventable conditions.

- Ensures a proper balance between investment in primary and tertiary health care services.

PHC was at the core of the ANC's approach to health while it was still banned and in exile. After 1990, it became a key part of the ANC's *National Health Plan for South Africa* (1994) that stated:

"The ANC is committed to the promotion of health through prevention and education. The PHC approach is the underlying philosophy for the restructuring of the health system. It embodies the concept of community development, and is based on full community participation in planning, provision, control and monitoring of services. It aims to reduce inequalities."

Reconstruction and Development Programme

When the ANC came to power in 1994, it promised to implement the principles of the Freedom Charter and PHC. It set these out in more detail in a policy document known as the *Reconstruction and Development Programme (RDP)*.

The RDP recognised that:

"The mental and physical health of South Africans has been severely damaged by apartheid policies and their consequences. The health care and social services that have been developed are grossly inefficient and inadequate. There are by international standards, probably enough nurses, doctors and hospital beds.

South Africa spends R550 per capita per annum on health care. This is nearly 10 times what the World Bank estimates it should cost to provide basic public health care services and essential clinical care for all, yet millions of our people are without such services or care.

Health services are fragmented, inefficient and ineffective, and resources are grossly mismanaged and poorly distributed. The situation in rural areas is particularly bad."

Under "Health Care" the RDP promised:

"The government will develop a national health system offering affordable health care. The focus will be on primary health care to prevent disease and promote health, as well as to cure illness.

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“The national health system will:

- *Give free medical care to children under 6 years and to homeless children.*
- *Improve maternity care for women.*
- *Provide free services to disabled people, aged people and unemployed people within 5 years.*
- *Organise programmes to prevent and treat major diseases like TB and AIDS.*
- *Expand counselling services (for victims of rape, child abuse, and other kinds of violence).*
- *Give women the right to choose whether to have an early termination of pregnancy.*
- *Improve and expand mental health care.*
- *Run special education programmes on health, aimed particularly at young people.*
- *Improve occupational health in the workplace.*
- *Involve the fullest participation of communities.”*

Source: Summary of the RDP from the ANC website

1.5 The state of health and the health care system in 1994

Recognising that health is a human right and improving human health are very different challenges. In 1994, South Africa’s first democratic government inherited great inequalities in health. These included inequalities in:

- The impact of disease across races.
- Access to health services between urban and rural areas, and between South Africa’s nine new provinces.
- The quality of health services in the public health system compared to the private health system.

We will briefly focus on each of these three aspects.

Racial inequalities

Owing to apartheid, the different races in South Africa experienced different diseases and different outcomes in the management of those diseases.

While white people generally experienced low levels of infant and child mortality (due to access to clean water and antenatal services), they had higher levels of “life-style diseases”, including cardiovascular disease.

By contrast, black people experienced high rates of infectious or transmissible diseases such as TB, as well as diseases of poverty such as cholera and kwashiorkor. The table below shows comparative mortality rates – however, it hides the full extent of discrimination because it does not reveal the different ages at which black and white people died, or the differences between the races on key indicators such as infant mortality and maternal mortality.

Deaths per 10 000 people in 1989 according to race	
Africans	83 per 10 000
Coloureds	77 per 10 000
Whites	67 per 10 000
Indians	44 per 10 000

Source: Department of Health and Population Development, 1992

Geographic inequalities

Great inequalities also existed in access to health services between urban and rural areas, and between South Africa's nine new provinces, several of which incorporated former "homelands" such as Venda and KwaNdebele that had become the most poverty-stricken parts of South Africa.

Thus, a detailed report on the distribution of health workers in South Africa in 1994/1995 found that:

- 63% of public sector doctors, 70% of dentists and 61% of pharmacists were located in 2 provinces – Gauteng and the Western Cape.
- In one Bantustan, Lebowa (now a part of Limpopo), the ratio of doctors to the population was 1: 33 000 people.

Public and private inequalities

There was also serious inequality between health services in the public health system, paid for with tax revenue, and the private health system, paid for mainly by employers and individuals who could afford it.

