School of Public Health

A Right to a Minimum Adequate Standard of Health Care

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Understanding, and action proceeding from understanding and guided by it, is the one weapon against the world’s bombardment, the one medicine, the one instrument by which liberty, health, and joy may be shaped or shaped toward, in the individual, and in the race.

James Agee (1909-1955)
PREFACE

My present interest in the justiciability of the right to health care under international law was triggered a few years ago when I was involved in consulting to the medical profession and, in the course of that consulting work, I became aware of the complex issue of resource allocation in health care. This thesis has taken me far beyond this initial interest and has taught me much about the important relationship that exists between public health and the law.

I have incurred a large number of debts while working on this thesis. The first and most extensive of these is owed to Professor Colin Binns, who supervised the thesis from its inception to completion. Colin's willingness to take on a lawyer as a postgraduate student in the field of public health and his belief in the rightful place of research of this nature within the parameters of public health scholarship deserves special recognition. Colin – me deepest thanks for your patience, understanding, support and encouragement. Your have been a wonderful and inspirational supervisor.

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Jennifer Westaway
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Chapter One

INTRODUCTION

"The skill of writing is to create a context in which other people can think."
- Edwin Schlossberg

§1 DESCRIPTION OF THE THESIS

This thesis undertakes a fresh inquiry into the status of the right to health care under international law, with a view to explaining how the right to health care has been variously interpreted. Previous studies\(^1\) into the right to health care have primarily focused on its philosophical basis, and while these studies have contributed significantly to the ethical debate on the existence of such a right, this thesis has as its foundation, the fact that there has been legal recognition of its existence in the form of its inclusion in international conventions and supporting documents, as well as, in particular, domestic Constitutions and related Bills of Rights. It should be noted that this thesis will not examine in detail all documentation in which a right to health care in its various forms is mentioned. Rather a purposely selective examination has been instituted.

In respect to this selective examination, the process of selection was a deliberate one, specifically in relation to the case studies undertaken. The choice of countries to be of focus was based upon
the different nature of the documentation in which the right to the
health care could be said to be founded: Constitution, Charter or
Bill of Rights, International Convention only, other legislative
basis, or, as will be seen in the case of Tibet, International
Convention but effectively in name only. In the opinion of the
writer, this selection will provide a representative overview of the
status of a right to health care in international law.

The thesis is centrally concerned with the idea that the legal
recognition of a socio-economic right, such as the right to health
care, does not ensure that it is capable of enforcement. Rather, this
thesis proposes that the legal recognition of a socio-economic right,
specifically, a right to health care, has value, and can only claim
validity from what the existence of the right can provide from a
moral or ethical perspective. Further, this thesis proposes that the
‘justiciability’ of socio-economic rights depends on their
‘definability’ – in other words, for a right to be the subject of
judicial scrutiny, it must be capable of sustaining a definition
sufficient in substance to allow for judicial determination as to
whether or not there has been a breach in its provision.

In this thesis, the term ‘justiciability’ is taken to mean that which
is “capable of being settled by a court of law”\textsuperscript{2}, a “matter
appropriate for court review”\textsuperscript{3} or a matter which is “proper to be
examined in a court of justice”\textsuperscript{4}. It should be noted however that
there are various other broad definitions of the term, including
definitions which distinguish between justiciability by a judicial

\begin{itemize}
\item \textsuperscript{2} Butterworths Business and Law Dictionary (2\textsuperscript{nd} Ed.) (Butterworths: Sydney 2002)
\item \textsuperscript{3} Blacks Law Dictionary (6\textsuperscript{th} Ed.) (West Publishing Co: St Paul Minnesota, 1990)
\item \textsuperscript{4} Jowitt’s Dictionary of English Law (2\textsuperscript{nd} Ed.) (Sweet & Maxwell: London, 1977)
\end{itemize}
body and a quasi-judicial body\textsuperscript{5}. These definitions will not be of relevance.

\section{Method of the Thesis}

The methodology used for this thesis is a combination of doctrinal and theoretical, being principally library based, focusing on a reading and analysis of primary and secondary materials. In this regard, the methodology employed differs significantly from the qualitative and quantitative methodologies traditionally used within Schools of Public Health.

The methodology that has been chosen for this thesis could be said to be that traditional to legal research – doctrinal research. Doctrinal research has been defined as "Research which provides a systematic exposition of the rules governing a particular legal category, analyses the relationship between rules, explains areas of difficulty and, perhaps, predicts future developments."\textsuperscript{6} In other words, doctrinal research is library based, with a focus on the reading and analysis of the primary materials (legislation and case law) and supplementing this analysis with the extensive use of secondary materials, being commentary found in legal journals and textbooks. There were several databases used in research, the most

\textsuperscript{5} The distinction between a ‘judicial body’ and ‘quasi-judicial’ body is significant in the sense that rulings made by judicial bodies are binding in law, whereas orders made by quasi-judicial bodies, such as the Human Rights and Equal Opportunity Commission, are generally unenforceable. It is the power to give a binding and authoritative decision which is said to evidence the existence of judicial power. The mere capacity of a body/tribunal to give decisions which affected the rights of the contending parties did not mean that the body/tribunal could be said to be a judicial body, for in the absence a capacity to bind the parties, the body/tribunal could only be said to be quasi-judicial. See for example, \textit{Brandy v Human Rights and Equal Opportunity Commission} (1995) 183 CLR 245. Further see \textit{R v Davison} (1954) 90 CLR 368 at 369 per Dixon CJ and McTiernan J: "The truth is that the ascertainment of existing rights by the judicial determination of issues of fact or law falls exclusively within judicial power so that the parliament cannot confide the function to any person or body but a court constituted under ss.71 and 72 of the Constitution.”.

\textsuperscript{6} Hutchinson, T. \textit{Researching and Writing in Law} (Lawbook Co: Australia, 2002) at p.9
specific being those obtained from Quicklaw, Lexis, Medline, EBSCO Host and AustlII. Various other internet resources were used, such as those available through the World Health Organization and the United Nations.

However, whilst this approach has been primarily undertaken, it is appropriate to state that there is another methodology that has been applied, and this is what has been called fundamental research methodology. This approach was first identified as a methodology in 1982 in Canada by the Arthurs Report\(^7\) and recommends the combining of traditional social science research methodology with doctrinal methodology. The reason for this collaboration of methodologies was to ensure that papers could be written in such a manner, using a variety of research techniques which would see a wider acceptance of legal research. It is hoped that this thesis has achieved this goal.

\section{Relevance of the Thesis}

When this thesis was commenced, the relevance and significance of the subject was seen to lie within the parameters of international public health from the perspective of assisting in the identification of those components of health care that could be said to constitute ‘basic’ or ‘adequate’ health care.

\footnote{The Arthurs Report, otherwise known as Law and Learning: Report to the Social Sciences and the Humanities Research Council of Canada by the Consultative Group on Research and Education in Law (Ottawa: Information Division of the Social Sciences and Humanities Research Council of Canada, 1983) was commissioned as a result of the 1982 Toronto conference of the USA Law and Society Association. Harry Arthurs, John Hagan and Fred Zemans called together a group of Canadian law teachers and social scientists to set the basis of a scholarly association as a means of fostering law and society research and scholarship in Canada. This report was the result of that collaboration – See Prue, W. Wesley., A Short History of the Canadian Law and Society Association at http://www.acds-csla.org/en/acds/cslahistory.pdf retrieved 17/10/03}
It has become increasingly clear that the true relevance of the research undertaken for this thesis lies primarily in the fields of international public health law and human rights. Specifically, this thesis shows the manner in which countries around the world, including a significant number of developing, third world and transitional countries, have attempted to constitutionally and/or legislatively recognize the right to health care and the approach of the courts in interpreting these attempts. It is necessary to state that not every country which has undertaken to constitutionally or legislatively recognize health care as a right is listed here. Furthermore, the choice of countries for case study has been a personal one, guided primarily by the opinion of the writer as to the use that could be made of the comparisons able to be drawn with respect to the basis upon which a claim to a violation of the right to health care could be formulated.

Whilst this approach may be said to limit the relevance of the thesis to those with a particular interest in the law, it is more accurate to describe its relevance as to applying to all those who work within the field of international public health, as it will assist in the determination of the constraints which may apply to the provision of health care. This will certainly be the case where the issue of provision is linked to resources.

§4 OUTLINE AND STRUCTURE OF THE THESIS

In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research ("the Commission") issued its three volume report on "Securing Access to Health Care: The Ethical Implications of Differences in
the Availability of Health Services. The Report had been commissioned and mandated to study the “...ethical and legal implications of differences in the availability of health services” and was instructed to examine the extent of the differences and the manner in which the differences arise. In submitting the report to the President, the Commission Chairman, Morris Abram wrote:

In examining the special nature of health care, we discern in our country's traditional commitment of fairness an ethical obligation on the part of society to ensure that all Americans have access to an adequate level of care without the imposition of excessive burdens. This obligation does not require that everyone receive all health care that he or she may want or even all that could conceivably be of benefit. Instead it is a moral responsibility to see that adequate care is accessible, a commitment that recognizes the competing claims on available resources of other worthwhile social goals.

The obligation we have described is one of all to all, not a special standard that applies only to the poor.... Thus, in practical terms, the responsibility that ultimately rests with the Federal government is to make sure that those who otherwise could not obtain adequate care are able to do so and that the costs of care and shared equitably.

It is the purpose of this thesis to examine the concept of a right to an adequate level of health care within the parameters of the right to health under the international law of human rights. In particular, this thesis with examine the concept of a standard of "an adequate level of care" as proposed by the President's Commission – a standard stated by the Commission “...as a floor below which no one ought to fall, not a ceiling above which no one may rise” in order to determine whether it is possible to provide a definition that is capable of forming the foundation upon which the right to health care, a component, it is alleged, of the right to

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10 Ibid, p.4
health, may prove to be justiciable under the international law of human rights

In an episode of the long-running television series *Law and Order*, the issue of the legal status of the human right to life was the subject-matter. In addressing the U.S. Supreme Court, the character of Jack McCoy, Assistant District Attorney, made the statement that "People only have those rights which they can defend – only those rights." Whilst this is only television drama, it is proposed that the essence of this statement is indeed both valid and central to the justiciability of human rights and bringing the violators of human rights to justice. For, without the ability of human rights to be defended in a court of law – without the element of justiciability – what true value do human rights have. The fact that rights exist in International Conventions and Declarations does not mean that they are of any value to those who are denied the benefit of such rights.

Following a brief historical introduction to human rights and the relationship between human rights and health in Chapter 2, the focus of Chapter 3 of this thesis will be in setting out the relevant International Conventions, Declarations and related documents which contain references to the right to health and/or health care and will also detail all those World Constitutions in which the right to health and/or health care has been recognized.

Chapter 4 will discuss a definitional proposal for 'basic' or 'adequate health care' as well as providing a brief discussion of some of the philosophical concepts surrounding such terms as 'rights', 'obligations', the 'universality' and 'cultural relativism' of human rights.
In Chapter 5 there will be an examination of the notion of justiciability and of the issue of the available methods of reporting of violations of human rights, looking at constitutional and legislative enforcement measures within certain countries that have recognised a right to health care as well as looking at relevant case law and case studies.

Chapter 6 will conclude the thesis providing some comment and perspective on future developments.

Figure 1

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Chapter Two

The Companionship of Health and Human Rights

"It is my aspiration that health will finally be seen not as a blessing to be wished for; but as a human right to be fought for"


Human rights and public health are two complementary approaches, and, one might suggest, languages, to address and advance human well being. The human rights approach seeks, by description, to promote and protect, the societal-level prerequisites for human well-being in which each individual can achieve his or her own full potential, albeit within the constraints of the society in which they live.

Modern human rights are essentially a constitutional achievement, an historic attempt to identify and then agree upon what governments should not do to people and what they should assure all people. Human rights, it is argued, are nonprovable statements\(^\text{12}\) that derive their legitimacy from having been developed, voted upon and adopted by the nations of the world and having then been incorporated into the domain of international law. It is the central part of this thesis that human rights are indeed ‘provable’, and that in the absence of ‘provability’, or ‘justiciability’, to use a term familiar to international and domestic law, human rights are of little value, even if they are ‘legitimate’. It is in this context that health care as a human right will be examined.

In discussions about health and health care, the topic of human rights is rarely raised and certainly in discussions regarding access to health care, human rights considerations have not been the primary or even secondary focus. It is even argued\(^{13}\) that, except where the primary manifestation of an abuse of human rights is damage to health, such as is the case with torture, there has been an absence of health perspectives from human rights discourse.

Explanations for the paucity of communication between the fields of health, and specifically public health, and human rights include differing philosophical perspectives, the vocabulary of human rights dialogue, societal roles and methods of implementation. It has also been suggested that a lack of human rights education in public health may be a significant cause of the disparity.\(^{14}\) In addition, modern concepts of health and human rights are complex and continually evolving, although the definitional basis from which this evolution is emanating seems clearly identifiable.

There may also be the issue that health workers, struggling to meet the basic health needs of populations in underdeveloped or developing countries, see little point, either from a utility perspective or from a position of necessity, of incorporating into their already difficult task, human rights perspectives, which, if we accept the unprovability of human rights, are seemingly of little or no constructive benefit.

Furthermore, despite pioneering work which has sought to bring a closer working relationship between bioethics\(^{14}\), jurisprudence\(^{15}\)


\(^{14}\) Ibid

\(^{15}\) Bioethics has been variously defined, but for the purposes of illustration, the definition provided by Reich is cited: Bioethics is “the systematic study of moral dimensions –
and public health law\textsuperscript{16}, a history of conflict between medicine and the law, or between civil libertarians and public health officials, may have contributed to anxiety and doubt about the potential for mutually beneficial collaboration between human rights exponents and health care workers.

Despite the reservations and lack of collaboration, it is clear that health and human rights are equally powerful approaches to the advancement of human well-being. Closer attention to where health and human rights intersect should provide practical benefits to those engaged in health or human rights work, and may as a result, help reorientate thinking about major global health challenges, especially if it is possible to legitimise health as a human right by establishing justiciability.

In order to provide a platform from which to develop the relationship between health and human rights, it is necessary to briefly examine modern concepts of health how human rights have developed to this point in history. It is acknowledged that a comprehensive examination of the history of human rights is beyond the scope of this thesis, however, it is contended that without an understanding of human rights history and the significance of rights dialogue, the linkage between health and human rights will fail to be adequately revealed and so therefore, will the concept of justiciability of health and health care within the framework of human rights.

\textsuperscript{16} Including moral vision, decisions, conduct and policies – of the life sciences and health care, employing a variety of ethical methodologies in an interdisciplinary setting.” (Reich, W. Introduction to the Encyclopedia of Bioethics (Revised Edition) (New York: Simon & Shuster Macmillan, 1995) at p.xxi

\textsuperscript{15} Dworkin, R. Taking Rights Seriously (Cambridge; Harvard University Press, 1978)

Modern concepts of health derive from two related although quite distinctly different disciplines – medicine and public health. While medicine focuses on the health of an individual, public health focuses its emphasis in the health of populations. At the risk of oversimplifying, it can be said that individual health has been the concern of medical and other health care services, such as nursing, generally in the context of the physical illness and disability. In contrast, public health has been defined as “[ensuring] the conditions in which people can be healthy”.\textsuperscript{17} It is within this context that public health can be seen to have a distinct health promotion goal, emphasising prevention of disease, disability and premature death, rather than the goal of medicine which is to cure the disease or disability. It is this distinction in perspective which indicates the attitude that the availability of medical and other health care services is just once condition, albeit an essential one, for the achievement of health – medical and health care services are not synonymous with ‘health’. Indeed, it has been argued that while health care is necessary for health, it is clearly not sufficient and so therefore only a small fraction of the variance in health status within and among populations can reasonably be attributed to the availability of health care.\textsuperscript{18}

The most widely used modern definition of health was developed by the World Health Organisation (WHO)\textsuperscript{19}. Its preamble states:

\begin{quote}
“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
\end{quote}

\textsuperscript{17} Institute of Medicine, \textit{Future of Public Health} (Washington, DC: National Academy Press, 1988)
The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provisions of adequate health and social provisions.

Through this definition, the WHO has helped move thinking about health beyond the traditional biomedical and pathological based perspective to what some may regard as a more positive domain – that of complete well being. Another implication of this definition, it is argued\textsuperscript{20}, is that by explicitly including the social and mental dimensions of well-being, the WHO has expanded the scope of

\textsuperscript{20} Mann et al, op cit, p.8
health and therefore the roles and responsibilities of health professionals and their relationship to the societies which they serve.

![Image](image-url)

**Figure 2**

The WHO definition also highlights the importance of health promotion. Health promotion as a concept is clearly stated in the Ottawa Charter\(^22\) which has been defined as “the process of enabling people to increase control over, and to improve, their health.” To enable this to happen, “an individual or group must be able to identify and realise aspirations, to satisfy needs, and to change or cope with the environment.”\(^23\) The Declaration of the Alma-Ata (1978) re-emphasised this point by describing health as a “social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.”\(^24\) However, the Alma-Ata Conference declined to formulate a global action plan and instead, the World Health Assembly in 1979, while endorsing the Alma-Ata Declaration, invited Member States to “..individually... formulate national strategies for attaining health


\(^{22}\) The Ottawa Charter was a declaration of the 1986 first world conference on health promotion health in Canada under the auspices of the World Health Organisation.

\(^{23}\) Ibid.

for all by the year 2000 and collectively to formulate regional and
global strategies on the basis of these.”

The phrase “health for all”, arose out of a 1977 resolution of the
WHO’s governing body, the World Health Assembly, which stated
that:

“...the main social target of governments and WHO should be the
attainment of all people of the world by the year 2000 of a level of
health that will permit them to lead a socially and economically
productive life.”

