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# South Africa's Right to Health Care: International and Constitutional Duties in Relation to the HIV/AIDS Epidemic

by Roger Phillips

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**W**HEN APARTHEID ENDED IN SOUTH AFRICA, a new populist government, headed by Nelson Mandela, aimed to create a more just and equal society which would seek to address the economic and social rights of its citizens. The 1996 Constitution guaranteed a range of rights, including the right to health care. In addition, the government signed the International Covenant on Economic, Social and Cultural Rights (ICESCR), which includes the right to health. These efforts represented a shift in government policy which would ultimately result in enforceable legal mechanisms to ensure access to health care.

Unfortunately, slow implementation by the executive branch delayed the realization of this new right to health. Contributions from a variety of institutions, including the South African Human Rights Commission, the South African Constitutional Court, the South African Parliament and some civil society organizations, such as the Treatment Action Campaign, pushed the executive branch to fulfill its commitments under international and domestic law.

In understanding this issue, it is important to examine South Africa's response to its obligation to protect, respect, promote, and fulfill the right to health and the role various other governmental and non-governmental forces have played in pushing the national government to adhere to these responsibilities. South Africa's legal obligations are defined under the ICESCR, the South African Constitution, and several health laws passed by the legislature. These obligations form the basis for confronting questions of access to health care that affect everything from the availability of primary health care to the implementation of a comprehensive HIV/AIDS plan by the government.

## DEFINING THE RIGHT TO HEALTH

ON OCTOBER 3, 1994, SOUTH AFRICA signed the ICESCR, affirming its commitment to take concrete steps to enhance access to health care. Although it has not yet ratified the ICESCR, South Africa's Constitutional Court must consider international law, including the ICESCR, when making constitutional decisions. In addition, South Africa's Human Rights Commission considers the ICESCR in defining the right to health. Though not legally binding, South Africa has made several commitments to respect the provisions of the ICESCR.

Several articles in the ICESCR help define the right to health. Article 12 of the ICESCR guarantees "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and instructs that the provision of these rights must be progressively realized. Article 2 instructs "each State Party . . . 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."

The duty to "progressively realize" the rights guaranteed by the ICESCR is demanding. Progressive realization entails sustained and continuously increasing allocation of resources towards the realization

of these rights. However, the breadth of health measures necessary to satisfy the progressive realization standard remains ill-defined. The drafters of the ICESCR left progressive realization intentionally vague in order to allow individual states to determine the parameters of socio-economic rights within the abilities of each nation. Recognizing this ambiguity, the Limburg Principles and the Maastricht Guidelines provide persuasive authority in defining various aspects of social and economic rights—including the right to health—and help define progressive realization.

## THE LIMBURG PRINCIPLES (1986) AND THE MAASTRICHT GUIDELINES (1997)

THE LIMBURG PRINCIPLES (PRINCIPLES) WERE DEVELOPED IN 1986 by a group of experts in international law considering the nature and scope of the obligations of states parties to the ICESCR. Along with the Maastricht Guidelines (Guidelines), the Limburg Principles are one of the benchmark standards for interpreting the ICESCR and have been used to help interpret the right to health. They provide insight into the measures or government actions that would achieve progressive realization of the rights enumerated in the ICESCR.

Specifically, paragraph 21 of the Limburg Principles states, "The obligation to achieve progressively the full realization of the rights' requires States parties to move as expeditiously as possible towards the realization of the rights." States must begin immediately to take steps to fulfill their obligations under the covenant. Further, according to the Principles, the obligation of "progressive realization" exists independently of increases in resources. It requires the effective use of available resources. Thus, not only must a signatory state intend to provide health care to all its citizens, but it must also move immediately to do so even if there are limited resources in the national coffers.

The effectiveness of the Limburg Principles was hindered by states parties' use of lack of resources as an excuse for not complying with the ICESCR. The Maastricht Guidelines remedied this weakness by refining and supplementing the Limburg Principles. The Guidelines



UNAIDS/Louise Grubb

Free condom dispenser in use in South Africa.

mandate that "State[s] cannot use the 'progressive realization' provisions in Article 2 of the Covenant as a pretext for non-compliance."

Taken together, the Limburg Principles and Maastricht Guidelines provide guidelines for states to use in complying with the progressive realization standard. If a state party does not continually take new steps to improve the general health of its citizens or fails to effectively address major impediments to health, such as epidemics like HIV/AIDS, it is not in compliance with its obligation under the ICESCR.