For example, in 1994/1995, although the private sector served only 20% of the population, it had 58% of medical doctors, 89% of dentists and 94% of pharmacists. Unfortunately, this division remains much the same today.

See Chapter 6 for a discussion of the private health sector in South Africa.

1.6 The challenges of health reform after 1994

The overriding aim of health reform since 1994 has been to undo the effects of the past and to fulfil a promise made in the Constitution to build a “democratic state founded on the values of human dignity, the achievement of equality and the advancement of human rights and freedoms”.

Fulfilling the promise of the Constitution

The principle that health is a human right has been the foundation of health policy since 1994. Good health and access to health care services are essential for people’s rights to dignity. Human dignity and the advancement of human rights are core values of our Constitution.

The right of access to health care services is sometimes called a socio-economic right. As with all rights it can be limited, as long as the basis for limiting it is reasonable and justifiable. The Constitution says that the government has a duty steadily to improve (“progressively realise”) people’s access to health care. It says that the state must:

“take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation”

of the right of access to health care services.

The right to health care does not mean that any person can demand and receive whatever type of health care they want. The government has to raise the budget of publicly provided health services through taxes. They therefore have a duty to make sure that the money that is spent on health is spent properly and reasonably.

Example: Rationalising health spending

The cost of allowing one person a very expensive heart transplant may deny to 100 other people more effective types of preventative health interventions, such as vaccinations against certain viruses.

The role of courts in ensuring access to health care

In implementing health care reform, disputes have arisen about whether the government is fulfilling its constitutional duties regarding the right to health. As Chapter 4 explains, Parliament is meant to allow some of these disputes

to be raised and hopefully resolved through debate. This can also be done by making submissions to the Department of Health (DoH).

But when this fails and litigation follows, the Courts have to interpret the Constitution and to explain precisely what the meaning and duty of the government is in relation to the right to health. In South Africa, there have been several very important Constitutional Court judgments about access to health care.

- In the 1998 case of *Soobramoney v the Minister of Health (KwaZulu Natal)*, the Constitutional Court said that the government was justified in restricting access to kidney dialysis, because of the high cost of this type of care, and the need for the government to have reasonable plans for spending its health care resources.
- In the 2002 case of *Minister of Health v Treatment Action Campaign*, the Court said that the government was wrong to restrict severely access to the antiretroviral medicine, nevirapine, that is effective in reducing the risk of mother-to-child HIV transmission. It ordered the government to make the medicine available to pregnant women living with HIV.
- In the 2005 case of *Affordable Medicines Trust v Minister of Health*, the Court ruled that the Minister of Health was justified in making regulations that require doctors who dispense medicines to have a licence issued by the DoH.

See Chapter 2 for a fuller explanation of the meaning of the constitutional right to health.

Restructuring and transforming health systems

Since 1994, many new policies and laws have been introduced that aim to transform the health system. There have also been important programmes to build new clinics, revitalise hospitals and improve the training of health workers.

Examples: Improving access to health care

- According to the Minister of Health, 13 000 new clinics and 18 new hospitals had been built by 2004.
- Free medical care for people with disabilities and children under six has been introduced.

Enormous government challenges

The government faces great challenges in fulfilling its duty to ensure that all

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people are able to access health care services. These involve improving the social conditions that influence health and restructuring the management of the health service itself.

Examples: Challenges

- **Integrating racially divided health services:**
14 separate health departments had to be integrated into a national health department and nine provincial health departments.
- **Establishing a district-based health system:**
This was seen as critical to implementing the PHC approach. A key obstacle was the difference in conditions of service between staff in different health authorities, eg provincial health departments paying their staff differently to local authority staff.
- **Creating equity in access to health services:**
Equity was needed between races, classes and people in different parts of the country. The principle of equity means ensuring that all people have an equal opportunity to access a basic package of health services. It may require the government to increase spending in historically disadvantaged parts of the country, and decrease spending in other areas.
- **Transforming the human resources profile of the health system:**
Apartheid skewed the distribution of health workers, depriving black people of access to health care and black health care workers from access to skills, training and experience. The new government had to have plans to:
 - ▶ improve racial and gender diversity among health workers
 - ▶ redistribute health workers to rural and poor urban areas
 - ▶ provide new skills to health workers in order to manage and provide an effective primary health care system.