In 1981, the World Health Assembly passed a resolution adopting
the Global Strategy for Health for All by the Year 2000. This
resolution set out 12 indicators for global monitoring and
evaluation, and, to assist in implementation, an explanatory
volume on the use of the indicators was also approved. Indicators
are identified by the United Nations as being:

“...statistical data which attempts to provide or ‘indicate’ (usually
based on some form of numerical quantification) the prevailing
circumstances at a given place at a given point in time.”

While the WHO defines indicators as being “indicators that
measure change.”

These indictors have been summarised by Hunt in the following
terms

9 Ann Rev Public Health 71 as quoted in Hunt, P. Reclaiming Social Rights: International
and Comparative Perspectives (Aldershot: Dartmouth Publishing Company, 1996)
26 Ibid p.72
27 WHO resolution WHA 34, 36, May 1981
28 Development of Indicators for Monitoring Progress Toward health for All by the Year
and Cultural Rights – four annual reports – report No. 2
30 Ibid, para 5.
31 Hunt, op.cit, pp.128-129
32 Note the similarities in content to the documents identified in Appendix 1 and 2 of this
thesis.
"(1) Political Commitment – Does health for all continue to receive endorsement as policy at the highest level?

(2) Community Development – Are there functioning mechanisms for the involvement of people in the implementation of health for all?

(3) Resources – Is at least 5% of GNP spent on health?

(4) Resources – Is a reasonable percentage of the national health budget spent on local health services?

(5) Resources - Are the resources for primary health becoming more equitably distributed?

(6) Resources - How much international aid for health is received or given?

(7) Availability of Primary Health Care - What is the percentage of the population covered by primary health care, including the percentage with:
   (a) reasonable access to safe water and adequate sanitary facilities/
   (b) immunisation against diphtheria, tetanus, whooping-cough, measles, poliomyelitis, and tuberculosis?
   (c) local health services, including the availability of essential drugs, within one hour's walk or travel?
   (d) trained personnel for attending pregnancy and childbirth, and caring for children up to at least one year of age?

(8) Health Status: Nutrition
   (a) What is the percentage of newborns weighing at least 2500 grams at birth?
   (b) What is the percentage of children whose weight-for-age and/or weight-for-height is acceptable?

(9) Health Status: Mortality – In all identifiable sub-groups, what is the:
   (a) infant mortality rate?
   (b) maternal mortality rate?
   © probability of dying before the age of five years?

(10) Health Status: Life Expectancy – In all identifiable sub-groups, including sex, what is life expectancy at birth?

(11) Literacy. In all identifiable sub-groups, including sex, what is the adult literacy rate?

(12) Per Capita GNP- What is the per capita gross national product?"
Hunt cites comments of Virginia Leary and Rebecca Cook\textsuperscript{33}, who both acknowledge the importance of these indicators as the basis for monitoring and determining implementation of the right to health. From a legal perspective, it is interesting to note that Hunt identifies that the indicators use what he calls ‘vague wording’ – terms such as ‘reasonable’ and ‘acceptable’ – terms which have acceptability for legal determination. This writer suggests that given the question of justiciability which surrounds the right to health, the use of these ‘vague’ terms may be of judicial benefit.

Interestingly, research has revealed that in 1850, the \textit{Report of the Sanitary Commission of Massachusetts} was presented to the Massachusetts State Legislature by Lemuel Shattuck. This report was based upon a survey of the health status of the population of Massachusetts and set out in some 50 recommendations what were believed to be the essential elements of primary health care. According to Evans, Lashman Hall and Warford\textsuperscript{34} (who suggest that the WHO might well have found the text for the ‘Global Strategy for Health for All by the Year 2000’ plan in this report), these recommendations can be summarised as being:

"Immunization and communicable-disease control; promotion of child health; improved housing for the poor; environmental sanitation; training of community-oriented health manpower; public health education; promotion of individual responsibility for one's own health; mobilization of community participation through sanitary associations; and creation of multidisciplinary boards of health to assess health needs and plan programs in response to sound epidemiologic evidence."

\textsuperscript{33} Ibid, p129. Work of both these authors can be found in the Bibliography of this Thesis.

\textsuperscript{34} Evans, J.R., Lashman Hall, K. & Warford, J. \textit{Shattuck Lecture – Health care in the developing world: Problems of scarcity and choice} – Delivered at the Bicentennial meeting of the Massachusetts Medical Society, Boston, October 21, 1981 (http://media.payson.tulane.edu:8086/cgi-bin/...&q=right%20to%20health&a=t&d=B.207.6.2.2 retrieved 18/7/00.)
Indeed, it has been suggested that should this report be published today, it would still be ahead of its time in some aspects as it showed significant insight and foresight of the present and future public health needs of Massachusetts as well as the nation as a whole. It is also reasonable to suggest, given the similarities that can be found between the Report and the Indicators, that the Report would have international significance. Indeed, as a document, it still has a usefulness from an international perspective, in that it reveals that many of the public health concerns that existed in 1850 are still not being addressed.

While expanding the concept of health in these ways may seem to be a laudable course of action from a public health perspective, from a human rights perspective, health has become an even more difficult issue to define and contain. The implications for determinations of alleged violation and subsequent enforcement are therefore significant. Indeed, the scope and complexity of this issue can best be seen from the preamble to the WHO Constitution, which declares that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.”

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35 Lemuel Shattuck (1793-1859) at [http://www.hsc.usf.edu/~kmbrown/shattuck.htm](http://www.hsc.usf.edu/~kmbrown/shattuck.htm) (retrieved 7/11/01) for a more detailed analysis of his recommendations.
37 WHO, Constitution op.cit
HISTORICAL BACKGROUND

The concepts and philosophy behind human rights and the development of what are known as modern human rights have been explored extensively. It is however, important that an understanding of some of the historical background be achieved so that one is able to begin to comprehend the importance of focusing on the issue of justiciability in relation to human rights, specifically in relation to health and health care. It is important to note that what follows is not comprehensive, but is included for the purpose of informing those who may have little knowledge of the history of human rights.

At the end of the eighteenth century in Europe and America, the century was heralded as that which had clearly and unequivocally proclaimed the inalienable and imprescriptible rights of man. The natural law philosophy of John Locke38, formalized the view that certain rights were inherent in nature, supported by a belief in God and founded in human reason and therefore equally available to all and subject to universal application.39 It was Locke’s view that the content of these rights was directed at freedom from harmful interference by others, to the person, their health, liberty and personal property. Locke also developed the notion that while each person had certain natural rights, in the interests of better government of the whole, each individual would surrender some of those rights. This concession to government would enable the government to protect the rights of individuals who were unable or ill-equipped to protect themselves. Accordingly, the legitimacy of

38 A biography of John Locke can be found at http://www.utm.edu/research/iep/l/locke.htm or at http://plato.stanford.edu/entries/locke/
39 It should be noted that Thomas Hobbes and Hugo Grotius were also exponents of the natural law theory.
government flowed from the will of the people and this legitimacy
generated a positive obligation on the part of government to act for
the general good of the people.\textsuperscript{40} These views together with the Act
of Settlement and Bill of Rights of 1688 were the underpinnings of
the revolt against absolutism\textsuperscript{41} and the concern for freedom and
tolerance. Indeed, the trial of Charles 1 in 1649, has been said to
be the first trial whereby the rights of the people were the primary
consideration, for although it was bungled and arguably illegal, it
still was a trial of a king as king for failing in his duties to his
subjects.

Figure 3\textsuperscript{42}

Charles believed in the "divine right of kings"\textsuperscript{43}, that he was
answerable only to God, and that no mortal subject should
question his judgement and any attempt to restrict the power of

\textsuperscript{40} Piotrowicz & Kaye. op.cit.
\textsuperscript{41} The theory of ‘absolutism’ fundamentally proposes that the best form of government is
autocracy – the person in power is not to be questioned or disobeyed. See
http://www.ausu.edu/~dee/GLOSSARY/ABSOLUTE.HTM for a more detailed analysis of
the theory.
\textsuperscript{42} Charles I (1625-49) retrieved from
http://www.britannia.com/history/monarchs/mon47.html
\textsuperscript{43} This notion derived from the theory of ‘absolutism’ and argued that certain kings ruled
because they were chosen by God to do so. In other words, power was bestowed by God and
this bestowal legitimated autocracy. The king ruled by virtue of God’s authority and
therefore should be obeyed in all things. See
http://www.ausu.edu/~dee/GLOSSARY/DIVRIGHT.HTM for more discussion.
the King was fundamentally wrong. This was to embitter those who saw the faults in his decisions. He fell out with parliament almost immediately over religious differences and foreign policies. He found the unruly commons difficult to get on with.

Rather than deal with parliament, he collected money for his expensive foreign campaigns from nobles and knights, arresting anyone who wouldn’t pay what he demanded. Parliament condemned this arbitrary taxation and imprisonment, and Charles dismissed parliament for their revolutionary remarks.

Charles ruled for 11 years without a parliament, introducing the collection of ship money in ports, and later inland as well, to keep money coming in to the royal coffers. However, Charles was eventually forced to re-call parliament in order to raise more funds and in extracting funds from parliament, Charles had to agree to giving them more power. They were allowed to reconvene every three years without being called, and could not be dismissed without their own consent.

Parliament then went too far, when they attempted to gain control of the army by passing a militia bill. Differences escalated, and Charles declared war on parliament by raising his standard at Nottingham (Aug 22 1642). Two civil wars followed. Charles was arrested and put on trial for treason. He was found guilty and beheaded in Whitehall on January 30, 1649.

The period from the early seventeenth century also saw the beginnings of British immigration to the New World, with significant numbers of religious non-conformists seeking the religious freedom they believed unavailable to them in Britain, emigrating to America to set up new communities. When the
French threat to the British colonies in America was removed in 1763, the colonists began to agitate against the taxation which was being imposed by Britain. The call ‘no taxation without representation’ was a call for participation in government – the exercise of a human right. This denial of the right of representation and therefore the denial of a human right, was a factor in the initiation of the American War of Independence.\footnote{Ibid. p.13.}

It was therefore some one hundred and thirty years after the trial of Charles I, on 12 June, 1776, that the representatives of Virginia introduced their Declaration of Rights\footnote{Known as the Virginia Declaration of Rights. A full copy of this document can be found at http://www.archives.gov/national_archives_experience/virginia_declaration_of_rights.html}. This declaration set out the rights that were deemed to pertain to all the people of Virginia and that would form the basis and foundation of the government of Virginia.

The Declaration stated, inter alia;

1. *That all men are by nature equally free and independent, and have certain inherent rights, of which, when they enter into a state of society, they cannot by any compact deprive or divest their posterity; namely, the enjoyment of life and liberty, with the means of acquiring and possessing property, and pursuing and obtaining happiness and safety.*

2. *That all power is vested in, and consequently derived from, the people; that magistrates are their trustees and servants, and at all times amenable to them.*

3. *That government is, or ought to be, instituted for the common benefit, protection, and security of the people, nation or community; of all the various modes and forms of government, that is best which is capable of producing the greatest degree of happiness and safety, and is most effectually secured against the danger of maladministration; and that, when a government shall be found inadequate or contrary to these purposes, a majority of the community hath an indubitable, unalienable, and
indefeasible right to reform, alter or abolish it, in such manner as shall be judged most conducive to the public weal.

This declaration was followed on 4 July, 1776 by 'The unanimous Declaration of the thirteen united States of America' drafted by Thomas Jefferson⁴⁶, which contains the words:

"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness. That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed. That whenever any Form of Government becomes destructive of these ends, it is the Right of the People to alter or to abolish it, and to institute new Government, laying its foundation on such principles and organizing its powers in such form, as to them shall seem most likely to effect their Safety and Happiness."

In 1789, the French National Assembly promulgated its Declaration of the Rights of Man and of Citizens⁴⁷, a document firmly based on and reflective of the sentiment and language of the American declarations and the philosophical and political tradition that shaped them. This Declaration identified 'natural and imprescriptible rights' of all men and citizens, these rights being 'liberty, property, security, and resistance of oppression'⁴⁸. In a new declaration, dated 24 June, 1793, the French proclaimed that the goal of society is common happiness and the government is established to guarantee to man the enjoyment of these identified rights.⁴⁹

⁴⁶ A full copy of which can be found at http://www.archives.gov/national_archives_experience/declaration.html
⁴⁷ A full copy of which can be found at http://www.hrcr.org/docs/frenchdec.html
⁴⁸ Article 2.
⁴⁹ It should be noted that a further declaration followed as a prefix to the Constitution of 5 Fructidor of the Year III (22 August 1795) that further defined these rights. See Kamenka, E. Ideas and Ideologies Human Rights (New York; St Martin’s Press, 1978) p.4.
Several other revolutions rocked Europe in the first half of the nineteenth century, all of which fixed upon the fundamental values of freedom of speech, freedom of association and the establishment of democratic institutions as their desired outcome. While some constitutions were drafted guaranteeing rights such as jury trials, wider male suffrage and freedom of speech, there was a movement in Britain that opposed the natural law theory of Locke and others. Edmund Burke in 1790, in his *Reflections on the Revolution in France*\(^{50}\) attacked the French Revolutionary movement as being based upon unenforceable abstractions of freedom and equality. This concept of the unenforceability of natural rights also gained expression in Jeremy Bentham’s theory of utilitarianism\(^{51}\) of the 1830s. This theory held the idea that governments should seek the greatest good for the greatest number, thus weakening the position and the rights of the individual and setting the individual’s happiness as subservient to the happiness of the wider population.

Kamenka\(^{52}\) has proposed that while the eighteenth century invented the idea of happiness in which the concept of natural rights as political rights was deeply grounded, it also invented the idea of revolution, from which the political slogan ‘Liberty, Equality, Fraternity’ is so closely identified. This slogan, it is suggested, can also be read socially, in that it called for “...an economic, social and cultural reconstruction of society that went far beyond the political claims of the American revolutionists”\(^{53}\).

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\(^{50}\) Full title – *Reflections on the Revolution in France & On the Proceedings In Certain Societies in London Relative to that Event In a Letter Intended to Have Been Sent To A Gentleman In Paris.* A full copy of this can be found at [http://www.ourcivilisation.com/burke/](http://www.ourcivilisation.com/burke/)

\(^{51}\) See [http://www.utilitarianism.com/bentham.htm](http://www.utilitarianism.com/bentham.htm) for a more detailed discussion on this point.

\(^{52}\) Kamenka, E. *Ideas and Ideologies of Human Rights* (New York: St Martin’s Press, 1978)

\(^{53}\) Ibid. p.5
Further to this, Kamenka has also proposed that from the eighteenth century onwards, new and different concerns from those of seventeenth and eighteenth centuries, which were focused largely on issues such as despotism and political disfranchisement – claims against the state - arose. The claims to and demands for rights in the nineteenth and twentieth centuries became claims upon the state – claims that demanded the state guarantee and provide the means for the people to achieve happiness and well-being.

It should be noted however, that the desire to incorporate basic human rights into constitutions was not universal. In 1790, as previously mentioned, Edmund Burke argued that the French revolutionary movement was based upon abstractions of freedom and equality that were simply not enforceable. Jeremy Bentham, in the 1830’s, developed the concept of utilitarianism, arguing that governments should seek the greatest good for the greatest number thus weakening any individual claim to happiness, and making an individual’s happiness subservient to the happiness of the total population.

These concepts were followed by notions of positivism, which replaced natural rules and rights with obligations identified as flowing from the state. The common law was seen to be the appropriate instrument for the protection of the individual and there was little if any incentive, to incorporate expressions of human rights in formal documents, such as constitutions.54 Piotrowicz & Kaye cite the Australian constitution as an example of the move to positivism, in that it contains very few references to individual rights. In particular, it is noted that the expression ‘for

54 Piotrowicz & Kaye, op.cit.p.16.
the peace, order and good government of the Commonwealth' that accompanies the s.51 grant of power to the Commonwealth Parliament, has been held by the High Court as having no limited meaning. In other words, it is for Parliament to decide what is for the peace, order and good government of the people, and therefore any act of Parliament will automatically meet this requirement.

The advent of World War I and its negotiated settlement, saw the introduction of the mandate system and the formation of the League of Nations. The mandate system meant that conquered territory of the defeated powers was handed to the control of various allied states, but it was specified that the control had to be exercised for the benefit of the local population. The League of Nations, with the assistance of the Permanent Mandates Commission, was assigned the task of supervising the mandates, which were divided into three different classes – A, B & C. A Class territories were those closely approaching independent status, while B Class territories were much further from self-determination and therefore had certain human rights obligations imposed by the administering power, such as freedom of religion and conscience. Class C mandates were furthest from independence and required administration and were provided with guarantees as to rights of individuals which were to be administrated as if part of the integral territory of the administering power.

55 See Union Steamship Co of Australia Pty Ltd v King (1988) 166 CLR 1 and Builders’ Construction Employees and Builders’ Labourers Federation of New South Wales v Minister for Industrial Relations (1986) 7NSWLR 372 re breadth of power in parliaments of Australia.
In the event that the inhabitant/s of a mandated territory formed a view that their rights under the mandate were being infringed, a petition could be forwarded to the Permanent Mandates Commission, through the administering power. While there were some successful Petitions\(^{57}\) there were limitations on the effectiveness of the system, and just prior to the outbreak of World War II, none of the A Class mandates had obtained independence.

The Peace Settlement that followed World War II, included a series of treaties and declarations guaranteeing the rights of minorities – specifically, rights to life, liberty and free exercise of religion and practices consistent with public order and morals, equality of treatment before the law, various other civil and political rights as well as security in law. There was no mention of rights to health, education, marriage, or adequate food and housing. There was, however, one significant contribution to human rights that came out of the Peace Settlement and that was the creation of the International Labour Organisation (ILO)\(^{58}\). Article 23 of the Covenant of the League of Nations\(^{59}\) obliged member states to provide ‘fair and humane conditions of labour for men, women and children’ and to establish an international organisation that would assist in the fulfillment of this goal. It is interesting to note that the ILO survived WWII and after severing ties with the League of Nations became an agency of the United Nations in 1946.

