EVENTS

Roundtable on States' Obligations to Realise the Right to Health

On 12 April, 2018, the Socio-Economic Rights Project at the Dullah Omar Institute at the University of the Western Cape held a roundtable entitled 'Deconstructing States' Obligations to Realise the Right to Health'. In his introductory statement, Ebenezer Durojaye noted that there are problems with the nature of state obligations as defined by the CESCR, particularly regarding the reality of states' capacity to meet the minimum core obligations. Unending questions are 'what are these minimum cores?', 'how can their realisation be measured?' and 'how, and on what basis, are they achievable?'

There is also the issue of state accountability in relation to obligations to realise the right. In essence, what is the meaning of accountability and who can be held accountable for the fulfilment of the right to health as well as its violation? The role of the regional human rights bodies in ensuring the realisation of the right to health is also an important area of concern. These are issues which the panel sessions and discussions sought to answer.

The keynote address was delivered by Commissioner André Gaum of the South African Human Rights Commission. He noted that the Commission, one of the institutions created by Chapter 9 of the Constitution, has its mandate in section 184 of the Constitution (1996), which is to monitor compliance with the observance of human rights and secure redress in case of a human rights violation. Through its investigative functions, the Commission has been able to uncover several violations of human rights, including those of the right to health. The latter is one of the most important socio-economic rights recognised in the Constitution. Everyone has the right of access to health-care services, including reproductive health care, as well as other determinants of good health, such as food, water (section 27(2)) and adequate housing (section 26). Also, no one may be refused treatment in case of an emergency (section 27(3)).

The commitment of the government of South Africa to reengineering the health-care system is demonstrated by the introduction of a national health insurance programme aimed at promoting universal health coverage as well as by the establishment of the office of health standards and compliance responsible for ensuring that health facilities comply with norms and standards. South Africa has also made progress in providing access to primary health care.

The Commissioner noted some successes recorded by the government in the realisation of the right to health. These include the building of hospital facilities, the significant reduction in maternal and child mortality rates, increased access to anti-retroviral drugs, declining rates of HIV transmission from mother to child, increased life expectancies, and an overall improvement in access to primary health care.

However, despite receiving the second largest share of the budget, health outcomes remain poor and the health-care system continues to face multiple challenges, among them a shortage of human resources, poor management, underfunding, and deteriorating infrastructure. There have also been declining levels of community participation, spiralling costs in the private health-care sector, delays in service delivery, long waiting times, medicine stock-outs – mostly in rural health care facilities, especially in the Eastern Cape and KwaZulu-Natal – as well as concerns about cleanliness, safety and security, and disregard of patients' rights. All of these are frequently cited as major issues.

Some questions the Commissioner thought needed

to be answered are: What does section 27(3) regarding non-denial of access to emergency medical treatment mean? What are the parameters of acceptability and quality of care? This was one of the core issues emanating from the inquiry into access to health-care services, which emphasises the fact that policies are needed to guide the provision of services in order to prevent the perverse form of rationing and unequal access to health-care services.

In 2015, the Commission also conducted a provincial hearing on access to emergency medical services in the Eastern Cape. What was discovered were transport problems and an insufficient number of operational ambulances due to poor planning, funding and lack of accountability. Poor road networks also led to delays in the arrival of ambulances. Ambulances lack basic equipment and supplies, and staff are not adequately trained to respond to emergency cases. Policies lack a human rights approach, which, when combined with other factors, leads to a denial of health-care services. The Commission is working with the Department of Health to address these problems.

The panel session was moderated by Leslie London, a professor and chair of public health medicine in the School of Public Health and Family Medicine at the University of Cape Town. He is an active researcher in the field of occupational and environmental health research, and leads the health and human rights programme in the School, which has a broad research and training mandate addressing health as a socio-economic right and examining human rights and ethical issues in relation to the practice of health professionals. The panellists were Lisa Forman of the University of Toronto; Daphine Agaba of the School of Public Health, University of Western Cape; and Ciara O'Connell of the Center for Human Rights at the University of Pretoria.

