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Access To Healthcare Services As A Human Right

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Abstract.*Access to healthcare services is increasingly recognized as a fundamental human right, essential for achieving health equity and promoting social justice. This article explores the legal and ethical dimensions of healthcare access, emphasizing its implications for individuals and communities. It examines international human rights frameworks, including the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights, which underline the obligation of states to ensure that healthcare services are available, accessible, acceptable, and of good quality. The article also discusses barriers to accessing healthcare, such as socioeconomic disparities, geographic challenges, and systemic discrimination. Through an analysis of case studies from various countries, the paper highlights successful strategies for enhancing healthcare access and provides recommendations for policymakers to address persistent inequalities. Ultimately, recognizing access to healthcare as a human right is crucial for fostering an inclusive society where all individuals can attain the highest standard of health, thereby advancing human dignity and equality.*

Keywords: *Healthcare access, Human rights, Health equity, Social justice, Legal frameworks.*

1. INTRODUCTION

The provision of healthcare services is always an emotional and political debate. This dynamic is due to the fact that the healthcare of the individual is paramount to the individual in so far as his or her contribution to society is concerned both in the context of his or her obligations to his or her family and as a productive member of society. Coupled with this centrifugal version if you will, of healthcare is the understanding of healthcare as a service that is to be provided by the State to the individual. However, the precise parameters of the right to healthcare or the right to health are not clear. This is especially so in relation to the obligations imposed upon a State to provide such services so as to be consistent with the individual's need for and expectations of healthcare and healthcare services. The parameters of the healthcare debate normally occur within political debate in or around electioneering or decisions by courts, which prescribe what healthcare services should or should not be available to the individual and, to a greater degree, to society in a particular jurisdiction.

More often than not, the State is hindered by economic considerations in relation to the provision of healthcare services to each individual. The individual requirements and expectations of adequate healthcare vary greatly from one person to another. It is therefore inconceivable or unreasonable, some may argue, for the State to provide comprehensive healthcare services that meet the needs of every member relying on such services. One is therefore left with the question as to what constitutes healthcare as a right bearing in mind its economic consequences for the State.

Healthcare is unlike other rights in the South African Constitution, which are individually guaranteed such as, by way of example, the rights to free speech or political

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association. The right to healthcare presupposes a positive obligation on the State, which it is required to fulfil in order to meet constitutional directives. In terms of section 27(1)(a) of the South African Constitution, a right is granted to the population to access healthcare services. Whilst the South African courts have grappled with the parameters of this right, within the context of the provision of anti-retrovirals to patients who are HIV positive and emergency medical care, the precise scope and ambit of the right remains a contentious debate.

The Right Defined

- The right to access healthcare, as distinct from the right to health, when considered within the adherence to and respect for international instruments that guarantee the right to all persons to access healthcare services;
- the provision of healthcare services to vulnerable groups in society such as infants and the aged;
- the enactment of legislation to ensure the orderly provision of healthcare services by regulating health professions, private healthcare services and the control of public health expenditure;
- the provision and availability of public healthcare services through universal legislation;
- the protection of the public from diseases through the enactment of appropriate legislation so as to ensure that isolation and quarantine laws are in place; and
- the promotion of access to all healthcare services through effective policy.

a constitutional democracy, as defined by the South African Constitution, it is submitted, is constituted by a number of primary obligations on the State. These obligations may be described as follows –

Taking into account all of the factors listed above, the right to access healthcare services may be assessed. This assessment is critical in relation to both the provision by the State of public healthcare services, consistent with the Constitution, and the imposition in South Africa of the horizontal application of the Bill of Rights as between private individuals. Therefore, the rights that are set out in section 27(1)(a) are enforceable not only as between an individual and the State but also as between private individuals within South African society. This creates an interesting and unique dynamic within South Africa: an individual may usefully rely on the Constitution to access healthcare services to which he or she may otherwise be disqualified either by economic or social forces. Therefore the debate in South Africa concerning the

parameters of the right to access healthcare must be viewed within parameters that are defined with reference primarily to –

- the Constitution and the manner in which it usefully limits and proscribes rights; and
- the ability of the South African government to facilitate access to healthcare services in the private sector.

The Right Applied

South Africa is a third world country grappling with the issues that third world countries generally grapple with and that are arguably universal in so far as issues of a socio-economic nature, such as healthcare, are dealt with by third world countries. However, if one accepts that the parameters of accessing healthcare are those that are set out above, then an assessment of whether or not the South African government has met and continues to meet its requirements of fulfilling a right to access healthcare services and healthcare in general, is possible. The assessment, however, is not one that deals with health. No constitutional guarantee exists in respect of health *per se* in South Africa. A distinction therefore exists between health as a state of being and access to healthcare services as a right.