Following the December 21, 1941 attack on Pearl Harbour, Franklin D. Roosevelt committed the goal of the Allies in respect to human rights to the establishment for all people of four basic

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\(^{57}\) See Piotrowicz & Kaye, op.cit for a further discussion of this issue.  
\(^{58}\) See the website of the ILO at [http://www.ilo.org/public/english/about/index.htm](http://www.ilo.org/public/english/about/index.htm) for further information about the structure and function of the Organisation.  
\(^{59}\) A full copy of the Covenant can be located at [http://www.ku.edu/carrie/docs/texts/leagnat.html](http://www.ku.edu/carrie/docs/texts/leagnat.html)
freedoms: freedom of worship, freedom of speech, freedom from want, and, freedom from fear. In 1944, a major conference was organised between Britain, the United States, the Soviet Union and China to consider the establishment and structure of an organisation that could succeed the League of Nations. In 1945, after the defeat of Germany, a further conference with much broader participation was held to negotiate a charter for the new organisation. The Charter of the United Nations, opened for signature on 26 June, 1945, reflected a greater concern for human rights than had previously been evident.

Figure 460

60 Franklin D Roosevelt, 32nd President of the United States of America, 1933-1945 retrieved from http://www.whitehouse.gov/history/presidents/fr32.html on 21.04.04
Chapter Three

THE UNITED NATIONS AND CONSTITUTIONAL RECOGNITION OF HUMAN RIGHTS

"The goal of realizing human rights is fundamental to the global fight against AIDS. And in a world facing a terrible epidemic – one that has already spread further, faster and to more devastating effect that any other in human history – winning the fight against AIDS is a precondition for achieving rights worth enjoying.”

- Dr Peter Piot

In 1945, when the United Nations identified one of its principal purposes as the promotion of human rights, agreement was reached that all people are “born free and equal in dignity and rights”. As a result of this agreement, the Universal Declaration of Human Rights was adopted as a universal standard or common standard of achievement for all peoples and all nations.

The preamble to the Universal Declaration proposes that human rights and dignity are self-evident, the “highest aspiration of the common people”, and “the foundation of freedom, justice and peace.” “Social progress and better standards of life in larger freedom,” including the prevention of “barbarous acts which have outraged the conscience of mankind”, and further, that individual

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62 United Nations Charter, signed at San Francisco, June 26, 1945
63 Universal Declaration of Human Rights, adopted and proclaimed by UN General Assembly Resolution 217A (III) (December 10, 1948)
64 A full copy of this document is available at http://www.un.org/Overview/rights.html

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and collective well-being as considered to be dependant on the "promotion of universal respect for and observance of human rights". This group of statements in themselves provide a wealth of material for commentary and it should be noted at this point that the issue of the 'universality' of human rights, will be discussed (albeit briefly) later in this thesis in relation to the issue of cultural relativity.

There are a number of key documents that contain the corpus of human rights law. Foremost is the Universal Declaration of Human Rights (UDHR), which along with the United Nations Charter (UN Charter), the International Covenant on Civil and Political Rights (ICCPR) – and its Optional Protocols –and, of particular interest for this thesis, the International Covenant on Economic, Social and Cultural Rights (ICESCR), all form the 'International Bill on Human Rights'. The UDHR was drawn up to give more specific definition to the rights and freedoms referred to in the UN Charter. The ICCPR and the ICESCR elaborate further on the content set out in the UDHR, as well as set out the conditions in which states can permissibly restrict rights.

Prior to a discussion of the ICESCR, it is important to identify the significance of the division between the rights contained in the ICCPR and those contained in the ICESCR. Historically, recognition has been given to two broad categories of rights: civil and political rights, on the one hand, and economic, social and cultural rights on the other. Civil and political rights include such rights as the rights to life, liberty and security of persons, the right not to be subjected to torture, to arbitrary arrest, the right to a fair trial, the right to a nationality and the right to freedom of expression and opinion. In comparison, economic, social and
cultural rights include the rights to the highest obtainable standard of health, to education, to adequate food, to work, to housing and to participate in the cultural life of a community.

These rights have also been categorized as first and second generation rights, with what have been called the ‘core rights’ of the ICCPR being described as first generation rights, while the rights contained in the ICESCR being described as second generation rights. This categorization is said\textsuperscript{65} to reflect the different stages in their "..conception, institutionalization and achievement", in that first generation rights were said to have been conceived and expressed early in the historical development of human rights, having an associated history of institutional protection, while second generation rights, many having been conceived of at the same time as the first generation rights, have had limited development and even more limited institutional protection.\textsuperscript{66}

It has been suggested\textsuperscript{67} that the reason that social, economic and cultural rights have had limited development and protection stems from the differing ideological views as to how such second generation rights ought to be met, given the vast economic and cultural differences which exist between states. Equally, there is argument\textsuperscript{68} to suggest that rights that have widespread social welfare implications, such as the rights to education, social welfare and health care, require a higher level of commitment to implement due to economic and legislative factors and are more difficult to enforce than are the first generation rights such as the

\textsuperscript{65} Kirby,J in Galligan & Sampford, op.cit at p. 3
\textsuperscript{66} Ibid.
\textsuperscript{67} Piotrowicz & Kaye, op.cit, at p.6
\textsuperscript{68} Ibid p.7
right to a fair trial and the right to life. Therefore, given these inherent difficulties, such rights have languished behind those rights known as first generation.

There are also a category of rights which are known as third generation rights, otherwise referred to as ‘solidarity’ rights. These rights are said to include such rights as the right to development and the right to a healthy and sustainable environment, which according to Kirby, have content which is not at all clear. It has also been suggested that these rights include the concept of ‘group rights’, that is, the rights of minority groups as distinct from the rights of an individual, which are rights specifically the focus of the Universal Declaration.

However, even though it can be said that there are these three categories of rights, they are all interdependent and interrelated,

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69 Kirby, op.cit p.4. See also Mann et al, op.cit at p.25, where third generation rights are described in the following manner:

"In addition to these two basic recognised rights, a third category of rights, known as solidarity rights, should be mentioned. These rights which have not yet been generally recognised at the international level as legally enforceable, urge solidarity with the less privileged in order to rectify the unequal distribution of resources and to prevent and respond to human suffering. This category of rights includes the rights to development, to peace, to the equal enjoyment of the common heritage of humankind, and to an unpolluted natural environment."

70 Allan Rosas cited by Kirby, ibid, provides a useful evaluation of the third generation ‘right of development’ when he states:

The right to development should, perhaps, be seen as an umbrella concept and programme rather than a specific human right. It may be of particular relevance as a summary and pointer of the human rights dimension for development cooperation and development aid purposes, including the notion of 'human rights impact statements'. It could then play a role in planning and implementing policies and programmes, rather than function as a legal mechanism per se. For the right to development to play a constructive role in such contexts, however, there must be less political controversy and more analytical and critical discussion surrounding the concept. [From Rosas, A (1995) ‘The Right to Development’ in Eide, A. & Rosas, A. (eds) (1995) Economic, Social and Cultural Rights (Nijhoff).]

71 Ibid.

72 Piotrowicz & Kaye, op.cit. p.7

73 In 1979, Karel Vasak, a French Jurist at the International Institute of Human Rights in Strasbourg, proposed that this three generation division was based upon the three watchwords of the French Revolution – Liberté, Égalité and Fraternité. First generation rights dealing with liberty being mostly negative rights, second generation rights dealing with equality being mostly positive rights, and third generation rights focusing on fraternity. See http://en.wikipedia.org/wiki/Three_generations_of_human_rights for more discussion.
in that together they form a “...system of norms which function to protect human dignity by thwarting systems of oppression...”\textsuperscript{74} This interdependence has been formally recognized. The Vienna Declaration and Programme of Action states:\textsuperscript{75}

“All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of the States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.”

The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights\textsuperscript{76} also recognize this relationship, by stating in Guideline 4:

“It is now undisputed that all human rights are indivisible, interdependent, interrelated and of equal importance for human dignity. Therefore, States are as responsible for violations of economic, social and cultural rights as they are for violations of civil and political rights.”

The Committee on Economic, Social and Cultural Rights\textsuperscript{77} has also emphasized this notion when it called for equal recognition of

\textsuperscript{74} Winston, M. On the Indivisibility and Interdependence of Human Rights at http://www.bu.edu/wcp/Papers/Huma/HumaWins.htm retrieved 21.04.04


\textsuperscript{76} These Guidelines were formulated by some 30 experts who met at Maastricht from 22-26 January, 1997 for the purpose of elaborating on the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, which had been formulated 10 years previously. The elaboration was specifically in relation to the nature and scope of violations of economic, social and cultural rights and appropriate responses and remedies. A full copy of these guidelines is available from the Netherlands Institute of Human Rights, Faculty of Law – SIM Special 20 @ http://www.uu.nl/uupublish/homerechtsgeleer/onderzoekscholen/sim/english/publications/sim specials/203076/main.html retrieved 20/02/04

\textsuperscript{77} The Committee on Economic, Social and Cultural Rights, Fact Sheet No.16 (Rev.1) – a copy of which can be found at http://www.unhchr.ch/html/menu6/2/fs16.html retrieved 23/11/00.
economic, cultural and social rights with civil and political rights from the perspective of violation. The Committee stated:

"Under international human rights law (as well as in terms of its application at the national level, civil and political rights have, in many respects, received more attention, legal codification and judicial interpretation, and have instilled in public consciousness to a far greater degree, than economic, social and cultural rights. It is therefore sometimes wrongly presumed that only civil and political rights...can be subject to violation, measures of redress and international legal scrutiny. Economic, social and cultural rights are often viewed as effectively "second-class rights" – unenforceable, non-justiciable, only to be fulfilled “progressively” over time.

Such perspectives, however, overlook a postulate of the global human rights system formulated as long ago as 1948 with the adoption of the Universal Declaration of Human Rights, namely, that the indivisibility and interdependence of civil and political rights and economic, social and cultural rights are fundamental tenets of international human rights law. [Emphasis added]. This point of view has been repeatedly reaffirmed, most recently at the World Conference on Human Rights in 1993.

Finally, the resolution of the General Assembly of the United Nations of December, 1977\textsuperscript{78} should be mentioned as it states in para.1:

"(a) All human rights and fundamental freedoms are indivisible and interdependent; equal attention and urgent consideration should be given to the implementation, promotion and protection of both civil and political, and economic, social and cultural rights;

(b) The full realization of civil and political rights without the enjoyment of economic, social and cultural rights is impossible; the achievement of lasting progress in the implementation of human rights is dependent upon sound and effective national and international policies of economic and social development, as recognized by the Proclamation of Teheran of 1968;..."

\textsuperscript{78} Resolution 32/130, 16 December, 1977
The International Covenant on Economic, Social and Cultural Rights

For the purposes of this thesis it is important to provide at this point a brief overview of the ICESCR, for it is the rights identified in this document, and specifically the right to health – and by extension, health care – that is of focus. A more detailed discussion of implementation and enforcement will follow.

The ICESCR\(^79\) contains the rights from the Universal Declaration that were not taken up by the ICCPR. The Covenant was adopted by the General Assembly in 1996.\(^80\) Although the rights only take up 10 articles, they cover a wide range of social, cultural and economic issues. Social security is identified as a fundamental right and the family is recognised as the fundamental unit of society. While Article 11 guarantees the basic elements needed for life, food, shelter and clothing, Article 12 provides that:

(1) The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

(2) The steps to be taken by the State Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:

(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;

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\(^80\) General Assembly resolution 2200 A (XXI) of 16 December 1966.
(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.

Other Articles deal with education and culture, with States required to make primary education free and secondary and tertiary education accessible and available, while individuals are guaranteed the right to take part in cultural life and to 'enjoy the benefits of scientific progress and its application'.

Figure 5

It is worth noting that during the time that the ICESCR was being drafted, another document, the European Social Charter was also being drafted, enshrining economic and social rights. This Charter was signed in 1961 coming into force in 1965. It contained two Articles – 11 and 13 – related to the right to health.

81 The signing of the Civil Rights Act (US), July 2, 1964 extracted from http://www.humanrights.state.mn.us/resources_hp11.html on 21.04.04
82 A full copy of the Charter is available at http://www1.umn.edu/humanrts/euro/z31escch.html
Article 11 entitled – “The Right to Protection of Health” states

"With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed, inter alia

1. to remove as far as possible the causes of ill-health;

2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

3. to prevent as far as possible epidemic, endemic and other diseases [as well as accidents]^83

Article 13. entitled “The Right to Social and Medical Assistance” states, inter alia,

"With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and in case of sickness, the care necessitated by his condition.

2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;...”

^83 This phrase was inserted in the text of the Revised Charter – Strasbourg, 3.V.1996 a full copy of which is available at http://www.ilo.org/english/actv/telediv/global/ilo/law/coesoci.htm
While only Article 13 mentions health care, it has been noted that Article 11 covers an extremely wide field and when it was drafted, was recognised as the most detailed elaboration of the international right to health.\textsuperscript{84} However, in order to provide some further insight into why these provisions are drafted in the manner in which they are, it is useful to note some of the history behind the acceptance of these provisions.

During the drafting of the Charter, a draft on the adoption of a right to health was prepared that had considerable similarities with Article 12 of the ICECSR. This draft read:

"Every person shall have access to facilities for ensuring a high standard of health.

The measures to be taken by the signatory Governments to secure the enjoyment of this right, in cases where the private resources and initiatives of individuals or communities are inadequate, will include;

(a) the reduction of infant mortality and provision for the healthy physical and moral development of the child; assistance to mentally defective children and those deserted or in distress; re-education of maladjusted children;

(b) the improvement of nutrition, housing, children, recreation and other health factors connected with his surroundings;

(c) the prevention, treatment and control of epidemic, endemic and other diseases;

\textsuperscript{84} See Harris, D. \textit{The European Social Charter} (Charlottesville: University Press of Virginia, 1984) at 105. Harris also remarks that there are earlier ILO conventions protecting health in employment, but not health in general.
(d) the organisation of services and facilities to ensure for all effective medical attention in the event of sickness;

(e) free basic medical care and treatment\textsuperscript{85}

Toebes\textsuperscript{86} indicates that when this draft was presented for discussion, some Committee members had difficulty with the provision of 'free basic medical care' as contained in paragraph (e), with the representative from the Netherlands, Mrs Klompe, holding that 'the charter should not proclaim provisions which create false illusions and cannot be implemented in the end'. She also questioned the need to provide everyone with free medical care and treatment, given that individuals should take responsibility for their own medical care, an opinion supported by the representative of the Federal Republic of Germany, Mrs Weber.

Another committee of the Consultative Assembly raised the issue of the role of private organisations in the provision of medical care and indicated that there should be greater emphasis put on the role and responsibility of private organisations. This committee recommended that the role of the State should be to encourage and support such private organisations, intervening only when private services with either absent or inadequate. Other issues that were raised in debate included the role of specialized agencies such as the WHO, UN and the ILO and their relevant charters and obligations and the relationship of these charters to the provisions of the European Social Charter. The differences between the draft provision and the final provision can be seen when the two are


\textsuperscript{86} Ibid, p.65

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compared, however the most significant difference is the absence of paragraph (e) - the provision of free medical care and treatment – of the first draft in the final provision.

It is important for the purposes of this thesis to note that the Charter's Committee of International Experts regards Article 13(1) as granting a justiciable right to social and medical assistance (emphasis added) and has found that several states are 'not in conformity with' their obligations under Article 13(1). Indeed, the Committee commented on the United Kingdom in the following terms:

The Committee recalled that its case law has consistently held that social assistance, as provided for under Article 13 paragraph 1 must be guaranteed to those in need 'as of right' and not depend solely on a decision at the administration 's discretion; and this guarantee must be supported by a right of appeal to an independent body...The Committee concluded that...the United Kingdom is not in conformity with its obligations under this provision of the Charter.\textsuperscript{87}

The significance of these comments will become obvious when the Case Study of the United Kingdom in Chapter 5 of this thesis is read.

**Other Declarations and Conventions**

There are also a large number of additional declarations and conventions that have been adopted at both international and regional levels, focusing either on specific issues (such as the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of 1987) or specific


Within some of these documents, as well as in others, the right to health/health care is specifically addressed and the relevant provisions are set out for reference purposes as these provisions may be referred to in later parts of these thesis.

In relation to health care, the Convention on the Elimination of all Forms of Discrimination Against Women\(^88\) in Article 12 states:

\begin{quote}
1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."
\end{quote}

Article 14(2)(b) of the Convention also guarantees rural women a right of “access to adequate health care facilities, including information, counselling and services in family planning”.

In the Convention on the Rights of the Child\(^89\), Article 24 reads as follows:

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\(^{88}\) A full copy of this Convention is available at [http://www.unhchr.ch/html/menu3/b/c1cedaw.htm](http://www.unhchr.ch/html/menu3/b/c1cedaw.htm)

\(^{89}\) A full copy of this Convention is available at [http://www.unhchr.ch/html/menu3/b/k2crc.htm](http://www.unhchr.ch/html/menu3/b/k2crc.htm)
1. States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with the emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventative health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognised in the present article. In this regard, particular account shall be given of the needs of developing countries."
Leary\textsuperscript{90} describes this provision as 'excellent' and 'far superior' to Article 12 of the ICESCR and Fox & Young\textsuperscript{91} regard this Article as international law's "most elaborate and specific guarantee" in relation to children's right to health.

In the \textit{International Convention of the Elimination of all Forms of Racial Discrimination}\textsuperscript{92}, Article 5 states, \textit{inter alia},

\begin{quote}
In compliance with the fundamental obligations laid down in Article 2 of this Convention, State parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without discrimination as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: ....
\end{quote}

(f) Economic, social and cultural rights, in particular:

.....