The new vision for health was to be achieved through a re-organisation of the structure and management of the health system, and through reforms in policy legislation and financing.

Examples: Reforms

- **Policy:**
In April 1997, the government published its *White Paper for the Transformation of the Health System in South Africa* to improve health through achieving a new mission, goals and objectives for the health sector. It stated that in future the national health system would aim to “provide caring and effective services

through a primary health care approach”, based on the district health system. The *White Paper* said that the challenge was to establish an integrated health system and an effective referral system between the different levels of care. The objective is to ensure that most people enter the health system at the primary care level, where they receive basic care and health education, and that more complicated health care services are dealt with by district and specialist hospitals.

Another important new policy was the 1996 *National Drug Policy* that set out to “ensure the universal availability of high-quality, low-cost drugs”. This policy aimed to:

- Rationalise the use of medicines by creating an Essential Drug List (EDL) of medicines that should be available at all health facilities.
- Encourage the use of affordable generic medicines, rather than expensive patented medicines.

See Chapter 14 for more on access to affordable medicines.

■ **Legislation:**

Parliament introduced new laws to regulate health care to meet the needs of people. For example, the Medical Schemes Act of 1998 changed the law governing private medical schemes to re-establish the principle of cross-subsidisation between healthy and sick members of medical schemes. The Act makes it illegal for a medical scheme to refuse membership to a person on the ground of his or her “state of health”.

See Chapter 6 for more on policy and law governing the private health sector.

■ **Financing:**

Under apartheid, health funding was predominantly directed at white people in urban areas who used hospitals for health care. The new challenge was to:

- ▶ fund health care equitably for all people in both urban and rural areas, and
- ▶ correct the balance between funds available for the private sector and the public sector, by spending more on the public sector as the sector servicing the majority of South Africans.

See Chapter 3 for more detail on health budgeting.

1.7 How can we measure if the right to health is being realised?

It is important for human rights activists to monitor health reform closely, and to understand health law and policy. But one of the big problems inherited from apartheid was the lack of accurate information about the health of the majority of the population. This was because the apartheid government did not keep accurate statistics on black people's health. Once again, new systems had to be created

For accurate monitoring of population health a government needs systems that report on:

- The incidence (rate of new infections) and prevalence (overall level of infection) of communicable diseases.
- Births, levels of perinatal mortality, infant mortality and child mortality.
- Natural and unnatural deaths.
- The causes and ages at which people die.

Systems are also needed to analyse this information and to feed it back to policy-makers and health-planners.

How does the government measure the nation's health?

Universities, non-governmental organisations (NGOs) and government departments are all involved in research and monitoring of different aspects of population health. This research looks at the social conditions that have an impact on health and directly at particular aspects of health. In South Africa, there are a number of types of surveys that are used more regularly. These include:

■ The Census:

Every five years, the government conducts a census of the whole population, as was done in 1996 and 2001. This is based on door-to-door interviews and looks at many socio-economic factors having an impact on health, such as:

- ▶ How many people have jobs.
- ▶ What people earn.
- ▶ How many people live in formal housing.
- ▶ How many people have access to clean water and electricity.

■ **The Demographic and Health Survey:**

This is a survey carried out by the DoH to collect and measure specific health indicators. There were surveys in 1998 and 2003.

■ **Antenatal surveys:**

Every year the DoH conducts a survey of syphilis and HIV among pregnant women attending public sector clinics. This is called “the antenatal survey”. By testing the blood of pregnant women, it is possible to establish the prevalence of HIV among women in different provinces and districts. In 1994, the national antenatal prevalence was 7.6%. In 2005 it was 30.2%.