### **SOUTH AFRICA'S RIGHT TO HEALTH CARE**

IN ADDITION TO ITS INTERNATIONAL LEGAL COMMITMENTS, South Africa's 1996 Constitution guarantees a number of social and economic rights, including the right to health. Specifically, section 27(1)(a) provides that "everyone has the right to have access to health care services including reproductive health care . . ." In addition, section 27(3) states that no one can be denied emergency medical treatment. Section 28(1)(c) provides for "basic health care services" for children, while section 35(2)(e) provides for "adequate medical treatment" for detainees and prisoners at the state's expense.

While the framers of the 1996 Constitution may have intended to incorporate all of South Africa's international legal obligations

The SAHRC's 4th Annual Economic and Social Rights Report, covering the years 2000-2002, notes that the government failed to report key statistics regarding budgetary allocations and infant and maternal mortality rates. The executive branch's inability to provide this data exhibits a lack of external accountability and a reluctance to prioritize compliance with South Africa's constitutional obligations. In addition, the executive branch has not shown initiative in pursuing solutions to major health problems in South Africa in relation to the HIV/AIDS epidemic. For example, the executive stalled efforts to make antiretroviral drugs available until outside pressures forced them to reconsider their position.

### **THE 2003 NATIONAL HEALTH BILL**

In contrast to the executive branch, the South African parliament has been more conscious of the government's constitutional obligations and ICESCR commitments to guarantee the right of access to health care. On November 18, 2003, the controversial National Health Bill (Bill) was approved by the South African Parliament and now awaits signature by President Thabo Mbeki. The Bill attempts to regulate and create equity in the provision of health care in compliance with the ICESCR. In an attempt to fulfill South Africa's obligation to provide free reproductive health, the Bill requires the South African

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under the ICESCR in the constitution, the plain language stops short of the ICESCR in a few areas. The ICESCR guarantees the right to health, including preventative measures such as the control of epidemics, and the right to the highest attainable standard of mental health. By contrast, South Africa's constitution only guarantees access to health care and mentions only the right of children to mental health. While South Africa has yet to ratify the ICESCR, by signing the convention it has indicated its intent to satisfy the ICESCR obligations. In addition, the Constitutional Court must consider international law, of which the ICESCR is a part, in making its decisions. This could potentially force the government to adhere to the ICESCR when disputes regarding economic and social rights are adjudicated by the Court.

### **THE HUMAN RIGHTS COMMISSION REPORT**

The South Africa Human Rights Commission (SAHRC) is an effective source for interpreting South Africa's obligations under the ICESCR and its own constitution. The SAHRC was created by the South African Constitution to "monitor and assess the observance of economic and social rights in South Africa." It examines South Africa's constitutional and international legal obligations by acquiring data from the government to assess the extent of the government's compliance with these obligations. SAHRC reports are invaluable sources in ascertaining South Africa's legal obligations, and, by criticizing or commending on the government's efforts, they effectively encourage compliance with international and constitutional law.

government to provide free health care services to "pregnant and lactating women and children below the age of six years." In addition, the Bill allows free services for termination of pregnancy. The Bill also takes the first step towards the provision of health care for all by mandating free primary health care to all individuals not currently covered by a health scheme. The Bill leaves defining primary health care to the minister of health. Primary health care would likely include the provision for basic health needs and address the socio-economic causes of poor health. The Bill also creates national and provincial advisory boards that would focus on creating equity in a system characterized by a disparate distribution of resources.

Some critics of the Bill argue that it will prove too costly and will interfere with market forces by forcing doctors into rural areas that cannot or will not pay for medical services. An explanatory memorandum attached to the Bill points out the potential need for an increase in funding sources, especially for the provision of free primary health care. In addition, health care providers dislike the Bill because it centralizes the certification of all physicians and gives the minister of health discretion in determining where health care resources are needed and, consequently, where doctors should be authorized to practice. In effect, this would force many doctors to practice in rural areas. But assuming the government allocates the necessary funds, the law would be a major step towards progressively realizing the constitutional right to health care in South Africa by taking steps to guarantee individual access to health care services.

## CONSTITUTIONAL COURT DECISIONS

The most effective institution in holding the executive branch to their obligations has been the Constitutional Court (Court) of South Africa. The Court, which is the highest court for all constitutional matters in the country, is required to consider international law under section 39 of the South African Bill of Rights, and can consider the law of other democratic countries in making its decisions. The Court has construed its role as "to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation."