(iv) The right to public health, medical care, social security and social services;

In 1991, the UN General Assembly adopted the \textit{Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UN Mental Health Principles)}\textsuperscript{93}. This instrument consists of 25 principles, with the focus of the principles on individuals receiving mental health care, whether or not they have been admitted to a mental health facility. Principle 1 deals with fundamental freedoms and basic rights while others deal with standards to health care and the rights of patients. Principle 23 provides that states "should implement" and "shall

\textsuperscript{90} Leary, V. "Implications of a Right to Health" in Mahoney, K & Mahoney, P. (eds), \textit{Human Rights in the Twenty-First Century: A Global Challenge} (1993) 481, 489 and 491
\textsuperscript{91} Fox, S. Young, D. "International Protection of Children's Right to Health: the Medical Screening of Newborns" (1991) 11 Boston College Third World Law Journal 1
\textsuperscript{92} GOAR 20\textsuperscript{th} Sess, Res. 2016A; UNTS Vol.660, p. 195 as found in Ernacor, F., Nowak, M. & Tretter, H. \textit{International Human Rights - Documents and Introductory Notes} (Law Books in Europe: Vienna, 1993) at p.37. A full copy of this Convention is available at \href{http://www1.umn.edu/humanrts/instree/d1cehrd.htm}{http://www1.umn.edu/humanrts/instree/d1cehrd.htm}
\textsuperscript{93} General Assembly resolution 46/119 of 17 December 1991. A full copy of this document is available at \href{http://www1.umn.edu/humanrts/instree/i2pppmii.htm}{http://www1.umn.edu/humanrts/instree/i2pppmii.htm}
review periodically” the enumerated principles. It should be noted that these principles, like other UN documents, do not impose legally binding obligations, and therefore the impact and effectiveness of the principles will depend on the extent to which they are able to influence domestic law of the states.\textsuperscript{94} It is also significant to note that in a compilation of human rights instruments\textsuperscript{95}, the UN Mental Health Principles run to 13 pages, not an insignificant amount.

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{image.png}
\caption{Figure 6\textsuperscript{96}}
\end{figure}

In 1994, the WHO issued a \textit{Declaration on the Promotion of Patients' Rights in Europe} to which was annexed the \textit{Principles of}

\begin{flushleft}
\textsuperscript{94} See New Zealand's \textit{Mental Health (Compulsory Assessment and Treatment) Act 1992} as an example of implementation.


\textsuperscript{96} Canadian Medic with UNTAC examines an elderly Cambodian man – UN/159762c UN/DPI/J/Isaac retrieved from http://www.un.org/UN50/Photos/90s.html
\end{flushleft}
the Rights of Patients in Europe. This Declaration confirms the intent of the WHO's 'health for all' policy and describes the text as "a set of guidelines which could be used in policy discussions" with the qualification that it "is a matter for decision by countries how they might make use" of the document. Again, while the Declaration does not impose legal obligations, it is important because it addresses the health care rights of all patients in more detail than any previous international initiative. Hunt comments that this document however, "...will certainly assist the drafters of any future international treaty seeking to elaborate patients' health care rights."

The Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families in Article 24 provides for migrant workers to have access to medical care by stating:

"Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm of their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused to them by reason of any irregularity with regard to stay or employment."

Another useful document is the Standard Minimum Rules for the Treatment of Prisoners approved by the UN Economic and Social

Council in 1957. Rules 23 to 26 set out detailed principles for the treatment of sick prisoners, such principles dealing with issues that include the availability of medical services and qualified doctors, as well as the examination of prisoners.

The Declaration on the Rights of Disabled Persons approved by the UN in 1975, provides in Article 6 that:

“Disabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthotic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the processes of their social integration or reintegration.”

Article 24 of the Draft Declaration on the Rights of Indigenous Peoples provides for indigenous peoples to:

“...have the right to their own traditional medicines and health practices, including the right to the protection of vital medicinal plants, animals and minerals...the right to access, without any discrimination, to all medical institutions, health services and medical care.”

The International Labor Organisation’s Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries should

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101 A full copy of this document is available at [http://www1.umn.edu/humanrts/instree/g1smr.htm](http://www1.umn.edu/humanrts/instree/g1smr.htm)
104 This Draft Declaration has been referred to by both the Australian High Court in Commonwealth v Yarrmurr [2001] HCA 56 at 295 per Kirby J and the South Australian Supreme Court in James v Doda [1999] SASC 125 at 59 per Perry J.
105 A full copy of this document can be found at [http://www.ciesin.org/docs/010-282/010-282.html](http://www.ciesin.org/docs/010-282/010-282.html)
also be mentioned. Article 25 of this Convention stipulates the right to health of such peoples in the following terms:

“1. Governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.

2. Health services shall, to the extent possible, be community-based. These services shall be planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventative care, healing practices and medicines.

3. The health care system shall give preference to the training and employment of local community health workers, and focus on primary health care while maintaining strong links with other levels of health care services.

4. The provision of such services shall be co-ordinated with other social, economic and cultural measures in the country.”

The American Convention on Human Rights of November 22, 1969106 recognised a number of economic, social and cultural rights, but did not specifically mention the right to health or health care. What Article 26 of the Convention did state however, was that:

“The States Parties undertake to adopt measures, both internally and through international cooperation, especially those of an economic and technical nature, with a view to achieving progressively, by legislation or other appropriate means, the full realization of the rights implicit in the economic, social, educational, scientific and cultural standards set forth in the Charter of the Organisation of American States as amended by the Protocol of Buenos Aires, Argentina.”

106 Organisation of American States (OAS) Treaty Series No.36. A full copy of this document can be found at http://www1.umn.edu/humanrts/oasinst/zoas3con.htm
In 1988, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, otherwise known as the Protocol of San Salvador, was approved by the OAS General Assembly.\textsuperscript{107} This Additional Protocol in its Preamble, specifically reaffirmed the importance of fundamental economic, social and cultural rights, stating that such rights needed to be "perfeeted, developed and protected in order to consolidate in America, on the basis of full respect for the rights of the individual." Furthermore, the Protocol set out in Article 10, a comprehensive Right to Health in the following terms:

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.

2. In order to ensure the exercise of the right to health, the States Parties agree to recognise health as a public good and, particularly, to adopt the following measures to ensure that right;

   (a) Primary health care, that is, essential health care made available to all individuals and families in the community;

   (b) Extension of the benefits of health services to all individuals subject to the State's jurisdiction;

   (c) Universal immunization against the principal infectious diseases;

   (d) Prevention and treatment of endemic, occupational and other diseases;

   (e) Education of the population on the prevention and treatment of health problems; and

   (f) Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

There are clear similarities between this provision and Article 12 of the ICESCR, with the aspirational first paragraphs having

\textsuperscript{107} OAS Treaty Series No.73 – note: not yet in force. A full copy of this document is
much in common, and Article 12(2)(c) on the prevention and treatment of diseases being close to 10(2)d. What this Article does do however, is to include what Hunt\textsuperscript{108} calls "a relatively precise and measurable obligation" - universal immunization against principal infectious diseases -contained in 10(2)c. It is argued that it is measurable because "...it is easy to ascertain whether or not states have complied with it", and while acknowledging that there may be debate about which are the 'principal' infectious diseases in a particular country, reference to the WHO or other bodies should provide a means for resolution "...while giving the benefit of any reasonable doubt to the state concerned."\textsuperscript{109}

The *African Charter on Human and Peoples Rights* of June, 26, 1981\textsuperscript{110} states in Article 15 that:

1. *Every individual shall have the right to enjoy the best attainable state of physical and mental health.*

2. *State parties in the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.*

Further, the *African Charter on the Rights and Welfare of the Child* \textsuperscript{111} which came into force on November 29, 1999 states in Article 14:

1. *Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.*

\textsuperscript{108} Hunt op.cit. p.119

\textsuperscript{109} Ibid.

\textsuperscript{110} OAU Doc CAB/LEG/67/3/Rev.5. A full copy of this document is available at http://www1.umn.edu/humanrts/instree/e/african.htm

\textsuperscript{111} OAU Doc. CAB/LEG/24.9/49 (1990) a full copy of which is available at http://www1.umn.edu/humanrts/africa/africa.htm
2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:

(a) to reduce infant and child mortality rate;

(b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) to ensure the provision of adequate nutrition and safe drinking water;

(d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;

(e) to ensure appropriate health care for expectant and nursing mothers;

(f) to develop preventative health care and family life education and provision of service;

(g) to integrate basic health service programmes in national development plans;

(h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents;

(i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and management of a basic service programme for children;

(j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.

It is interesting to note that this particular Charter is the first regional and international treaty on the rights of the child. One of the key reasons why this separate Charter came into existence was
that, according to the Institute for Human Rights and Development in Africa\textsuperscript{112}, there was an under-representation of African nations during the drafting process, with only Egypt, Algeria, Morocco and Senegal participating in any meaningful manner. This under-representation meant that issues with specific relevance to the African situation were omitted, these being:

\textit{...the situation of children living under the then prevailing apartheid regime in South Africa, practices and attitudes having a negative effect on the life of the girl child and widespread practices in African society such as female genital mutilation...problems of displaced persons arising from internal conflict, the African conception of the community's responsibilities and duties and the particularly difficult socio-economic conditions of the continent.}\textsuperscript{113}

The \textit{Cairo Declaration on Human Rights in Islam of 1990}\textsuperscript{114} states in Article 17(b)& (c) that:

\begin{quote}

\textit{"Everyone shall have the right to medical and social care, and to all public amenities provided by society and the State within the limits of their available resources.}

\textit{The State shall ensure the right of the individual to a decent living which will enable him to meet all his requirements and those of his dependents, including food, clothing, housing, education, medical care and all other basic needs."}
\end{quote}

There also exist certain United Nations consensus agreements that contain provisions which extrapolate the central tenets of access to health and health care. The Programme of Action of the International Conference on Population and Development (ICPD)\textsuperscript{115} held in Cairo in 1994, specifically requires governments to address the issue of health care in a number of its Chapters.

\textsuperscript{112} \url{http://www.africaninstitute.org/eng/afSystem/child/child.php} retrieved 21.06.05

\textsuperscript{113} Ibid

\textsuperscript{114} UN Doc A/45/421/5/21797. A full copy of this document is available at \url{http://www.humanrights.harvard.edu/documents/regionaldocs/cairo_dec.htm}

\textsuperscript{115} A full copy of this document is available at \url{http://www.un.org/popin/icpd/conference/offeng/poa.html}
### Coverage of adults in developing countries on antiretroviral treatment, by WHO Region, situation as of November 2003

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of people on treatment</th>
<th>Estimated need</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>100 000</td>
<td>4 400 000</td>
<td>2%</td>
</tr>
<tr>
<td>Americas</td>
<td>210 000</td>
<td>250 000</td>
<td>84%</td>
</tr>
<tr>
<td>Europe (Eastern Europe, Central Asia)</td>
<td>15 000</td>
<td>80 000</td>
<td>19%</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>5 000</td>
<td>100 000</td>
<td>5%</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>60 000</td>
<td>900 000</td>
<td>7%</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>10 000</td>
<td>170 000</td>
<td>6%</td>
</tr>
<tr>
<td>All WHO Regions</td>
<td>400 000</td>
<td>5 900 000</td>
<td>7%</td>
</tr>
</tbody>
</table>

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In Chapter 8 under paragraphs 8.3 and 8.4, governments are required to ensure access to ‘basic health care’ and health promotion assigning ‘sufficient resources’ so that ‘primary health services attain full coverage of the population’. Paragraph 8.10 provides that governments must create the environmental conditions for health – access to clean and safe water, waste management – while addressing workplace hazards and air pollution. In the Platform of Action of the Fourth World Conference on Women (FWCW), held in Beijing in 1995, governments were committed in paragraph 106e to “Provide more accessible, available and affordable primary health care services of high quality.”.

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It is important to note that although the UDHR and related covenants are not legally binding documents, nations (states) have endowed them with considerable legitimacy through their actions, including, in particular, the legal and political invocation of the UDHR at national and international levels, through incorporation in numerous national constitutions. Governments also freely refer to the UDHR when accusing other governments of violating human rights. Parties ascribing to the Covenants accept certain procedures and responsibilities, including periodic submission of reports on their compliance with the substantive provisions of the texts. It is however interesting to note that in recent times the Australian Federal Government has been critical of these reporting procedures and of the critical use then made by UN Committees of the material forwarded in compliance.\textsuperscript{118}

There is no doubt that the health impacts are obvious and inherent in the popular understanding of certain severe human rights violations such as those covered by the Conventions mentioned above. Torture, imprisonment, inhumane conditions and rape are just a few of the types of violations that have significant and obvious health impacts, not only from a physical perspective, but from the broader health issues of social and mental well-being, as previously mentioned.\textsuperscript{119}

\textsuperscript{118} See Appendix 1 for information regarding guidelines required for Article 12 of the ICESCR from the Revised Guidelines Regarding the Form and Contents of Reports to be Submitted by States Parties under Articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights [ECOSOC, Official Records, 1992, Supplement No.3 (E/1992/23)]

It is useful therefore at this point, to detail the relevant sections of some of those Constitutions\textsuperscript{120} that have adopted in some form the specific issue of a right to health or a right to healthcare pursuant to Article 12 of the ICESCR so as to see how this issue has been addressed from a compliance perspective. The fact that some Constitutions have included this specific issue, does not address the significant issue of the legal status of these rights. Indeed it has been suggested that: “Written constitutions...are not panaceas for human rights. They are vulnerable both to the cunning of those who draft them and the lack of imagination of those who interpret them”.\textsuperscript{121} However, such recognition does mean that violations of these constitutional provisions theoretically provide a basis for justiciability.

**Constitutions and the Right to Health and/or the Right to Health care**

These Constitutions have been variously sourced.\textsuperscript{122}

**Afghanistan** -

**The Constitution of Afghanistan 1990**

**Article 57**

Citizens of the Republic of Afghanistan have the right to health and social security. The State shall adopt necessary measures for expansion

\textsuperscript{120} The Constitutions listed here are those which were available in English at the time of the preparation of this thesis. It should also be noted that given the volatility of the political situation in certain areas of the world, some of these constitutions may be suspended or amended without the knowledge of the author at the time of the completion of this thesis.

\textsuperscript{121} Robertson, G. *The Justice Game* (Vintage, London, 1999) at p.85

\textsuperscript{122} [http://www.washlaw.edu/forint/alpha/c/constitutionallaw.htm](http://www.washlaw.edu/forint/alpha/c/constitutionallaw.htm); [http://www.confinder.richmond.edu](http://www.confinder.richmond.edu); [http://www.uni-wuerzburg.de/law/home.html](http://www.uni-wuerzburg.de/law/home.html); [http://www.constitution.org/cons.natlcons.htm](http://www.constitution.org/cons.natlcons.htm)
of all round, balanced and countrywide medical services, expansion of hospitals, health centres, training of doctors and personnel for medical services, universal prevention of diseases, expansion of free health services, arrangement of private medical services, improvement of material welfare of the aged, war and work disabled and dependents of martyrs.

Draft Constitution of Afghanistan of 2003

Article Fifty-two Ch. 2, Art. 30

The state is obliged to provide the means of preventive health care and medical treatment, and proper health facilities to all citizens of Afghanistan in accordance with.

The state encourages and protects the establishment and expansion of private medical services and health centers in accordance with law.

The state in order to promote physical education and improve national and local sports adopts necessary measures.

Albania –


Article 55
1. Citizens enjoy in an equal manner the right to health care from the state.
2. Everyone has the right to health insurance pursuant to the procedure provided by law.

Algeria


Article 54 [Healthcare]

(1) All citizens have the right for the protection of their health.
(2) The State ensures the prevention and the fight of endemics and epidemics.
Andorra

Constitution of the Principality of Andorra (adopted 28 April, 1993)

Article 5
The Universal Declaration of Human Rights is binding in Andorra.

Article 30
The right to health protection and to receive services to look after personal needs shall be respected. With that intent the State shall guarantee a system of Social Security.

Angola


Article 47
1. The State shall promote the measures needed to ensure the right of citizens to medical and health care, as well as child, maternity, disability and old-age care, and care in any situation causing incapacity to work.

Argentina

Constitution of the Argentine Nation (Adopted 1853, as amended)

Section 42

As regards consumption, consumers and users of goods and services have the right to the protection of health, safety, and economic interests; to adequate and truthful information; to freedom of choice and equitable and reliable treatment.

The authorities shall provide for the protection of said rights, the education for consumption, the defense of competition against any kind of market distortions, the control of natural and legal monopolies, the control of quality and efficiency of public utilities, and the creation of consumer and user associations.

Legislation shall establish efficient procedures for conflict prevention and settlement, as well as regulations for national public utilities. Such legislation shall take into account the necessary participation of
consumer and user associations and of the interested provinces in the control entities.

**Armenia**

**Constitution of the Republic of Armenia** (Adopted 5 July, 1995)

**Article 34.**

Everyone is entitled to the preservation of health. The provision of medical care and services shall be prescribed by law.

**Azerbaijan**


**Article 41 – Right for protection of health**

1. Everyone has the right for protection of his/her health and for medical care.
2. The state takes all necessary measures for development of all forms of health services based on various forms of property, guarantees sanitary-epidemiological safety, creates possibilities for various forms of medical insurance.
3. Officials concealing facts and cases dangerous for life and health of people will bear legal responsibility.

**Bahrain**

**Constitution of the Kingdom of Bahrain** (14 Feb. 2002)

**Article 8**

(a) Every citizen shall have the right to health welfare. The State shall care for public health and ensure means of prevention and treatment by establishing various kinds of hospitals and provide medical facilities.