Professor Forman's presentation focused on the evolution of core obligations as well as on trends in concluding observations and their implications for core obligations. Given the provision of article 2 of the ICESCR, the obligation of the state as defined by the Committee is limited largely to the progressive realisation of the right to health. Due to the challenges in realising socio-economic rights, including the right to health, it becomes necessary to define the obligations of states in a way that will protect the rights of the people, especially vulnerable groups in society. The Committee has noted that if the obligation of states is limited by progressive realisation, there needs to be something more fundamental that is protected. In order words, governments will not be permitted to deny access to health-care services simply based on non-availability of resources. This has brought to the fore the idea that the core content or obligation should reflect the most essential part of the rights – parts so fundamental that if they are denied, the essence of the right is defeated.

The problem with the reasonableness standard is that it could engender real deprivation.

Another issue Professor Forman noted with regard to core obligations as defined by the Committee is that they are non-derogable (General Comment 14, 2000). She maintains that strict standards may not be feasible in low-income settings. The definition of core obligations has a contrasting definition at the domestic level. Latin American Courts (Colombia, Costa Rica) define the essential minimum core of the right to health irrespective of resource constraints and budgetary impacts. The South African court, by contrast, has rejected core obligations in favour of a reasonable standard focused on the urgent needs of the poor (as in the ***Grootboom*** and ***TAC*** cases). This standard requires the state to act reasonably in the realisation of socio-economic rights.

Professor Forman believes, however, that the problem with the reasonableness standard is that it could engender real deprivation, as happened in the ***Mazibuko*** decision (2013) in which a water policy that deprived 100,000 households in Johannesburg of access to water was considered reasonable.

Dr Daphine Agaba's presentation dealt with the prevalence of maternal mortality in different parts

of the world and emphasised the disparity between high- and low-income countries. She highlighted the human rights issues associated with maternal mortality, stressing that timely access to reproductive health care is an important means of preventing maternal mortality and that states had to be held accountable for their obligations in this regard.

Accountability is a core human rights principle, as various human rights documents make clear. For instance, the CESCR General Comment 22 emphasises that it is key for the realisation of sexual and reproductive health and rights (2016). Describing accountability as concerned mainly with limiting or restraining power, Dr Agaba said it entails conducting regular bottom-up diagnostic exercises to identify systemic blockages that hinder women in giving birth safely and to provide feedback prompting action that addresses these blockages.

Accountability involves ensuring that duty-bearers or public officials are answerable for their actions, make citizens aware of their decisions, and, where necessary, are sanctioned for them. It is a process that goes beyond mere supervision or monitoring to include the development of guidelines, protocols or institutions by which standards of performance can be measured. In this way a system is established to make duty-bearers more responsive to rights-holders. Accountability is thus not solely focused on assigning blame; rather, it entails responsibility, answerability and enforcement.

In her presentation, Dr Ciara O'Connell examined approaches that have been adopted in the Inter-American System of Human Rights (ISHR) to realise rights to health. After giving an overview of the ISHR, she focused on two approaches for developing the justiciability of the right to health. The first is direct protection, which entails realising the right to health in the American Convention and the Protocol of San Salvador. The other approach is an indirect method that involves using the civil and political rights enshrined in the American Convention to argue for socio-economic rights.

With regard to the right to life with dignity, Dr O'Connell referred to the case of ***Street Children (Villagran-Morales et al) v Guatemela*** (1999) in which the Inter-American Court stated that the right to life concerns not only the right all persons have not to be deprived of life arbitrarily but the right to have access to the conditions necessary for leading a dignified life.

Similarly, in ***Yakye Axa Indigenous Community v Paraguay*** (2006), which dealt with indigenous people who had been forced out of their ancestral lands and were living in deplorable conditions, the Court said the state had failed to adopt the positive measures that were necessary to ensure the community lived under dignified conditions while its was without its land. The Court concluded that the state has the obligation to adopt positive measures promotive of a dignified life; this is particularly so when high-risk, vulnerable groups are at stake – their protection then becomes a priority.

References

CESCR General Comment No. 22 on the right to sexual and reproductive health (2016)

Committee on Economic, Social and Cultural Rights General Comment 14 on the right to the highest attainable standard of physical and mental health (2000)

Constitution of the Republic of South Africa, 1996

Government of the Republic of South Africa v Grootboom CCT11/00) [2000] ZACC 19; 2001 (1) SA 46

Mazibuko and Others v City of Johannesburg 2013 (6) SA 249 (CC)

Minister of Health v Treatment Action Campaign (2002) 5SA 721 (CC)

Street Children (Villagran-Morales et al) v Guatemela IACtHR November 19 1999

Yakye Axa Indigenous Community v Paraguay IACtHR 6 February 2006.