The Court clarified the constitutional requirements of the right to health in several landmark cases. In *Soobramoney v. Minister of Health*, the Court ruled that the citizenry's constitutional right of equal access to healthcare must be balanced with a governmental need to prioritize the allocation. *Soobramoney* involved a renal patient who was refused regular kidney dialysis at a government health clinic because of the government-instituted system of priorities. The Court held that the minister of health was justified in instituting a program of prioritization where renal patients with the potential to be cured received kidney dialysis before renal patients who merely had the potential of prolonged life. Further, the Court held that because Mr. Soobramoney was ineligible for kidney transplant due to heart disease and other limiting factors, the government was justified in providing dialysis treatment to individuals with fewer complications. Although the Court allowed the minister of health discretion in the allocation of resources, it required a standardized priority system and reaffirmed the principle of progressive realization.

A later case, *Minister of Health v. Treatment Action Campaign*, rejected the UN concept of "minimum core" rights. The UN Committee on Economic and Social and Cultural Rights (CESCR) prepares General Comments on specific key articles of the ICESCR to assist states in clarifying the duties the ICESCR imposes on the state. The CESCR developed the concept of "minimum core" rights to ensure that essential levels of ICESCR rights, such as access to food-stuffs and primary health care, were prioritized by governments and implemented immediately. According to the Maastricht Guidelines, the minimum core rights apply irrespective of the availability of resources of the country concerned or any other factors and difficulties.

In *Treatment Action Campaign*, the Court rejected the CESCR's defined standard of minimum core rights. The Court ruled that it was impossible to give everyone access even to a "core" service immediately, stating, "All that is possible, and all that can be expected of the state, is that it act reasonably to provide access to the socio-economic rights identified in Sections 26 [Right to Housing] and 27 [Rights to Health Care, Food, Water and Social Security] on a progressive basis."

## ANTIRETROVIRALS—ONE MORE STEP

Despite its refusal to recognize the CESCR concept of minimum core rights, the Court ordered the government to provide HIV/AIDS preventative measures to all pregnant women. In *Treatment Action Campaign*, the Court applied a balancing test to determine whether measures taken by the government with respect to the prevention of mother-to-child transmission of HIV was reasonable.

Despite a number of factors proving to the contrary, the government argued that distribution and transportation costs were not covered and would be substantial and that the drug in question (Nevirapine) was not shown to be safe and effective. Several points belie the government's argument. First, a joint US/Ugandan study showed an 80-90% reduction of mother-to-child infection if a single

dose of Nevirapine is administered to the mother before childbirth, and it has not been shown to cause serious side effects. Second, a pharmaceutical group agreed to provide Nevirapine free of charge to the South African government. Finally, in 1996, the US Food and Drug Administration (FDA) approved Nevirapine for use by HIV positive pregnant women. Despite all of these factors, the minister of health determined that a pilot program consisting of a small group was necessary before the government could allow distribution of Nevirapine to all HIV positive pregnant women.

The government's decision denied all HIV-positive South African women access to the drug—except the few women implicated in the pilot program. Treatment Action Campaign (TAC), a South African NGO whose main objective is to campaign for greater access to HIV/AIDS treatment for South Africans by raising public awareness about HIV treatments, filed suit. TAC claimed that the government failed its constitutional duty to safeguard the citizenry's right to health, as 70,000 children were infected with HIV every year.

In *Treatment Action Campaign*, the government argued that the pilot program was necessary to ensure that the drug was

safe and to prevent viral resistance to the drug. The government also argued that the services necessary to comprise a full treatment (i.e., provision of baby formula and counseling) were unavailable because the government did not have the financial resources to provide them. Considering the FDA had approved the drug for use after clinical trials and the fact that the drug was to be given free to the government, the government's arguments were not well received. Accordingly, the Court ruled that the need to immediately implement a program to prevent any further mother-to-child HIV transmission was compelling and rejected each of the government's arguments. As a result, the Ministry of Health is currently expediting its distribution of the Nevirapine anti-retroviral in compliance with the Court's ruling.

In these cases, the Constitutional Court compelled the executive branch to act in compliance with a constitutional right to health care and the government largely complied. By requiring the government to implement the Nevirapine distribution program, the Constitutional Court put the executive on notice that it was the government's responsibility to distribute drugs to fight HIV/AIDS. Given the result of *Treatment Action Campaign*, the executive could expect a similar ruling if a case involving a general rollout of anti-retrovirals to all sufferers of full-blown AIDS were brought before the Court. This type of pressure undoubtedly had an effect upon the executive's decision-making process, as a general antiretroviral program is now being considered.

## CHANGES IN SOUTH AFRICA'S HEALTH POLICY

Despite the fact that South Africa has one of the highest HIV prevalence rates in the world with an estimated 4.7 million people living with HIV/AIDS, the executive branch has been reluctant to provide drugs to combat HIV/AIDS. Until recently, President Mbeki and



Andrew October/TAC; Treatment Action Campaign

Nelson Mandela meeting with TAC, a nonprofit working on HIV in South Africa.

other executive branch officials, including Minister of Health Manto Tshabalala-Msimang, had refused to distribute antiretrovirals to treat those already living with HIV/AIDS, citing concerns about the toxicity of the drugs.