(b) Individuals and bodies may establish hospitals, clinics or infirmaries under the supervision of the State and in accordance with the law.
**Bangladesh**

**The Constitution of the People's Republic of Bangladesh**  
(Adopted 16 Dec. 1972 as amended)

**Article 15 – Basic necessities**

It shall be a fundamental responsibility of the State to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens-

- the provision of the basic necessities of life, including food, clothing, shelter, education and medical care;
- the right to work, that is the right to guaranteed employment at a reasonable wage having regard to the quantity and quality of work;
- the right to reasonable rest, recreation and leisure; and
- the right to social security, that is to say to public assistance in cases of undeserved want arising from unemployment, illness or disablement, or suffered by widows or orphans in old age, or in other such cases.

**Belarus**

**The Constitution of the Republic of Belarus**  
(Adopted 1 March, 1994)

**Article 45 [Health]**

Citizens of the Republic of Belarus shall be guaranteed the right to health care, including free treatment at state health-care establishments. The right of citizens of the Republic of Belarus to health care shall also be secured by the development of physical training and sport, means to improve the environment, the opportunity to use fitness establishments, and improvements in occupational safety.

**Belgium**

**Constitution of Belgium**  
(Adopted, 1970)

**Article 23 [Dignity]**

(1) Everyone has the right to lead a life in conformity with human dignity
(2) To this end, the laws, decrees, and rulings alluded to in Article 134 guarantee, taking into account corresponding obligations, economic, social, and cultural rights, and determine the conditions for exercising them.

(3) These rights include notably:

1) the right to employment and to the free choice of a professional activity in the framework of a general employment policy, aimed among others at ensuring a level of employment that is as stable and high as possible, the right to fair terms of employment and to fair remuneration, as well as the right to information, consultation and collective negotiation;

2) the right to social security, to health care and to social, medical, and legal aid;

3) the right to have decent accommodation;

4) the right to enjoy the protection of a healthy environment;

5) the right to enjoy cultural and social fulfillment.

**Brazil**

**Constitution of the Federative Republic of Brazil** (Adopted 5 Oct. 1988)

**Article 6.**

Education, health, work, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute, are social rights, as set forth by this Constitution.

**Bulgaria**

**Constitution of Bulgaria** (Adopted 12 July, 1991)

**Article 52 [Health Care]**

(1) Citizens shall have the right to medical insurance guaranteeing them affordable medical care, and to free medical care in accordance with conditions and procedures established by law.

(2) Citizens' medical care shall be financed from the state budget, by employers, through private and collective health-insurance schemes, and
from other sources in accordance with conditions and procedures established by law.

(3) The state shall protect the health of citizens and shall promote the development of sports and tourism.

(4) No one shall be subjected to forcible medical treatment or sanitary measures except in circumstances established by law.

(5) The state shall exercise control over all medical facilities and over the production and trade in pharmaceuticals, biologically active substances, and medical equipment.

Cambodia

Constitution of Cambodia (Adopted 21 Sept., 1993)

Article 31 -
- The Kingdom of Cambodia shall recognize and respect human rights as stipulated in the United Nations Charter, the Universal Declaration of Human Rights, the covenants and conventions related to human rights, women's and children's rights.

Article 72 -
- The health of the people shall be guaranteed. The State shall give full consideration to disease prevention and medical treatment. Poor citizens shall receive free medical consultation in public hospitals, infirmaries and maternity units.
- The State shall establish infirmaries in rural areas.

Cape Verde


Article 68 (Health)

1. Everyone shall have the right to health and the duty to defend and promote it, irrespective of his economic condition.

2. The right to health shall be achieved through an adequate network of health services and the gradual creation of economic, social and cultural conditions necessary to guarantee the improvement of quality of life of the populations.
3. With a view to guaranteeing the right to health, the State shall, namely:

a) Ensure, in conformity with the economic resources available, a national, universal and hierarchical health service, based on complete coverage, priority being given to preventive activities.

b) Encourage the participation of the community in different levels of health services;

c) Coordinate and discipline public and private initiatives in the field of health;

d) Discipline and control the production, commercialization and the use of the chemical, biological, pharmaceutical and other means of treatment, as well as the diagnoses.

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**Figure 8**

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**Chechnya**

**Constitution of the Chechen Republic** (Adopted 27 March, 2003)

**Article 30.**

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123 Map of the Caribbean region retrieved from [http://www.geographic.org/maps/caribbean_maps.html](http://www.geographic.org/maps/caribbean_maps.html) - 17.06.2005
The citizens of Chechen Republic have the right to protection of health, charge-free use state medical establishments, as well as paid medical service rendered by establishments of public health services, The state takes measures directed on increase of quality of medical service.

Chile

Political Constitution of the Republic of Chile (Adopted 29 Sept., 1986)

Article 9  The right to protection of health.

The State protects the free and egalitarian access to actions for the promotion, protection and recovery of the health and rehabilitation of the individual.

The coordination and control of activities related to health shall likewise rest with the State.

It is the prime duty of the State to guarantee health assistance, whether undertaken by public or private institutions, in accordance with the form and conditions set forth in the law which may establish compulsory health quotations.

Each person shall have the right to choose, the health system he wishes to join, either State or private-controlled.

China

Constitution of the People's Republic of China (Adopted 4 Dec., 1982)

Article 21 [Health]

(1) The state develops medical and health services, promotes modern medicine and traditional Chinese medicine, encourages and supports the setting up of various medical and health facilities by the rural economic collectives, state enterprises and undertakings and neighborhood organizations, and promotes public health activities of a mass character, all to protect the people's health.

(2) The state develops physical culture and promotes mass sports activities to build up the people's physique
Columbia

Political Constitution of Columbia of 1991

Article 44.

The following are basic rights of children: life, physical integrity, health and social security, a balanced diet, their name and citizenship, to have a family and not be separated from it, care and love, instruction and culture, recreation, and the free expression of their opinions. They will be protected against all forms of abandonment, physical or moral violence, imprisonment, sale, sexual abuse, work or economic exploitation, and dangerous work. They will also enjoy other rights upheld in the Constitution, the laws, and international treaties ratified by Colombia.

Article 49.

Public health and environmental protection are public services for which the state is responsible. All individuals are guaranteed access to services that promote, protect, and rehabilitate public health.

It is the responsibility of the state to organize, direct, and regulate the delivery of health services and of environmental protection to the population in accordance with the principles of efficiency, universality, and cooperation, and to establish policies for the provision of health services by private entities and to exercise supervision and control over them. In the area of public health, the state will establish the jurisdiction of the nation, territorial entities, and individuals, and determine the shares of their responsibilities within the limits and under the conditions determined by law. Public health services will be organized in a decentralized manner, in accordance with levels of responsibility and with the participation of the community.

The law will determine the limits within which basic care for all the people will be free of charge and mandatory.

Every person has the obligation to attend to the integral care of his/her health and that of his/her community.

Article 50.

Any child under a year old who may not be covered by any type of protection or social security will be entitled to receive free care in all health institutions that receive state subsidies. The law will regulate the matter.
Congo

Constitution of the Congo (Approved 15 March, 1992)

Article 34 [Health, Aged, Handicapped]

(1) The State is the guarantor of public health. Every citizen shall have the right to a level of life sufficient to assure his health, his well-being and that of his family, notably food, clothing, shelter, medical care as well as necessary social services.

(2) The right to create private socio-sanitation establishments shall be guaranteed. Socio-sanitation establishments shall be submitted to the approval of the state and regulated by law.

(3) Aged or handicapped persons shall have the right to specific measures of protection coinciding with their physical and moral needs.

Croatia

Constitution of the Republic of Croatia (Adopted 1990, as amended April 2001)

Article 58 [Health Care]

Everyone shall be guaranteed the right to health care, in conformity with the law.

Cuba

Constitution of the Republic of Cuba 1992

Article 9.

The state:...

(c) as the power of the people and for the people guarantees

that no sick person be left without medical care.

Czech Republic

Article 10 [Human Rights Treaties]

Ratified and promulgated international accords on human rights and fundamental freedoms to which the Czech Republic has committed itself, are immediately binding and are superior to law.

*East Timor (Constitution of 2002)*

**Section 57 – Health**

1. Everyone has the right to health and medical care, and the duty to protect and promote them.

2. The State shall promote the establishment of a national health service that is universal and general. The national health service shall be free of charge in accordance with the possibilities of the State and in conformity with the law.

3. The national health service shall have, as much as possible, a decentralised participatory management.

*Egypt*

**Constitution of the Arab Republic of Egypt** (issued 11 Sept., 1971)

**Article 16**

The State shall guarantee cultural, social and health services and shall work to ensure them particularly for villagers in an easy and regular manner in order to raise their standard.

**Article 17**

The State shall guarantee social and health insurance services. All citizens shall have the right to pensions in cases of incapacity, unemployment, and old-age in accordance with the law.

*Ethiopia*

**Constitution of the Federal Democratic Republic of Ethiopia** (1994)
Article 41

4. The State shall allocate progressively increasing funds for the purposes of promoting the people's access to health, education and other social services.

Eritrea

Constitution of Eritrea (Adopted July 1996)

Article 21 Economic, Social and Cultural Rights and Responsibilities

(1) Every citizen shall have the right of equal access to publicly funded social services. The State shall endeavor, within the limit of its resources, to make available to all citizens health, education, cultural and other social services.

Estonia

Constitution of Estonia (Adopted 28 June, 1992)

Article 28 [Welfare Rights]

(1) Everyone shall have the right to health care. Estonian citizens shall be entitled to state assistance in the case of old age, inability to work, loss of provider, and need. The categories, the extent, and the conditions and procedures for assistance shall be determined by law. Unless otherwise determined by law, this right shall exist equally for Estonian citizens and citizens of foreign states and stateless persons who are present in Estonia.

(2) The state shall encourage voluntary and local government social care.

(3) Families with many children and the disabled shall be entitled to special care by state and local authorities.

Finland

Constitution of Finland (Adopted 11 June, 1999)

Section 19 The right to social security
(3) The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population.

Figure 9

Georgia

Constitution of Georgia (based upon the Referendum of 1991)

Article 37

1. Everyone has the right to health insurance as a means of gaining medical assistance. In circumstances determined by law, free medical services are guaranteed.

2. The state supervises every health institution and the production and distribution of medicine.

3. Everyone has the right to live in a healthy environment and use natural and cultural surroundings. Everyone is obliged to protect the natural and cultural surroundings.

4. The state guarantees the protection of nature and the rational use of it to ensure a healthy environment, corresponding to the ecological and economic interests of society, and taking into account the interests of current and future generations.

5. Individuals have the right to complete, objective and timely information on their working and living conditions.

Greece

Constitution of Greece (Effective from 11 June, 1975 as amended)

Article 21

4. The State shall care for the health of citizens and shall adopt special measures for the protection of youth, old age, disability and for the relief of the needy.

Guyana


Article 24

Every citizen has the right to free medical attention and also to social care in case of old age and disability.

Haiti

Constitution of Haiti (Pronounced 10 March, 1987)

Article 19

The State has the absolute obligation to guarantee the right to life, health, and respect of the human person for all citizens without distinction, in conformity with the Universal Declaration of the Rights of Man.

Article 23

The State has the obligation to ensure for all citizens in all territorial divisions appropriate means to ensure protection, maintenance and restoration of their health by establishing hospitals, health centers and dispensaries.
Hungary


Article 70D [Health, Safety]

(1) Everyone living in the territory of the Republic of Hungary has the right to the highest possible level of physical and mental health.

(2) The Republic of Hungary shall implement this right through institutions of labor safety and health care, through the organization of medical care and the opportunities for regular physical activity, as well as through the protection of the urban and natural environment.

Iran


Article 29 [Welfare Rights]

(1) To benefit from social security with respect to retirement, unemployment, old age, disability, absence of a guardian, and benefits relating to being stranded, accidents, health services, and medical care

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125 Mrs Roosevelt holds a Declaration of Human Rights poster, Lake Success, New York, Nov. 1949 – retrieved from [http://www.un.org/UN50/Photos/40s.html](http://www.un.org/UN50/Photos/40s.html) on 27/04/04
and treatment, provided through insurance or other means, is accepted as a universal right.

(2) The government must provide the foregoing services and financial support for every individual citizen by drawing, in accordance with the law, on the national revenues and funds obtained through public contributions.

**Iraq**

**Interim Constitution of Iraq** (Adopted 1990)

**Article 33 [Health]**

The State assumes the responsibility to safeguard the public health by continually expanding free medical services, in protection, treatment, and medicine, within the scope of cities and rural areas.

**Italy**

**Constitution of Italy** (Adopted 22 Dec., 1947)

**Article 32 [Health]**

(1) The republic protects individual health as a basic right and in the public interest; it provides free medical care to the poor.

(2) Nobody may be forcefully submitted to medical treatment except as regulated by law. That law may in no case violate the limits imposed by the respect for the human being.

**Japan**

**Constitution of Japan** (Adopted 3 Nov., 1946)

**Article 25 [Welfare Rights]**

(1) All people shall have the right to maintain the minimum standards of wholesome and cultured living.

(2) In all spheres of life, the State shall use its endeavors for the
promotion and extension of social welfare and security, and of public health.

Kazakhstan

Constitution of the Republic of Kazakhstan

Article 29

1. Citizens of the Republic of Kazakhstan shall have the right to protection of health.

2. Citizens of the Republic shall be entitled to free, guaranteed, extensive medical assistance established by law.

3. Paid medical treatment shall be provided by state and private medical institutions as well as by persons engaged in private medical practice on the terms and according to the procedures stipulated by law.

Kuwait

Constitution of Kuwait (Adopted 11 Nov., 1962)

Article 11 [Old Age Protection]
The State ensures aid for citizens in old age, sickness, or inability to work. It also provides them with services of social security, social aid, and medical care.

Article 15 [Health Care]
The State cares for public health and for means of prevention and treatment of diseases and epidemics.

Laos


Article 26

Lao citizens have the right to work and engaged in occupations which are not against the law. Working people have the right to rest, to receive
medical treatment in the time of ailment, to receive assistance in case of incapacity and disability, in old age, and other cases as prescribed by law.

Latvia


Article 111 [Health]
The State shall protect human health and guarantee a basic level of medical assistance for everyone.

(Note – this was the former provision contained in The Rights and Obligations of a Citizen and a Person, adopted 10 Dec., 1991)

Article 37

(1) Everyone has the right to medical care.

(2) Everyone has the responsibility to care for their own health and that of their family and society.

(3) The State protects the health of the public and guarantees each person with the minimum level of medical assistance determined by law.

Lithuania


Article 53

(1) The State shall take care of people’s health and shall guarantee medical aid and services in the event of sickness. The procedure for providing medical aid to citizens free of charge at State medical facilities shall be established by law.

(2) The State shall promote physical culture of the society and shall support sports.

(3) The State and each individual must protect the environment from harmful influences

Libya
Constitutional Proclamation of Libya (Adopted 11 Dec., 1969)

Article 15 [Health]

Health care is a right guaranteed by the State through the creation of hospitals and health establishments in accordance with the law.

Figure 11\textsuperscript{126}

\textit{Liechtenstein}

Constitution of the Principality of Liechtenstein (As at 5 Oct., 1921)

Art. 18

The State shall be responsible for the public health system, assist institutions for the care of the sick, and seek by legislation to combat intemperance and to reform alcoholics and work-shy persons.

\textit{Macedonia}


Article 39

(1) Every citizen is guaranteed the right to health care.

\textsuperscript{126} Map of Libya retrieved from http://www.geographic.org/maps/libya_maps.html - 17.06.2005
(2) Citizens have the right and duty to protect and promote their own health and the health of others.

_Madagascar_

**Constitution of Madagascar** (Adopted 19 Aug., 1992)

**Article 19 [Health, No Abortion]**

The State shall recognize every individual's right protection of his health, starting from conception.

_Malawi_

**Constitution of the Republic of Malawi** (Adopted 16 May, 1994)

**Article 13**

The State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving the following goals ....

(d) Health – to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care.

_Mali_

**Constitution of the Republic of Mali**

**Article 17**

Education, instruction, training, employment, housing, leisure, health and social protection constitute some of the recognized rights.

_Moldova_

**Constitution of the Republic of Moldova** (Adopted 29 July, 1994)
Article 36 – The Right of Health Security

(1) The right of health security is guaranteed.

(2) The State shall provide a minimum health insurance, that is free.

(3) Organic laws will establish the structure of the national health security system and the means necessary for protecting individual physical and mental health.

Mongolia

Constitution of Mongolia (Adopted 13 Jan., 1992)

Article 16

6) The right to the protection of health and medical care. The procedure and conditions of free medical aid are determined by law.

Mozambique

Constitution of Mozambique (Adopted and enacted Nov. 1990)

Article 94

All citizens shall have the right to medical and health care, within the terms of the law, and shall have the duty to promote and preserve health.

Netherlands

Constitution of the Netherlands (Adopted 27 Feb., 1983)

Article 22 [Health]

(1) The authorities shall take steps to promote the health of the population.
(2) It shall be the concern of the authorities to provide sufficient living accommodation.
(3) The authorities shall promote social and cultural development and leisure activities
Nigeria


Article 17 (3)

The State shall direct its policy towards ensuring that –

(d) there are adequate medical and health facilities for all persons:

North Korea

Socialist Constitution of the Democratic People’s Republic of Korea

Article 56

The State shall consolidate and develop the system of universal free medical service, and consolidates the section doctor system and the system of preventive medicine to protect people’s life and improve working people’s health.

Northern Cyprus

Constitution of the Turkish Republic of Northern Cyprus
(Adopted 15 Nov., 1983)

127 Mozambique villagers, the focus of UNICEF HIV/AIDS education from http://www.unicef.org/ mozambique/late_news.htm#97859685706985 retrieved 17.06.2005
**Right to Health:**

**Article 45**

It shall be the duty of the State to ensure that every person enjoys sound physical and mental health and receives medical attention.