Table 1.1: Maternal mortality rate: Indirect causes of death 2002–2004			
Indirect causes of death	Total no.	% Sub-category	% All deaths
Non-pregnancy related infections			
Pneumonia	316	25.4	9.6
AIDS	662	53.1	20.1
TB	104	8.3	3.2
Endocarditis	1	0.1	0.03
UII	6	0.5	0.2
Malaria	16	1.3	0.5
Meningitis	79	6.3	2.1
Other	62	5.0	1.8
Total	1246	100.0	37.8
Pre-existing medical disease			
Cardiac disease	74	40.2	2.2
Endocrine	14	7.6	0.4
Gastrointestinal tract	21	11.4	0.6
Central Nervous System	22	12.0	0.7
Respiratory	14	7.6	0.4
Haematological	17	9.2	0.5
Genito urinary	3	1.6	0.1
Auto-immune	4	2.2	0.1
Skeletal	2	1.1	0.1
Other	13	7.1	0.4
Total	184	100.0	5.6
Grand Total	1430		43.4

■ Special surveys:

The government sometimes commissions special surveys to investigate certain aspects of health. In 1998, 2003 and 2005 it carried out an investigation into maternal deaths in South Africa, estimating that 150 out of 100 000 live births result in the death of the mother and identified the main causes. As shown in the table above. HIV is one of the main causes of maternal death: Direct causes, such as hypertension, postpartum haemorrhage and pregnancy-related sepsis, accounted for 53.6% of all maternal deaths. Indirect causes – non-pregnancy related infections (such as pneumonia, HIV/AIDS and TB) and pre-existing medical diseases (such as cardiac disease and central nervous system diseases) accounted for 43.4% of all maternal deaths.

In 2005, Statistics South Africa published a report on *Mortality and causes of death in South Africa from 1997-2003*, showing that the number of registered deaths had risen by 57% during this period.

How can we assess if people's rights to health services are being met?

Realising the constitutional right of access to health care services also depends on the close monitoring of health by people in civil society outside the government. This is because, for political reasons, the government often tends to exaggerate its successes and deny failures.

While some government surveys provide valuable information, there are very few official tools that monitor the quality of care that is provided within health services. This is why NGOs and academics investigating health must create systems of research for evaluating indicators of quality.

Examples: Measures of quality of health care

- The length of time people spend waiting in a queue to see a health care worker or to receive medicines from a pharmacy.
 - The quality of counselling and health education available to a community.
- In South Africa, there are several NGOs that monitor health and gather valuable information. For example, the Health Systems Trust carries out a periodic survey of primary care facilities to help judge progress on service provision. It also publishes an annual health review. The Treatment Action Campaign (TAC) and the AIDS Law Project monitor the public sector antiretroviral (ARV) treatment programme. These organisations have useful websites where much of this information can be found.

1.8 New threats to the right to health in South Africa

Since 1994, many far-reaching improvements have been made to the South African health system. The legal and policy framework described in this handbook is almost entirely new and is a major achievement. However, much remains to be done to implement policies and to ensure that the vision of health as a human right becomes a reality for people, regardless of factors like their race or sex, or in which province they live.

In addition, serious threats remain to the health system and to people's rights of access to health care. These include:

- Continuing inequalities and imbalances between the public and private health sector.
- The shortage of doctors, nurses and pharmacists in many poorer parts of the country.
- The HIV/AIDS epidemic.
- International trade laws that limit access to affordable medicines.
- The failure of the Ministry of Health to fulfil its legal duties and to ensure that the laws and policies it adopts pass constitutional tests.

We will briefly examine each of these five threats.

Continuing inequalities and imbalances

South Africa still has great inequalities and imbalances between its private and public health services, between provinces, and between urban and rural areas. In reality, the public and the private health system are almost parallel health systems, one serving the rich and the other serving the poor.

Unfortunately, rather than complementing each other, the private health care system often lives like a parasite on the public health system. Because most parts of the private system are run for profit (such as hospitals and laboratory services), there are pressures to escalate costs paid by patients. This often results in squeezing out people who cannot afford to pay these costs.