Recent events indicate a surprising change in government policy. President Mbeki's cabinet assigned a committee to investigate treatment options for HIV/AIDS and, on November 13, 2003, Finance Minister Trevor Manuel announced a three year R12 billion (US\$1.2 billion) program to fight HIV/AIDS, including R1.9 billion (US\$284 million) marked specifically for antiretroviral treatment and the purchase of medicines. With this progressive move, the national government has finally acknowledged that the new government's AIDS policy is "based upon the premise that HIV causes AIDS."

The government's recent response to HIV/AIDS indicates a new willingness to fulfill its constitutional obligations and international legal commitments. The "Summary Report of the Joint Health and Treasury Task Team Charged with Examining Treatment Options to Supplement Comprehensive Care for HIV/AIDS in the Public Health Sector" (Task Team Report) signals a profound shift in government policy. In the report, the government recognizes that HIV causes AIDS and proposes a very expensive program to provide antiretrovirals to sufferers of full-blown AIDS. The antiretroviral distribution promises to treat at least 1.2 million persons living with AIDS by 2005 by allocating progressively increasing funds (a lower estimate of 200,000 people is given by TAC). Until now, the government has concentrated its efforts on the dissemination of prevention messages. Only limited antiretroviral treatment has been available to HIV-positive South Africans due to its prohibitive cost.

The reason for the government's sudden change in health policy is not entirely clear. One possibility is that pressure from governmental and non-governmental forces has successfully pushed the executive branch to reverse its original position. In addition to the Constitutional Court's demonstrated willingness to challenge the executive's decisions in this area, the SAHRC pushed the government in its report by saying, "A National Action Plan for the universal access to ARVs should be the government's top priority and it is highly recommended that the National Budget reflect this." Other efforts to make antiretrovirals available include a suit brought in South Africa by Treatment Action Campaign to challenge GlaxoSmithKline and Boehringer Ingelheim for excessive pricing of their antiretroviral medicines and securities violations.

Another possibility is that new sources of outside funding have convinced the executive branch that implementing a widespread ARV program is economically feasible and will not strip other areas of the government's budget—health and otherwise. The Clinton Foundation, an organization founded by former US President Bill Clinton to assist the world's poor and to battle HIV/AIDS, recently

brokered an agreement with four generic pharmaceutical manufacturers to provide ARVs to certain countries, including South Africa, for a greatly reduced price. Of course, this assumes that the executive branch did not actually believe "denialist" claims that HIV did not cause AIDS and that the only obstacle to ARV rollout was economic. The idea that a government would ignore its constitutional obligations until outside funding became available is at least troubling.

In the end, the change in policy was probably a combination of outside pressure and funding for a broad distribution initiative. Governmental and non-governmental pressures coupled with increased economic feasibility pushed the executive branch to change its position and to start to address the AIDS epidemic.

## CONCLUSION

GIVEN THE EXECUTIVE BRANCH HISTORY, ITS RECENT MOVES to rollout a national antiretroviral program are surprising and encouraging. Now, the South African executive branch has the opportunity to satisfy its international commitments and constitutional obligations by fighting the scourge of AIDS and offering treatment options. Several steps would be consistent with this new policy.

First, the executive could ensure that the first year's allocation for the antiretroviral rollout is completed. Even if the current plan of making antiretrovirals available to the 400,000-500,000 sufferers of full-blown AIDS is realized, over 4 million HIV-positive South Africans will remain with little or no treatment options. The proposal outlined in the Task Team Report should be followed and increased funding should be allocated each year to satisfy the progressive realization component of the ICESCR and the South African Constitution. If prevention efforts remain strong and the government continues to allocate increasing amounts of resources for treatment, a majority of South Africans sick with

HIV/AIDS could eventually have treatment options.

Second, and more generally, the executive branch could reconsider its constitutional obligations under sections 26 and 27 of the constitution. The role of the executive branch is not merely to assure fiscal restraint and follow the lead of other governmental and non-governmental institutions. It could take initiative to assure compliance with constitutional and international legal obligations concerning the right to health.

Third, the executive branch could cooperate with the SAHRC by instructing the Department of Health to produce statistics and by adhering to SAHRC recommendations.

Finally, the executive could provide substantial resources and leadership in implementing legislative measures, such as the new National Health Bill, that address and attempt to fulfill the right to health care. By signing the Bill, President Mbeki would send a strong signal that the executive is taking concrete steps to the realization of a right to health care in South Africa. *HRB*

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