**Oman**

**The Basic Law of the Sultanate of Oman** (Adopted 6 Nov., 1996)

**Article 12 [Social Principles]**

- The State cares for public health and for the prevention and treatment of diseases and epidemics. It endeavours to provide health care for every citizen and to encourage the establishment of private hospitals, clinics and other medical institutions under State supervision and in accordance with the rules laid down by Law.

**Pakistan**

**Constitution of the Islamic Republic of Pakistan** (Reinstated 2002)

**Article 38**

The State shall:

(d) provide basic necessities of life, such as food, clothing, housing, education and medical relief, for all such citizens irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment.

**Paraguay**

**Article 68 About Health Rights/ the Right to Health**

(1) The State will protect and promote human health as a fundamental right of each person and in the best interests of the community.

(2) No one will be deprived of public assistance to prevent or treat diseases, pests, or plague or of aid in case of disasters or accidents.

(3) Everyone must observe the health measures established by law, within a framework of respect for human dignity.
Article 69 About the National Health System

The State will promote a national health system to implement comprehensive health actions through policies that will result in concerted actions and in the coordination of related programs and resources from the private and public sectors.

Figure 13

Peru

Constitution of the Republic of Peru

Article 7

Everyone has the right to protection of his health and of the family environment and community and a duty to contribute to the betterment and defence. Anyone unable to take care of himself because of a physical or mental deficiency has the right to respect for his dignity and to a legal system of protection, care, rehabilitation, and security.

Article 9

The government determines national health policy. The Executive Branch regulates and oversees its application. It is responsible for

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128 Representation of Mestizos during Latin American colonial period. Mestizos make up 95% of the population in Paraguay, being of mixed European and Amerindian ancestry. Picture found at http://en.wikipedia.org/wiki/Mestizo retrieved 17.06.05
designing and directing it in a pluralistic, decentralizing manner in order to guarantee everyone equal access to health services.

**Philippines**

**1987 Constitution of the Republic of the Philippines**

**Article XIII – Health**

Section 11. The State shall adopt an integrated and comprehensive approach to health development which shall endeavour to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women and children. The State shall endeavour to provide free medical care to paupers.

**Poland**

**Constitution of Poland** (Adopted 2 April, 1997)

**Article 68**

(1) Everyone shall have the right to have his health protected.

(2) Equal access to health care services, financed from public funds, shall be ensured by public authorities to citizens, irrespective of their material situation. The conditions for, and scope of, the provision of services shall be established by statute.

(3) Public authorities shall ensure special health care to children, pregnant women, handicapped people and persons of advanced age.

(4) Public authorities shall combat epidemic illnesses and prevent the negative health consequences of degradation of the environment.

(5) Public authorities shall support the development of physical culture, particularly amongst children and young persons.

**Portugal (Constitution of 1976)**

**Constitution of the Portuguese Republic** (4th Revision, 1997)

**Article 64**

**Health**

1. Everyone has the right to have his or her health safeguarded and the duty to defend and foster it.
2. The right to the safeguarding of health shall be met by:

a. A national health service available to all and free of charge to the extent that the economic and social conditions of citizens require;

b. The creation of economic, social, cultural and environmental conditions that guarantee, specifically, the protection of children, the young and the old; the systematic improvement of living and working conditions; the promotion of physical fitness and sports in schools and among the people; the development of health education for the people and practices of healthy living.

3. In order to ensure the right to the safeguarding of health, the State has a primary duty:

a. To guarantee the access of all citizens, regardless of their economic circumstances, to both preventive and remedial medical care and rehabilitation;

b. To guarantee a rational and efficient coverage of health human resources and units throughout the whole country;

c. To direct its programme towards the provision of the costs of medical care and medicines from public funds;

d. To regulate and supervise privately funded medical practice, coordinating it with the national health service so as to ensure that adequate standards of efficiency and quality are achieved in public and private health institutions.

e. To regulate and supervise the production, distribution and marketing and the use of chemical, biological and pharmaceutical products and other methods of treatment and diagnosis.

f. To establish policies for the prevention and treatment of drug abuse.

4. The national health service shall have a decentralised management in which the beneficiaries participate.

_Qatar_

_Constitution of Qatar_

**Article 23**

The State shall care for the public health and provide means of prevention from diseases and epidemics, and medical treatment according to the law.
Romania


Article 33 [Health]

(1) The right to the protection of health is guaranteed.

(2) The State shall be bound to take measures to ensure public hygiene and health.

(3) The organization of the medical care and social security system in case of sickness accidents, maternity, and recovery, the control over the exercise of medical professions and paramedical activities, as well as other measures to protect physical and mental health of person shall be established according to the law.

Russia


Article 41. Health Care

1. Everyone shall have the right to health care and medical assistance. Medical assistance shall be made available by state and municipal health care institutions to citizens free of charge, with the money from the relevant budget, insurance payments and other revenues.

2. The Russian Federation shall finance federal health care and health-building programs, take measures to develop state, municipal and private health care systems, encourage activities contributing to the strengthening of the man's health, to the development of physical culture and sport, and to ecological, sanitary and epidemiologic welfare.

3. Concealment by officials of facts and circumstances posing hazards to human life and health shall involve liability in conformity with the federal law.

**Saudi Arabia**

*Constitution of the Kingdom of Saudi Arabia* (Adopted March 1992)

**Article 31 [Health Care]**

The state takes care of health issues and provides health care for each citizen.

**Serbia and Montenegro**

*State Union of Serbia and Montenegro – 2002*

*Charter of Human and Minority Rights and Civil Liberties*

**The Right to Health Care**

**Article 45**

Everyone shall have the right to health care.

The Member States shall ensure health care for children, pregnant women and old persons if they are not entitled to this right on another basis.
Republic of the Seychelles

Article 29.

The state recognizes the right of every citizen to protection of health and to the enjoyment of the highest attainable standard of physical and mental health and with a view to establishing the effective exercise of this right, the State undertakes –

(a) to take steps to provide for free primary health care in State institutions for all its citizens;

(b) to take appropriate measures to prevent, treat and control epidemic, endemic and other diseases;

(c) to take steps to reduce infant mortality and promote the healthy development of the child;

(d) to promote individual responsibility in health matters;
(e) to allow, subject to such supervision and conditions as are necessary in a democratic society, for the establishment of private medical services.

Sierra Leone

Constitution of Sierra Leone, 1991

Article 8

(1) The Social order of the State shall be founded on the ideals of Freedom, Equality and Justice.

...

(2) The State shall direct its policy towards ensuring that:

(d) there are adequate medical and health facilities for all persons, having due regard to the resources of the State.

Slovakia

Constitution of the Slovak Republic ( Adopted 1 Sept., 1992)

Article 40

Everyone has a right to the protection of his health. Based on public insurance, citizens have the right to free health care and to medical supplies under conditions defined by law.
Slovenia

Article 51 Health Care

(1) Each person shall have the right to health care as determined by statute.

(2) Rights to government-financed health care shall be regulated by statute.

(3) No person shall be compelled to undergo medical treatment except in such cases as are determined by statute.

Somaliland

Constitution of the Republic of Somaliland (Adopted 21 May, 2001)

Article 17: Health

In order to fulfil a policy of promoting public health, the state shall have the duty to meet the country's needs for equipment to combat communicable diseases, the provision of free medicine, and the care of the public welfare.

1. The state shall be responsible for the promotion and the extension of healthcare and private health centres
South Africa


Section 27 Health care, food, water and social security

(1) Everyone has the right to have 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.

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

(3) No one may be refused emergency medical treatment.

Section 28 Children

(1) Every child has the right -

(c) to basic nutrition, shelter, basic health care services and social services;

South Korea

Article 36 [Marriage, Family, Mothers, Health]

(3) The health of all citizens is protected by the State.

Spain

Constitution of Spain

Article 43 [Health Protection, Sports, Leisure]

(1) The right to health protection is recognized.

(2) It is incumbent upon the public authorities to organize and watch over public health and hygiene through preventive measures and through necessary care and services. The law shall establish the rights and duties of all in this respect.

(3) The public authorities shall foster health education, physical education, and sports. Likewise, they shall facilitate adequate utilization of leisure.

Sri Lanka


[31 Segregated stands in sports arena, Bloemfontein, South Africa, 6/69. UN# 177913, UN/DP1/H.Vassel retrieved from http://www.un.org/UN50/Photos90s.html on 22/04/04]
Article 50

(v) The realisation of an adequate standard of living for all citizens and their families including adequate food, clothing, housing and medical care;

Suriname

Constitution of Suriname, 1987

Article 36 – HEALTH

1. Everyone shall have a right to health.

2. The State shall promote the general health care by systematic improvement of living and working conditions and shall give information on the protection of health.

Figure 17132

Switzerland

Federal Constitution of the Swiss Confederation (As at 18 April, 1999)

Article 41

(1) The Confederation and the Cantons shall strive to ensure that, in addition to personal responsibility and private initiative, a. every person shall benefit from social security; b. every person shall benefit from necessary health care;

(2) The Confederation and the Cantons shall strive to ensure that every person shall be insured against the economic consequences of old age, disability, illness, accidents, unemployment, maternity, orphanhood, and widowhood.

(3) They shall strive to realize the social goals within the framework of their constitutional powers and with the means available to them.

**Syria**

**Constitution of Syria** (Adopted 13 March, 1973)

**Article 46 [Insurance, Welfare]**

(1) The state insures every citizen and his family in cases of emergency, illness, disability, orphanhood, and old age.
(2) The state protects the citizens' health and provides them with the means of protection, treatment, and medication.

**Article 47 [Services]**

The state guarantees cultural, social, and health services. It especially undertakes to provide these services to the village in order to raise its standard.

**Tajikistan**

**Constitution of the Republic of Tajikistan, 1994**

**Article 38:**

Each person has the right to health care. This right is ensured through free medical assistance in governmental health care institutions, measures to improve the condition of the environment, formation and development of mass athletics, physical fitness, and other sports. Other forms of medical assistance to be provided are determined by law.

**Thailand**

**Constitution of the Kingdom of Thailand, 1997**

Section 52.
A person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from public health centres of the State, as provided by law.

The public health service by the State shall be provided thoroughly and efficiently and, for this purpose, participation by local government organisations and the private sector shall also be promoted insofar as it is possible.

_Tibet_

_Constitution of Tibet_ (Adopted 14 June, 1991)

_Article 18 Health_

(1) The Tibetan Administration shall endeavor to promote adequate health, medical and sanitation services, and provide free medical treatment. It shall conduct special medical care programs for immunization and chronic illnesses; and educate people on environmental issues.

(2) In particular, it shall endeavor to promote the Tibetan pharmacy and the practice of ancient astro-medical sciences, and conduct comparative research in the fields of Tibetan and modern astro-medical sciences,

(3) The manufacture and prescription of Tibetan pharmaceutical medicines shall be authorized, regulated and standardized in accordance with the law.

_Tunisia_

_Constitution of Tunisia_ (Adopted I June, 1959)

_Preamble_

... We proclaim that the republican regime constitutes:
- the best guarantee for the respect of rights and duties of all citizens;
- the most effective means for assuring the prosperity of the nation through economic development of the country and the utilization of its riches for the benefit of the people;
- the most certain way for assuring the protection of the family and guaranteeing to each citizen work, health, and education.
Turkey

Constitution of the Republic of Turkey (As amended 17 Oct., 2001)

Article 56

Everyone has the right to live in a healthy, balanced environment. It is the duty of the State and the citizens to improve the natural environment, and to prevent environmental pollution.

To ensure that everyone lead their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased productivity, the State shall regulate central planning and functioning of the health services.

The State shall fulfil this task by utilizing and supervising the health and social assistance institutions, in both the public and private sectors. In order to establish widespread health services general health insurance may be introduced by law.

Turkmenistan

Constitution of Turkmenistan (Adopted 18 May, 1992)

Article 33

Citizens have the right to health protection, including use, free of charge, of the government network of health care institutions. Paid medical assistance is permitted in accordance with and in the manner established by law.

Uganda


XX. Medical Services

The State shall take all practical measures to ensure the provision of basic medical services to the population.
Ukraine

Constitution of the Ukraine (Adopted 28 June, 1996)

Article 49

- Everyone has the right to health protection, medical care and medical insurance.
- Health protection is ensured through state funding of the relevant socio-economic, medical and sanitary, health improvement and prophylactic programmes.
- The State creates conditions for effective medical service accessible to all citizens. State and communal health protection institutions provide medical care free of charge; the existing network of such institutions shall not be reduced. The State promotes the development of medical institutions of all forms of ownership.
- The State provides for the development of physical culture and sports, and ensures sanitary-epidemic welfare.

Uzbekistan


Article 40

Every person has the right to professional medical care.

Vietnam

Constitution of the Socialist Republic of Vietnam, 1992

Article 61

The citizen is entitled to a regime of health protection.

The State shall establish a system of hospital fees, together with one of exemption from and reduction of such fees.

The citizen has the duty to observe all regulations on disease prevention and public hygiene.

It is strictly forbidden to produce, transport, deal in, store and use unlawfully opium and other narcotics. The State shall enact regulations on compulsory treatment of drug addiction and treatment of dangerous social diseases.
Yemen

Constitution of the Republic of Yemen, 1994

Article (54)

Health care is a right for all citizens, the state shall guarantee this by building various hospitals and health establishments and expanding their care. The law shall organize the medical profession, the expansion of free health services and health education among the citizens.

Figure 18

It is clear therefore that since 1948, the promotion and protection of human rights have received increased attention from communities and nations around the world and that the right to health or health care is one these rights. What is more unclear however are the structural and substantive boundaries of human rights and how these boundaries impact upon the ability of human rights activists to bring to account those nations states and individuals who are perceived to be in violation of their constitutional and covenant-based obligations.

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133 Women at a UNICEF-assisted family planning clinic, Settat, Morocco, 7/87 – UN#156359c UN/DP/I.Isaac retrieved from http://www.un.org/UN50/Photos/90s.html
It is useful to provide at this point, given the proposition that there are problems in clearly identifying the structural and substantive boundaries of human rights, of how the content of legal rights is determined, so that a clearer understanding of the complex nature of human rights can be understood.

Legal rights are said to be ‘institutional’ – that is, they are created by a society, specifically defined and then maintained by the legal system in that society.134

Kinley135 quite rightly proposes that human rights do possess “non-legal dimensions”136 and are therefore capable of expression in non-legal terms. Indeed, it is within the context of moral or ethical debate that human rights and the obligations they impose are generally discussed and debated, as human rights are generally claimed to operate at a moral level. It can also be argued that while questions as to the true nature of human rights remain within the parameters of philosophical debate, there is no need for politicians to fear, for there is no reason to believe that substantive or structural definitions or boundaries will be found or even if found, implemented in any constructive manner. Kinley points out that there is however, some overlap between the philosophical and legal dimensions of human rights at the ‘conceptual level’ as well as at the practical implementation level, commenting further that the extent of such overlap will depend on the “perspective of the observer”.137

136 Ibid, p.2
137 Ibid, p.3
Chapter Four

DEFINING AND CONFINING HEALTH CARE AND HUMAN RIGHTS

"Give us grace, O God, to dare to do the deed which we well know cries out to be done. Let is not hesitate because of ease, or the words of people's mouths, or our own lives. Mighty causes are calling us – the freeing of women, the training of children, the putting down of hate and murder and poverty – all these and more. But they all call with voices that mean work and sacrifice and death. May we find a way to meet the task.

- W.E.B. Du Bois (1868-1963)

'ADEQUATE' OR 'BASIC' HEALTH CARE – A DEFINITIONAL PROPOSAL

As mentioned in the introduction to this thesis, in 1963, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research released its report entitled Securing Access to Health Care for All wherein it concluded that "...society has an ethical obligation to ensure equitable access to health-care for all"\textsuperscript{138}. Within this report the Commission specified four reasons why access to health-care is a matter of equity and justice and these reasons are:

1. That health care provides a central contribution to the promotion of personal well-being, by "preventing

pain, suffering, and disability and by avoiding loss of life".  

2. That health care can broaden the range of a person's opportunities, "..that is, the array of life plans that is reasonable to pursue within the conditions obtaining in society".  

3. That health care "..has the ability to relieve worry and enable patients to adjust to their situation by supplying reliable information about their health".  

4. That health has a special interpersonal significance – "Health care expresses and nurtures bonds of empathy and compassion. The depth of a society's concerns about health can be seen as a measure of its sense of solidarity in the face of suffering and death...[and] reflects some of its most basic attitudes about what it is to be a member of the human community."  

The report also recommended that the right to health care should be viewed from a human rights perspective or approach, as such an approach acknowledges that all persons, irrespective of their social status, financial position or personal merit, are entitled to basic and adequate health care.

\[\textbf{References} \]

139 ibid. p.16  
140 ibid.  
141 ibid. p.17  
142 ibid.
There were seven reasons identified as the basis for this human rights approach and these are as follows:

1. A human rights approach focuses on both the ethical and normative foundations of health care reform. In other words, it is fundamentally wrong for major decisions affecting all members of society to be made on economic grounds alone, as consideration must be given to the ethical issues of what members of society owe one another because of their status as members. A human rights approach would ensure that the moral claims of individuals are clarified and the boundaries of societal obligation are identified and resolved.

2. A human rights approach provides solid criteria for the development and evaluation of proposals for shaping health care reform. As will be discussed below, this provides for the clear identification of specific obligations and commitments within the parameters of the available resources.