The private system provides better conditions to health workers. As a result, many doctors and nurses leave the underfunded public system.

See Chapter 6 for more on the private health sector.

Human resource challenges

Access to health care depends on access to health care workers such as doctors, nurses, dentists and pharmacists. In South Africa and internationally, there are several different crises confronting human resources, including:

- A personnel shortage in rural areas and poor urban areas.
- Many health care workers leaving the public health system and going to rich countries where payment and conditions are much better.
- The impact that HIV is having on the capacity of the health system by greatly increasing the numbers of people in need of care.

In April 2006, the Department of Health published a human resource plan in an attempt to overcome this crisis. However, this plan is weak and lacks concrete targets and proposals to address either the short or long term crisis of human resources. It is likely that it will be subject to severe criticism, and possibly even constitutional challenge, in coming years.

The HIV/AIDS epidemic

When Nelson Mandela was freed from prison in 1990, HIV prevalence amongst pregnant women was estimated to be 0,7%. By 2005, it had risen to 30.2%, and it was estimated that 5,6 million people were infected. The table below, produced by Statistics South Africa, illustrates the impact of HIV upon mortality patterns in South Africa:

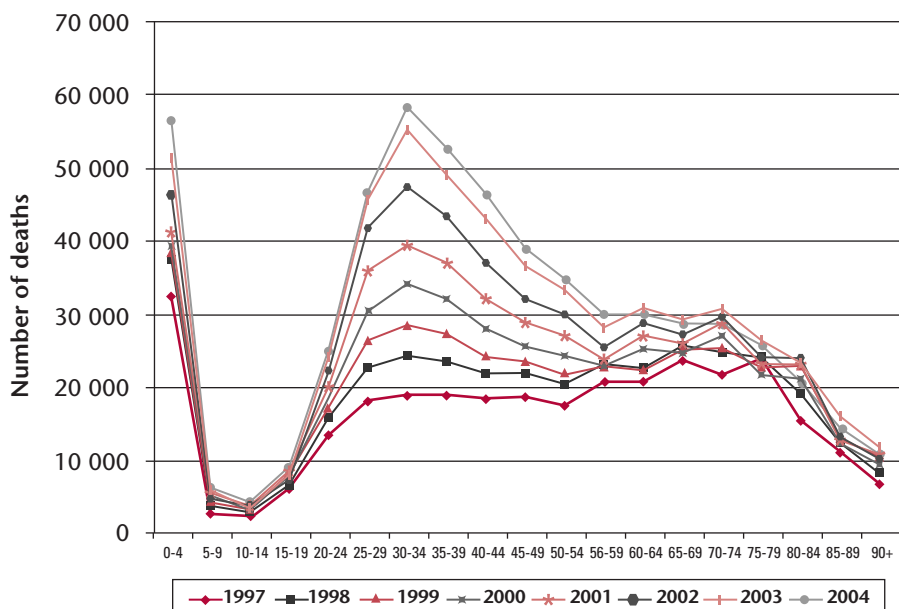


Figure 1.1: Distribution of deaths by age and year of death: 1997–2004

HIV affects the health system in two ways:

- HIV creates much more demand for health care as many people get sick with opportunistic infections caused by HIV, and develop AIDS.
- HIV undermines the capacity of health care workers, many of who are themselves living with HIV. A survey conducted in 2002 found that 15.7% of health workers in the Free State, Kwazulu-Natal, Mpumalanga and North West were living with HIV.

In November 2003, the government announced its approval of South Africa's *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment* that aims to provide ARV treatment to up to 1.5 million people by 2008. The plan itself recognises civil society claims that access to treatment is a human right. However, between 2004 and 2006 the implementation of the plan was extremely slow and did not come near to its original targets. In September 2006, for example, the government claimed that treatment had been initiated for 175 000 people. But according to the TAC only 111 000 were on ARV treatment. The plan's target, however, was that by early 2006 treatment should have been initiated for 381 000 people nationally.