The parameters referred to above are defined and contingent upon a divide between public health and private healthcare services. The South African marketplace is divided between the provision of private healthcare services, usually through the existence of a medical scheme, and the existence of a public health service. The public health service is accessible to all South Africans whilst private healthcare is available to those who can afford it. The provision of funding for private healthcare services is controlled by legislation[i] but such legislation does not promote completely the State's obligations in terms of the Constitution. The Medical Schemes Act does enjoy a degree of State intervention in so far as its provisions oblige medical schemes to provide certain healthcare services at a cost that is not deductible from benefits due to a member and the recognition of certain chronic diseases as requiring obligatory cover by medical schemes. The State has also endeavoured to ensure that medical schemes cost contributions and premiums in a manner that avoids risk rating and promotes a community benefit to members of private medical schemes. This, however, does not mean that more people in South Africa are able to afford access to private healthcare funding as a means to accessing healthcare services.

The right to access healthcare must be looked at in the context both of the healthcare services that are available and offered and healthcare services as a socio-economic benefit

relating to, simply put, the ability of the individual to avoid and remedy disease. Certainly, when one considers constitutional rights, one does consider them from the point of view of the individual. A good example of this is freedom of expression, which although enjoyed by groups such as the media, is a right designed to be enjoyed by the individual. Similarly, other rights to the security of the person, privacy, a fair trial, freedom of speech, labour or dignity are rights designed to be enjoyed by the individual. The right to access healthcare is, unfortunately, as stated above, not capable of being adjudicated upon with reference to the individual's needs and hopes but rather the needs, albeit perceived, of the public health system. Such a right is, it is submitted, an institutional right, which is not capable of application successfully as against the State as an individual right. Consequently, debates relating to the costs of healthcare not only in developing countries but in developed countries and are the primary constituent of the right to access healthcare services as it is normally the cost of the service that determines the number of people who have access to it.

The commentary provided in South African jurisprudence on the precise scope and ambit of the right to healthcare is diverse and has been ongoing since the enactment of the Constitution in 1996. However, the debate has centred around the rights of the individual but subject to the State's ability economically to meet such rights. Therefore, the South African Constitutional Court stated, in a case that has become the *locus classicus* of the interpretation of section 27(1)(a) of the Constitution, that:

"What is apparent from these provisions is that the obligations imposed on the state by section 26 and 27 in regard to access to housing, healthcare, food, water and social security are dependant upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of a lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled. This is the context within which section 27(3) must be construed."

Therefore, the Constitutional Court has indicated that the realisation of a right to access healthcare services is a progressive right. The fixing of such a legal obligation in this manner means that the obligation imposed upon the State is, in fact and in law, the obligation to ensure that correct, coherent and coordinated programs are implemented and maintained to ensure that a right is realised over time for all of the citizens of the Republic. Therefore, the Constitutional Court lays the groundwork for the realisation of the right. However, the parameters referred to above are, it is submitted, those to be used to determine whether or not the right is being realised. Consequently, and bearing in mind that the *Soobramoney* decision was adjudicated

upon by the Constitutional Court in 1997, has the South African government taken significant steps in order to realise the right in section 27(1)(a) of the Constitution? Access to healthcare services therefore, as a right, is defined not with reference to the health of the individual but rather the deployment of the resources that are available to ensure that as many people as possible are healthy. Therefore, with reference to the parameters set out above, the following factors would arguably inform the debate about the realisation of the right –

- the South African government has taken significant steps to align itself with international treaties, as a member of the United Nations, to recognise the right to healthcare in international law. Such international instruments include article 12 of the United Nations International Covenant on Civil and Political Rights, article 25 of the Siracuse Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights and article 6 of the African Charter on Human and Peoples' Rights;
- legislative measures have been imposed to ensure the provision of free healthcare services to children under the age of twelve and pregnant women. Similarly, the National Health Act provides that no-one may be refused emergency medical treatment;
- legislative interventions have also occurred within the context of availability of medicines, which include the control of medicine pricing in South Africa by the introduction of single exit price regulations, the recognition of generic substitution of cheaper medicines for those of more expensive branded medicines, the expansion of those persons recognised as healthcare providers to provide primary healthcare services, the recognition of corporate ownership of pharmacies so as to promote more pharmaceutical services in more areas geographically throughout the country;
- the introduction of legislation to control healthcare services by the regulation of healthcare professionals, healthcare service providers – both in the public and private spheres – the introduction of social healthcare measures to reflect on the pricing of healthcare services that are available in the public and private sectors; and
- the enactment of appropriate public legislation to deal with isolation and quarantine to control certain communicable diseases and thus control the burden of disease within the Republic, which is recognised as a significant driver of healthcare costs; and
- the inception of the debate concerning the imposition of a national health insurance scheme.