3. A human rights approach provides for the possibility of meaningful and fundamental health care reform. The argument presented and substantiated by such writers as

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Donnelly\textsuperscript{144} and Brock\textsuperscript{145} is that because the most important political issues are framed as rights issues, the only way of moving the issue of the right to health-care forward is to ensure that it is seen as an important political issue. As Brock stated, "\textit{In the real word of politics and policy in the United States, the strongest moral claims, and in particular, the strongest claims grounded in justice, were and are expressed in terms of rights.}"\textsuperscript{146}

4. A human rights approach emphasises the importance of ensuring that health care reforms respond to the needs of the most marginalised and vulnerable groups within society. Therefore, an approach based upon such a response will assist in countering the much greater influence of the affluent and powerful individuals and interest groups that are seen as the significant shapers of health care policy and reform, thus producing greater justice and equity within the system, benefiting all members of society. One needs only to look at the significant influence that the Australian Medical Association has had and continues to


\textsuperscript{146} Ibid, p.69
have in the shaping of health policy in Australia for a clear example of this issue.\textsuperscript{147}

5. **A human rights approach provides for a series of specific and commanding obligations on government which extend far beyond the constraints of cost-containment or moves to increase efficiency within the health care system.** As Chapman\textsuperscript{148} states, "A secure and meaningful right to health care cannot be equated simply with legal recognition or the establishment of a nominal entitlement. It would require the federal and state governments to undertake structural reforms that rectify inadequacies in the health-care system, empowerment strategies to enable right holders to exercise their claims, and public policies that seek to protect and promote the public's health." However, this statement does, in the opinion of this writer, need to be qualified in that legal recognition is an essential component of this process for without legal recognition, it is doubtful that right holders (in the ethical/moral sense) would be able to exercise their claims.

6. **A human rights approach recognizes that a clear individual entitlement to health care is exists, thus empowering individuals and groups**

\textsuperscript{147} See Grbich, C. *Health in Australia – Sociological concepts and issues* (2\textsuperscript{nd} Ed.) (NSW: Prentice Hall Australia, 1999) for a discussion of the influence of the AMA in the health system.

\textsuperscript{148} Chapman, A. ‘Reintegrating Rights and Responsibilities – Towards a new Human Rights Paradigm’ in Hunter & Mack, op.cit. p.20
to assert their claim and providing a potential recourse where there is alleged violation of that right.

In the absence of such recognition, the affected party may have no alternative effective means of recourse, given that health care reforms rarely provide either the necessary empowerment mechanisms or the relevant safeguards and incentives.

7. A human rights approach provides for identifiable and significant linkages between rights and responsibilities. In other words, the recognition of human rights within a political system allows for the provision of an entitlement to health care as a trade-off for a general acceptance of certain limits on publicly funded benefits, together with other responsibilities and obligations such as a responsibility to live a healthy lifestyle. This also requires that barriers to full participation must be removed, including resource and institutional barriers.

Chapman\textsuperscript{149} argues that a recognition of a right to a basic and adequate standard of health care involves both claims to, and responsibilities for, benefits which would be covered by this approach. She suggests that there are 10 elements of a "...meaningful human right to a basic and adequate level of health

\textsuperscript{149} Ibid.
and whilst there will no doubt be those who would dispute the validity of each of these elements, and it is not asserted here that they are the definitive elements, they do serve to illustrate key issues for consideration.

1. The assertion of the existence of a right to health care mandates that an entitlement of basic and adequate health care be guaranteed to all members of that community. Chapman suggests that in countries with high per capita income there should be a 'standard package which would be both 'comprehensive' and 'generous'. She suggests that it would include"...preventative care, primary care, most types of acute care, reproductive care, long-term care, and mental health services...[but would also have] the flexibility to provide for special needs of the disabled and disadvantaged groups."\(^{151}\)

This assumes that current inequalities and inadequacies in any current health care system would be addressed, by not only necessary legal reforms but also by structural adjustments, including the re-distribution of health care providers as well as primary, secondary and tertiary facilities to ensure an even distribution of service providers to all sectors of the community.

However, as has been seen recently within the Australian health care system, policies designed to address the inequality of distribution in relation to general practitioners has had limited success, so the aspect of flexibility is one aspect of this element which would raise concern.

\(^{150}\) ibid p.21

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2. The universality of human rights would ensure that a rights approach to health care would underscore that equality and an inherent right to health care should form the basis of health care reform.\textsuperscript{152}

In essence therefore, if it is argued that human rights are based upon the principle of equality of moral claims, and on the basis that non-discrimination is another fundamental principle of international human rights, then, given the infeasibility of guaranteeing either health care distribution on the basis of quantitative equality or medical outcomes, the principle of universality of the right to health care requires that a specific entitlement to health care be defined. This specific definition would then ensure that all members of society would be guaranteed this defined entitlement, and that there would be no discrimination based upon such issues as disability, gender, race or employment status.

In the opinion of the writer, it is this issue of a definition that forms the basis of the justiciability of the right to health care, for in the absence of such a specific definition, it would be difficult, if not impossible, for an individual to claim discrimination, or indeed a violation of a constitutional or statutory entitlement to a 'non-descript' right to health care. It should also be noted that Chapman does not suggest how this definition could be achieved, however, this observation is not intended as a criticism.

3. The use of rights language would ensure that the provision of health care would be seen as a fundamentally important

\textsuperscript{151} Ibid
social good which should be treated quite differently from other social goals. ¹⁵³

According to Chapman, this use of rights language identifies both the priority which society gives to various social goods, as well the responsibility taken for their protection and promotion. By using moral criteria as the basis for determining equitable access rather than economic criteria, the status of health care is transformed from a commodity, where distribution is determined by market forces, to a social good, with distribution being determined by the principles of justice.

It should be noted that Chapman does not define what she means by the term ‘justice’, although it is probably accurate to suggest that she is referring to the concept of ‘distributive justice’ – defined by Beauchamp and Childress¹⁵⁴ as “...fair, equitable, and appropriate distribution determined by justified norms that structure the terms of social cooperation...the distribution of all rights and responsibilities in society...”

It is also useful to note that Beauchamp and Childress comment that whenever there is a discussion about fairness in relation to a distribution, questions arise regarding principles of justice. They emphasise that “...[N]o single principle can address all problems of justice...[indeed] several principles of justice appear in the common morality

¹⁵² Ibid.
¹⁵³ Ibid
and merit acceptance..." Furthermore, the variance in social conditions may mean that in times of scarcity, when society must choose between social goods, the "...principles of justice may end up being infringed, compromised, or sacrificed." Therefore, although the use of rights language may transform the status of health care, the principles of justice which are said to determine its distribution, are themselves subject to forces which may undermine the moral purpose or purposes for which they are employed.

4. A rights approach would provide the basis for individuals and groups to assert their relative claims of an entitlement to health care.

According to this principle, the use of a rights approach would see the introduction of a vocabulary which would allow both claims to be appropriately framed and rights holders identified. This in turn would mean that federal and state governments, as the bearers of the correlative duties, would be required to ensure that each rights holder is provided with the relevant entitlement. A failure to provide would therefore equate to either a rights violation for which redress could be sought, or alternatively, the basis of an action in administrative law for failing to do that which was required.

155 Ibid
157 Ibid, p.22
5. A rights approach would provide rights holders with a potential recourse should violations occur. 138

According to this approach, rights holders would be accorded a protected status, providing moral standing to not only demand an entitlement, but to complain when that to which they were morality entitled, was denied them. This moral standing could ( and should ) be complemented by the recognition of such rights as legal rights which would entitle the party claiming a violation, to institute legal proceedings to secure that right. While the institution of legal proceedings may not be the panacea for all, given the complexity and expense involved, Chapman suggests that:

"The possibility of legal action...may provide a significant potential means of securing rights of an individual or groups as well as offer incentives to respect rights."

In the opinion of this writer, while the potential may exist, in the absence of the requisite knowledge of the right to institute legal proceedings, or more significantly, the financial capacity to do so, the existence of a legal right is no more beneficial to the recipient than a moral right.

6. A rights approach would provide the basis upon which obligations of federal and state governments would be identified. 139

This principle identifies the relationship between obligations and duties – a right to health care must be meet by the corresponding positive and negative duties of government,

138 Ibid, p.23
specifically the duties to respect, protect and fulfil. The duty to respect goes to issues of equality and access; the duty to protect goes to prevention of violations of the right by other institutions and individuals as well as the development of health protection policies; the duty to fulfil identifies the need for the establishment of policy frameworks within which rights and access can be promoted by other agencies, and the on-going need to monitor the implementation of the right.

7. *A rights approach focusing on the needs of the most vulnerable and marginal members of society, requires society to remove barriers disadvantaging those members.¹⁶⁰*

This requirement would see the removal of those issues which historically have rendered the health system inequitable. Chapman argues that the current healthcare system¹⁶¹:

"...disproportionately benefits some groups - notably whites, the affluent, and the insured - and systematically disadvantages others - primarily the poor, the uninsured, and various racial and ethnic minorities - ..."

and that addressing these historical imbalances will ensure the fundamental structural change that is required. Furthermore, such a focus recognises that access to health care cannot be dependent on financial status - equality demands that everyone, regardless financial status will have

¹⁵⁹ Ibid
¹⁶⁰ Ibid, p.24
¹⁶¹ Chapman is referring to the health care system in the United States, but there are distinct similarities with the situation within both the Australian system, and as the Case Study on South Africa reveals, historical factors have had a significant impact on the state of health care within that country as well as the development of new health care policy,
access to the same quality and scope of health care services and facilities.

8. *A rights approach would ensure that the linkage of entitlements to resources would result in the right to health care being both affordable and publicly funded.*\(^{162}\)

By this, Chapman rightly recognises that no human right is ever ‘free’ and this is particularly the situation with social, economic and cultural rights, where there will always be conflict over which of the entitlements will be funded. Chapman suggests that a health care system structured on a human rights approach would see a regulated price structure, not manipulated by market forces. This in turn would ensure that affordability would not be dependent on services provided by specialist physicians, but would see the emphasis on “…preventative and primary health-care services through family, doctors, nurse practitioners, and other health-care professionals.”\(^{163}\)

9. *A rights approach would identify the importance of all members of society participating in the determination of health care priorities and reform-setting, while emphasizing the responsibility for members to be well-informed and involved in such debates.*\(^{164}\)

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\(^{162}\) Ibid
\(^{163}\) Ibid, p.25
\(^{164}\) Ibid
Chapman suggests that a part of the recognition of this "...new, universal legal entitlement..." requires a new form of political consensus, based upon a newly redefined understanding of the relationship between society and its members. For health reform to be legitimate, it must be based upon broad involvement of the members of society and not just reliant upon the input of medical specialists and policy makers, all of whom may have an agenda for structuring the system in a particular way. By requiring the participation of all member of society, those otherwise marginalised by discrimination can have a voice in the debate.

10. A rights approach implies that individuals have specific responsibilities in relation to the exercise of the right to health care.\textsuperscript{165}

This principle espouses the responsibility that individuals must have for their own health care – a responsibility to protect the health care system which they have helped to create. By ascribing a responsibility to the individual for their own health and to the protection of the system as a whole, then there is legitimacy in qualifying or restricting health care services to those who indulge in behaviour damaging to health. This notion of ‘collective responsibility’ must have however, realistic expectations – that is, no one individual has the right to claim an entitlement to perfect or optimal health care. Each individual can only claim that which can be said to constitute their ‘fair share’, accepting a

\textsuperscript{165} Ibid
certain level of inconvenience in the interests of cost containment.

Chapman concludes her assessment of these rights and responsibilities by indicating that the recognition of human rights as part of the social covenant which members of a particular society have with one another, will allow for the redefining of the claims against and responsibilities to, one another, thus building a social model within which the recognition of new rights would be possible. Even more significantly, Chapman suggests that:

“What is really at stake is not merely economic issues of cost control, but the more fundamental question of whether our social covenant in the late twentieth [and twenty-first] century should include recognition of the right of all persons to basic health care, and shared responsibilities to shape a new health-care system better able to promote and protect the health of the society and to provide for the health-care needs of the poorest and most vulnerable members of society...”

As one can see, there is a direct correlation between the reasons identified in the Commission’s report and those elaborated by Chapman. Finally, while Chapman’s comments are useful in putting into perspective what may be the rights and responsibilities which are required to be addressed in relation to a right to health care, there is little to be gleaned from her comments as to what constitutes adequate care. Again, this is not meant as a criticism, more as a focus on the fact that this is a multi-faceted issue and requires input from a number of perspectives.
The President's Commission identified that there were specific problems in spelling out in detail what adequate care should include and as a result, the concept of an adequate level of care could not be used as a tool to evaluate and improve equity of access, thus leaving open to criticism the assertion that a right to health care exists as a moral right. The Commission therefore suggested\textsuperscript{167} that not only should ethics be considered in attempting to determine what constitutes adequate care, but such issues as economics and medical science should also form part of the debate. The Commission highlighted three particular issues that needed to be addressed, and it is to these issues that discussion will now turn.

The first of the two issues the Commission addressed was what could be said to be the 'characteristics of adequacy'.\textsuperscript{168} The Commission was of the opinion that health care could only be

\textsuperscript{166} Congolese being vaccinated against smallpox, Leopoldville 1/62 – 73798
UN/DP1/B.Zarov - retrieved from http://www.un.org/UN50/Photos/80s.html 23/04/04
\textsuperscript{167} Op.cit. p.35
\textsuperscript{168} Ibid.
judged adequate “...in relation to an individual’s health condition”. This meant that policy that focused on techniques or procedures only, specifically in the creation of a list of such techniques or procedures, would prove inappropriate in that it would have no relevance in relation to the impact that a procedure had on an “...individual’s welfare and opportunity.”\textsuperscript{169} Because disagreement will always be present in relation to what health conditions should fall within the demands of adequacy, the President’s Commission suggested that:

\textit{“In determining adequacy, it is important to consider how people’s welfare, opportunities, and requirements for information and interpersonal caring are affected by their health condition.”}\textsuperscript{170}

However, such considerations must also be balanced against the amounts, types and the necessary quality of care required to respond to each health condition. In other words, to appropriately assess what constitutes an adequate level of health care, there must be reasoned judgment about not only the impact on the individual, but with respect to the cost and effectiveness of the care both in relation to other health conditions and in relation to that available to the individual.

Therefore, given that individual cases differ so significantly, there must be a preparedness on the part of the health care provider and the patient to be flexible and be prepared to entertain a range of options when assessing what constitutes adequacy of health care in relation to that individual patient.

The second issue discussed by the Commission concerned resource allocation, specifically, that the level of care available at any one

\textsuperscript{169} Ibid

\textsuperscript{170} Ibid
time is dependent on the availability of resources, which should reflect the costs and benefits of the care being provided. Such 'costs' and 'benefits' should be interpreted more broadly that in purely monetary terms – in other words, 'benefits' should include personal benefits such as improvement in an individual's functioning, and broader societal benefits as a reinforcement of the sense of community well-being, based upon the knowledge that all who are in serious need of health care will be so provided, while 'costs' should represent those funds diverted away from "...other socially desirable endeavours including education, welfare, and other social services". This latter element recognises that there are competing societal obligations in relation to such matters and that any corresponding moral right is limited to that which can be provided given the need to address each of the societal obligations.

In relation to this issue, Charlesworth notes that because the traditional debate over costs and benefits of resource allocation in health care has had as its foundation economic considerations, the ethical dimensions of the debate have been overlooked, on the assumption he suggests, that once satisfactory economic parameters can be drawn in relation to costs and benefits "...the ethical questions can be left to look after themselves." However, this is, in his opinion, "...wrong-headed and dangerous" as it overlooks those broader elements mentioned by the President's Commission – that

"...the allocation of health-care resources is not merely a matter of efficient cost-benefit rationing but above all a matter of human justice or equity where the interests of all concerned - patients,

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170 Ibid, p.36
171 Ibid
173 Ibid, p.110
health-care professionals, the community at large have to be given their due.

The World Health Organisation has provided some critical guidance on this issue and it is to this guidance that the discussion will now turn. The first issue to which attention is addressed is that of drugs and medicines, for the World Health Organisation has identified those drugs and medicines which it regards as the minimum needs for a basic health system.175

According to the Department of Medicine Policy and Standards at the World Health Organisation:

"Essential medicines are those that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness.

Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford.

The implementation of the concept of essential medicines is intended to be flexible and adaptable to many different situations; exactly which medicines are regarded as essential remains a national responsibility."176

174 Ibid
176 Retrieved from http://www.who.int/medicines/ 20.06.05
The Committee on Economic, Social and Cultural Rights has also made some highly relevant comments in regard to this issue. In analysing Article 12 of the ICESCR the Committee stated that the notion of the ‘highest attainable standard of health’ encompasses “…both the individual’s biological and socio-economic preconditions and a State’s available resources.” Further, the Committee interpreted the ‘right to health’ as an inclusive right, meaning that not only should the right extend to “…timely and appropriate health care…” but also to other underlying factors, which could assist in the determination of what constitutes basic and adequate health care, these factors being:

“…access to safe and portable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health…”

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177 Photo retrieved from [http://www.fotosearch.com/photos-images/pharmaceuticals-still-life.html](http://www.fotosearch.com/photos-images/pharmaceuticals-still-life.html) on 17.06.05
179 Ibid, para.9
180 Ibid, para.11
The Committee also noted the importance of participation by members of society in health-related decision-making, across all levels of government, a factor which has been previously identified as important by both the President’s Commission and Chapman.

The Committee also identified four specific interrelated and essential elements which it was said constitute this right. These elements can be summarised as:

(i) **Availability**: Health-care facilities, goods and services must be available in sufficient quantities, and although the exact quantities will be dependent on factors such as the particular developmental status of the State party in question, they must however include

> “...the underlying determinants of health, such as safe and portable drinking water and adequate sanitation facilities, hospitals, clinics and other health related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.”\(^{181}\)

\(^{181}\) Ibid, para.12. See also #165.