Key Point: ARV treatment programme

The Joint Civil Society Monitoring Forum (JCSMF) was set up to monitor all the different aspects of the ARV treatment programme. It is an example of how civil society can work together to gather information that can then be used in advocacy. Its reports are available electronically at www.alp.org.za.

At the end of 2006, the DoH – guided by the Deputy President and the South African National AIDS Council (SANAC) – was in the process of developing a new *National Strategic Plan* on HIV/AIDS for the years 2007–2011. When implemented the plan will potentially have far-reaching implications – not only for the management of HIV/AIDS in South Africa, but also for health system transformation. For example, to be effective, the plan will require better co-operation between the public and private health sectors, as well as more efficient budgeting to address health needs.

International trade law

International trade law is governed by the World Trade Organisation (WTO). In 1995, the WTO was formed and member countries agreed to be bound by its agreements.

Examples: Impact on health

- The General Agreement on Trade in Services (GATS) restricts the ability of governments to regulate and control the private health sector.
- The Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) limits the use of much-needed generic versions of patented medicines.

For more on TRIPS, see Chapter 14.

WTO agreements such as GATS and TRIPS, together with bilateral economic pressures from the conservative United States administration of George Bush, are being used to prevent developing countries from using more affordable generic medicines. This means that many essential medicines, including ARVs, are unaffordable to poor people and poor countries.

Failures of the Ministry of Health

As we have already explained, South Africa has passed many important laws which aim to protect and promote the right to health. However, in the last five years the Ministry of Health has also been the target of a number of constitutional challenges, particularly concerning the processes it has followed when passing legislation.

Ironically, laws that were intended to improve access to health care end up delaying access as they become tangled up in litigation. Some examples are:

- The Regulations to the Medicines and Related Substances Act, dealing with pharmacists' dispensing fees, which were challenged by the Pharmaceutical Society of SA (PSSA) and New Clicks in 2004, and which were finalised only in late 2006.
- The Traditional Health Practitioners Act, which was declared unconstitutional in 2006, not because of its substance, but because a proper process of consultation was not followed.
- The Choice on Termination of Pregnancy Amendment Act, which was declared unconstitutional in 2006 for the same reason.

It is important for both the government and health activists to understand that in formulating law and policy, the government has a duty to engage in public consultation, to be seen to consider submissions that are made, and to be responsive to these submissions. Thus, in the words of Judge Ngcobo, in the 2006 case of *Doctors for Life International v The Speaker of Parliament* CCT 12/05 (17 August 2006):

“Commitment to principles of accountability, responsiveness and openness shows that our constitutional democracy is not only representative but also contains participatory elements. This is a defining feature of the democracy that is contemplated. It is apparent from the preamble of the Constitution that one of the basic objectives of our constitutional enterprise is the establishment of a democratic and open government in which the people shall participate to some degree in the law-making process.”

The continuing responsibility of civil society

This introduction has illustrated how threats to the right to health come from many sources. Unfortunately, health rights are most likely to be ignored or violated when civil society is weak or oppressed, such as under apartheid, or under corrupt dictatorships in countries like Zimbabwe. This is why it is so important that governments are assisted to respect, protect, promote and fulfil health rights.

Because governments are often under pressure to meet competing social demands, or because they may be corrupt, it often requires civil society to put pressure on governments to ensure that people have access to appropriate health care services. There are many voluntary associations, community groups and NGOs whose work also has an impact on the realisation of people's rights to health care.

Examples: Civil society pressure

- The campaign against the damage being done to the environment by oil companies in Ogoniland in Nigeria led by people such as Ken Saro Wiwa, who was executed by the former Nigerian military dictatorship.
- The work of the TAC in South Africa successfully to pressurise government to introduce an ARV treatment plan in 2003.
- International NGOs campaigning for people's health, such as the World Medical Association or Médecins Sans Frontières (MSF).

The challenge for civil society is to take on these issues and to make health a central part of campaigns that aim to better the lives of the poor and fulfil the promises of the South African Constitution. This can be done only if people who care about health continue to educate themselves about the health system, law and policy, and to take constructive action for change.