Rights And Realities

Notwithstanding the introduction of the measures referred to above, the economics of the provision of public healthcare services in South Africa remains controversial. The allocation of adequate financial resources by the State to the public sector to ensure proper service delivery of healthcare services throughout all healthcare districts and the improvement of facilities in public hospitals presents a cause for concern. The reliance by the majority of the population on healthcare service delivery at public hospitals continues to increase especially in the light of the current disease burden in South Africa, which is heavily influenced by the HIV and AIDS epidemic and the prevalence of tuberculosis amongst the population. Making available appropriate economic resources will remain a controversial area of debate especially within the context of access to South African healthcare services.

Therefore, the debate on the availability of resources continues to preoccupy the provision of healthcare services in South Africa. The next frontier in the context of the debate is whether or not healthcare services may be costed in such a manner to make these services cheaper, thus more affordable and consequently more accessible to greater numbers of the population. Currently mooted therefore is the existence of a national health insurance scheme, which will be designed to provide a defined basket of healthcare services to all members of the population in exchange for the payment of a predetermined amount either as a tax or a social insurance payable by each individual from his or her salary or, in the case of the unemployed, the State. Healthcare delivery models are therefore being proposed within the context of section 27(1)(a) of the Constitution, as vehicles for the State to realise progressively the right to access healthcare services. However, it would appear that the South African government continues to battle its obligations in terms of the Constitution to ensure access to healthcare services by a greater number of South Africans.

The debate will now be brought to an end by the selection of the most appropriate healthcare delivery model for South Africans based on the economic ability of the State to realise such an obligation, which may be sufficient to satisfy the State's obligations in terms of the Constitution. However, the actual realisation of the provision of healthcare services and the enjoyment of a healthy lifestyle by the population will remain as the final arbiters of whether or not the State will have succeeded in meeting its constitutional obligations.

Whilst arguments have been developed concerning the adjudication of the satisfaction of the State's constitutional obligations; with reference to the particular historical context of South Africa and with reference to its discriminatory past, such debates fall short of the stringent provisions of the Constitution, which now rule the day. Certainly, the historical

context of South Africa must inform what the State is or is not able to do economically but it is submitted that such a context should not be used to determine whether or not the State meets its constitutional obligations. This is primarily so as historical context is not recognised as a basis on which a right may be reasonably limited pursuant to the provisions of the Constitution.

The next debate, with reference to the provisions of section 27(1)(a) of the Constitution, will be whether or not the State, with reference to its available resources, has taken such steps to realise the right to access healthcare services, which is foreseeably a debate in economics and not in healthcare delivery. Such a trend is of concern as it shifts the focus from the health of the individual to the ability of an individual to join a queue to access health services that are available albeit that these services are limited and potentially reduced in respect of diversity of services, medicines and outcomes. The current trend will therefore be judged not on how many people are healthy but rather on the implementation of effective economic policy in the healthcare sector. Consequently, access to healthcare services, as a right, will be defined not as the absence of disease but rather the effective implementation of policy by the State – an outcome that may not have been altogether foreseen or intended by the drafters of the South African Constitution.

2. CONCLUSION

The right to health is, in fact and in law, a fantastic formulation that is not recognised as being enforceable by South African law. The right is, in fact and in law, defined with reference to healthcare services and even then the provision of such services is not defined with reference to a level or quality of service but rather to a service that may be afforded by the State. Therefore, section 27(1)(a) of the Constitution constitutes an aspiration that may only find its meaning in science fiction as opposed to jurisprudence and practical implementation of healthcare delivery and services.

The right to health in South Africa is a right to access services, which may mean merely the right to stand in a queue and wait to receive services: it does not mean the absence of communicable diseases but rather the control of such diseases, it does not mean the right to have healthcare services paid for, for any one or more particular conditions but rather the ability to apply to access such services based on State policies and criteria imposed by economics and it does not mean a right to be healthy or to have one's health sustained at the expense of the State. As the right to healthcare or access to healthcare grows up in South African jurisprudence, it is becoming less about healthcare and more about economic efficiency. Within the context of constitutional jurisprudence, such an evolution of a right may not be the

most desirable means of ensuring that constitutional obligations are met and that the supremacy of the Constitution in South African law is ultimately respected.

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