\(^{182}\) Slum area, Nairobi, Kenya retrieved from [http://www.un.org/ecosoodev/medianet/afrec/vol18no2/182environ.htm](http://www.un.org/ecosoodev/medianet/afrec/vol18no2/182environ.htm) on 20.06.05
(ii) *Accessibility*: Health facilities, goods and services must be accessible to all, accessibility being defined as including:

a. *Non-discrimination*

b. *Physical accessibility*

c. *Economic accessibility (affordability)*

d. *Information accessibility*

(iii) *Acceptability*: Health facilities, goods and services must be not only medically ethical, but also show cultural, gender and life-cycle sensitivity.

(iv) *Quality*: Health facilities, goods and services must be medically and scientifically appropriate and of good quality, thus requiring the employment of skilled personnel, the use of scientifically approved hospital equipment, unexpired drugs, safe and portable water as well as adequate sanitation.

The Committee also addressed the components of the phrase 'health facilities, goods and services', a right under Article 12.2(d) and noted that the phrase - 'The creation of conditions which would assure to all medical services medical attention in the event of sickness' - requires the provision of:

"...equal and timely access to basic preventative, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care...the improvement and furtherance of participation of the population in the provision of preventative and curative health services, such as the organisation of the health sector, the insurance system and, in particular,
participation in political decisions relating to the right to health taken at both the community and national levels.” 183

It should also be noted that the Committee provides comment on what is calls the ‘Core obligations’ of States in relation to the satisfaction of the right to health under the ICESCR. The Committee states that these ‘core obligations’ must ensure the “…minimum essential levels of each of the rights enunciated in the Covenant…” and that in doing so must include the following184:

“(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; 

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone; 

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and portable water; 

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; 

To ensure equitable distribution of all health facilities, goods and services; 

(f) To adopt and implement a national health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.”

The Committee also cites that in addition to these ‘core obligations’, the following obligations are to be regarded as being of

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183 Ibid, para.17  
184 Ibid, para.43
‘comparable priority’\textsuperscript{185}, therefore giving very little differentiation between these obligations and those which it regards as ‘core’:

“(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To take provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.”

The conclusion which can be drawn from these statements, is that although there is only passing reference to the terms ‘basic’ or ‘adequate’, the use by the Committee of such terms as ‘core obligations’ and ‘essential’, provide a clear indication of those health facilities, goods and services which could be said to constitute ‘basic or adequate health care’, the provision of which should be guaranteed to all, to ensure that there is full realization of “…the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

\textsuperscript{185} Ibid, para.44
UNIVERSALITY OF HUMAN RIGHTS

Before one can discuss with any depth the justiciability of a human right to health care, it is important to briefly discuss the notion of the universality of human rights. It should be noted that this is a topic for which there is an extraordinary amount of authority and what follows here is only a cursory examination and any perceived limitations in content should be viewed in this light.

The meaning of the universality of human rights is not a settled issue and, in the opinion of this writer, will probably never be a settled issue, even though its resolution would seem to be a logical antecedent to addressing the question as to whether universality applies to all human rights or just to some human rights, and if so, which rights might they be and how are they determined.

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According to Perry\textsuperscript{187}, the idea of human rights consists of two parts: the premise or claim that every human being is sacred (inviolate, etc) and that secondly, that because every human being is sacred, certain choices should be made and certain other choices rejected; in particular, certain things ought not to be done to any human being while certain other things should be done for every human being.

There are two further parts to this concept or premise and they are firstly, that by being a member of the species Homo sapiens one is rendered sacred and secondly, that this sacredness does not depend on "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".\textsuperscript{188} To deny any class, race sex or other category of human being this concept of 'sacredness' places them in the category of 'pseudohumans', as was the case with Nazi ideology and the Jewish race.\textsuperscript{189} Indeed, Rorty\textsuperscript{190} has discussed this issue along similar lines, reflecting on the attitudes of the Serbs to their Muslim neighbours and stating that "...Serbs take themselves to be acting in the interests of true humanity by purifying the world of pseudohumanity".\textsuperscript{191}

\textsuperscript{188}Article 2, Universal Declaration of Human Rights, op. cit.
\textsuperscript{189}Morsink, J. "World War Two and the Universal Declarations", 15 Human Rights Quarterly. 357, 363 (1993)
\textsuperscript{191}Ibid.
The Francois-Xavier Bagnoud Centre for Health and Human Rights\textsuperscript{192} holds that the basic features of human rights can be summarised into six key points, the first of these being based upon a similar principle as that discussed above: that people have rights simply because they are human. It is this ‘humanness’ that entitles people to live a human and dignified life, with the assurance that the existence of these rights will enable life to be lived as humanely as possible in harmony and mutual respect. The second of these points is an extension of the first, and can be simply stated: human rights are universal. In other words, human rights apply to all people around the world, regardless of who they are (sex, gender, religion etc) or where they live. Universal human rights law therefore requires that all human beings be treated equally – that all human rights be applied to all people in the same manner, without discrimination. To do other than this would be to retreat to the position of regarding some humans as ‘pseudohumans’. It should be noted however, that whilst universal human rights law requires equality of treatment, there is an acknowledgement that in some parts of the world regional human rights law provides a lesser standard of recognition and protection\textsuperscript{193} and it must be mentioned that this issue will be addressed later in this thesis.

Kinley\textsuperscript{194} argues that the assertion of the universality of human rights – its applicability to all human beings – arises from the notion that as a human being one is automatically entitled to respect for one’s dignity. If one accepts this premise, then it can be argued that the object of preserving and promoting the dignity of individual human beings is what constitutes the central element or

\textsuperscript{192} Mann et al. \textit{op.cit.}
\textsuperscript{193} Ibid
\textsuperscript{194} Op.cit.p.4
concern of human rights, rather than the notion of being ‘sacred’. Indeed, the preamble to the *Universal Declaration of Human Rights* reads, inter alia, “Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world...” would seem to validate Kinley’s perspective. [It is also interesting to note that the concept of the human family has been extended by such writers as Peter Singer\textsuperscript{195}, who argues for the inclusion of animals into the concept of human – differentiating human from homo sapien, but this is a topic which, while interesting and certainly debateable, falls outside the focus of this thesis.]

Piotrowicz & Kaye\textsuperscript{196} propose that the fact that the term ‘human’ is used denotes the universality of application. All individuals therefore receive the benefit of human rights, simply by virtue of their membership of the human species and regardless of any of the internal characteristics that may otherwise be used to differentiate individuals. The fact that not all rights will be equally available to all people at all times, does not mean that the rights themselves are not universal – their unavailability at specific times is only as a result of an individual’s specific circumstances: human rights remain inherently universal.\textsuperscript{197}

An interesting aside to this discussion, is raised by Gaze\textsuperscript{198} who proposes that the law itself has a need to base its legitimacy in a

\textsuperscript{195} Piotrowicz, R. & Kaye, S. *Human Rights in International and Australian Law* (Sydney: Butterworths, 2000)
\textsuperscript{196} See Bailey, P.H. *Human Rights: Australia in an International Context* (Sydney: Butterworths, 1990 pp2-3 for a further discussion of this position)
claim of "...objectivity and universality...". In other words, legal authority cannot recognize the existence and validity of differing but equally valid viewpoints for this would mean that in relation to the basis of the making of judgments, the elements of power and force would prevail and this would "...seriously undermine the legitimacy and authority of the law..." Gaze suggests that the law has a need to adhere to a 'universal' model of the 'reasonable man' – white and middle-class as such a model forms the foundation upon which it is able to determine what constitutes, in Thornton's words the 'otherness' in our society. She does however propose that adherence to such a model is actually 'false universality' as it is based upon what she describes as an "...ostensibly neutral but actually male norm..." Rather, it is suggested that a recognition that sexual and other differences exist within society which deny the possibility of 'neutrality', actually contribute to, if not form the centrality of, the argument that "...equality requires treatment as equals, understood as equal respect for each person, and not merely equal treatment according to a model which is designed only for some individuals." If one applies this type of reasoning to the justiciability of human rights, then it could be argued that if the legal system and therefore judicial reasoning are based upon the concept of the universal model of the 'reasonable man', then the law will never truly be equipped to adjudicate on, as Gaze suggests, a "full and effective concept of equality". She suggests:

199 ibid, at p.191
200 ibid
201 Described as the 'benchmark man...possess[ing] all the characteristics of the dominant side of a string of dualisms against which 'otherness' is measured in our society' by Margaret Thornton 'Embodying the Citizen' in Thornton, M. (ed) Public and Private: Feminist Legal Debates (Oxford: Oxford University Press, 1995)
202 See above.
203 Op cit.
204 Ibid.
"A concept of equality which does not deny difference is more cautious about requiring similar treatment and is much more likely to be sensitive to issues of subordination and oppression than one which, by failing to challenge existing social arrangements, requires women to be treated like men."²⁰⁵

It should be noted that Gaze admits writing from a feminist perspective and therefore her gender bias may be revealed in this approach. However, given this acknowledgment, there is still some validity in her arguments from a human rights perspective, specifically in relation to economic, social and cultural rights, which so clearly address the rights of women, children and the disadvantaged.

²⁰⁵ Ibid, p.192
²⁰⁶ UN Charter with USSR, UK and US signatures, San Francisco, 26/6/45 (UNC1O 2715 UN/DP1M.Bolomey) retrieved from http://www.un.org/UN50/Photos/40s.html on 29/04/04
THE NOTION OF CULTURAL RELATIVITY

It is also important to briefly discuss the notion of cultural relativity in relation to human rights as this aspect is raised in relation to allegations of violations by specific States parties. Again, it is important to note that this is intentionally not a comprehensive discussion, but is briefly included for completeness and insight.

Cultural relativity is variously describe, but according to Piotrowicz & Kaye\textsuperscript{207} as amounting "...to a challenge to the absolute [or universal] nature of human rights." In other words, those who subscribe to this philosophy believe that human rights norms must be interpreted and applied in light of the culture of the state in which they are alleged to apply. Therefore, as cultural experiences will vary from state to state, so views on respective obligations in relation to the same human rights norms will vary.

Piotrowicz & Kaye suggest that this notion presents a "significant challenge" to the application of human rights law

"...in that there is no express recognition of the concept within the principal global and regional human rights instruments...[as this] has proved appealing to developing states, as some broader human rights norms are perceived as of Western origin, and do not sit comfortably with many of the cultural traditions of these states..."\textsuperscript{208}

The authors suggest that cultural relativism can be seen quite clearly when considers the different priorities given to human rights within varying cultural states. It is suggested, as has been discussed previously in this Thesis, that the hierarchy or

\textsuperscript{207} Op.cit at p.10  
\textsuperscript{208} Ibid
‘generation’ categorization of rights into first, second and third generation rights is a western phenomenon which is not adopted by all states. In other words, there are developing states which prefer to place greater emphasis on and therefore give priority to developmental rights rather than the rights of the individual, on the justification that ‘...the damage to individual human rights is far greater when the state cannot afford to feed, shelter or educate its citizens, than when they are deprived of the right to vote and to openly criticize the government...’\textsuperscript{209} However, as the authors rightly comment, it is suggested, this view wrongly equates the ascertainment of economic progress with the deprivation of personal and political liberties, a view which most countries where democracy is not restricted, would not ascribed to.

A useful example of the application of this notion, comes from a discussion of the practice of female genital mutilation\textsuperscript{210} which is practiced a number of Asian and Middle Eastern countries. Opponents of the practice argue that from a human rights perspective it oppresses women, runs counter to the International Declaration on the Elimination of Violence Against Women, the Convention on the Rights of the Child, the Convention against Torture and other Cruel Inhumane and Degrading Treatment or Punishment as well as the ICESCR and the UDHR. \textsuperscript{211}

For example, Article 19(1) of the Convention on the Rights of the Child obliges governments to ‘...take all appropriate legislative, administrative, social and educational measures to protect the child

\textsuperscript{209} Ibid, p.80
\textsuperscript{210} For a comprehensive human rights discussion on female genital mutilation see Amnesty International at \url{http://www.amnesty.org/ai/lib/intcom/fcmgen/fgm1.htm} retrieved 21.06.05
\textsuperscript{211} Note also reference to the unacceptability of female genital mutilation in Article 114(a) and 125(i) of the Beijing Declaration located in Appendix 3.
from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.’ Article 24(3) further provides that governments ‘...take all effective measures with a view to abolishing traditional practices prejudicial to the health of children.’

Proponents of the practice however, and those who therefore would or do argue from a cultural relativist perspective, state that it is acceptable as it is an integral rite of passage into adulthood and to cease its practice would be akin to, at the very least, showing indifference to long-standing and widespread traditions which occupy such important places within the cultural mores of those societies, or at worst, exercising cultural imperialism – judging acceptable standards of conduct from purely a Western perspective.212

It should also be noted that while arguments against cultural relativism are based upon the recognition by most of the Conventions and Declarations of the United Nations of the universality of human rights, there are a number of regional conventions which have specific references to cultural issues, such as the African Charter on Peoples’ Rights, where it is stated in contribute to the promotion of the moral well-being of Article 29 (7)

... "To preserve and strengthen African cultural values in his relations with other members of society, in the spirit of tolerance, dialogue and consultation and, in general, to society."

212 Ibid
If one reads this Article in light of the issue of female genital mutilation, then the cultural relativist would no doubt argue that the practice is acceptable given its significance as a cultural ritual and as a method of promoting the "...moral well-being of society".

However, importantly it should also be noted that in Article 21 of the *African Charter on the Rights and Welfare of the Child*\textsuperscript{214} specifically addresses such practices and states:

\begin{quote}
'I. States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular:
\end{quote}

\textsuperscript{213} Worshipper at a mosque in Djenné, Mali. Djenné, 4/86. (154730c UN/DP1/I.Issac retrieved from \url{http://www.un.org/UN50/Photos/80s.html} on 29/04/04

\textsuperscript{214} See above note 112
(a) those customs and practices prejudicial to the health or life of the child; and

(b) those customs and practices discriminatory to the child on the grounds of sex of other status.

It is therefore arguable that this Charter, given this specific provision and given the known harmful effect that female genital mutilation has on the health of the child and the discriminatory nature of the practice, overrides other provisions which recognize the importance of cultural rituals as forming part of the well-being of the society in question.

Given however that cultural differences do exist, there is still substantive argument that even given these differences, some social and biological needs are shared by all human beings and that these needs are universal because they are ‘human’ needs. Phillipa Foot\textsuperscript{215} describes this point in the following terms, which although extensive as a quote is, as Perry indicates, succinct and eloquent:

"Granted that it is wrong to assume an identity of aim between peoples of different cultures; nevertheless there is as great deal that all men have in common. All need affection, the cooperation of others, a place in the community, and help in trouble. It isn’t true to suppose that human beings can flourish without these things – being isolated, despised or embattled, or without courage or hope. We are not, therefore, simply expressing values that we happen to have if we think of some moral systems as good moral systems and others as bad. Communities as well as individuals can live wisely or unwisely, and this is largely the result of their values and the codes of behaviour that they teach. Looking at these societies, and critically also at our own, we surely have some idea of how things work out and why they work out as they do. We do not have to suppose it is just as good to promote pride of place and the desire to get an advantage over other men as it is to have an ideal of

\textsuperscript{215} Cited in Perry, op.cit at p.66
affection and respect. These things have different harvests, and unmistakably different connections with human good.

Perry goes on to suggest that just as there are some ‘needs’ that are universally human, so there are some things which have value to every human being – goods common to every person – goods that are universally human. He suggests that these goods:

"...include various human capacities or capabilities or virtues, namely, those that enable human beings to struggle 'against' those forces, inside them as well as outside, that periodically threaten the well-being of any human being and 'for' those things, those states of affairs or those states of being, congenial to the flourishing of any human being."

If there are both universal needs and goods which, irrespective of culture, are applicable to all, then although certain cultural practices based upon these needs and goods, may appear to be incompatible with the practices of others, and may eventually prove to be indefensible from a human rights perspective, it does not mean that, as in the words of Taylor216 "...we...start with a preshrunk moral universe in which we take as given that their goods have nothing to say to us or perhaps ours to them."

Cultural relativism has a role to play in differentiating between the values which are ascribed to particular human rights norms by different cultures, thus enabling the ‘particularities of culture’ to be brought into the human rights debate, particularly the debate on the universality of human rights. It is my belief that this inclusion can only enrich the debate and enlighten all those engaged in the promotion if human rights to the difficulties and challenges of implementation.

216 As cited in Perry, ibid, p.69
Chapter 5

JUSTICIABILITY - THE RIGHT TO HEALTH CARE AND RELATED LEGAL MATTERS

"We lawyers know well, and may find high authority for it if required, that life would be intolerable if every man insisted on his legal rights to the full."
- Federick Pollack (Jurisprudence)

As has been discussed earlier in this thesis, economic, social and cultural rights as detailed in the various international treaties and documents, are legally binding in that they create legal obligations to their States parties. For those countries that have incorporated these existing treaties into domestic law, or have incorporated specific elements into their constitutions, such as the right to health care, they are afforded legal domestic validity.

According to Scheinin\textsuperscript{217} the problem relating to such social and economic rights as the right to health care is in their applicability. Scheinin cites the opinion of some authors that social and economic rights lack 'justiciability' because their very nature precludes them being "...invoked in courts of law and applied by judges" while other authors base their objection to justiciability on the largely 'political' character of treaty obligations.\textsuperscript{218}


\textsuperscript{218} Ibid at p.41
In order to examine an example of how the right to health care is being constitutionally interpreted and implemented, several cases studies have been undertaken, including South Africa, Canada and the United Kingdom. A further major case study of Tibet is included to provide an example of how the right to health care is interpreted when a constitutional right does not exist but the ruling authority is a signatory to the relevant conventions. Documentation relevant to discussions in this chapter has been included as Appendices.

Prior to embarking on these Case Studies, it is appropriate to briefly discuss how violations of the ICESCR are determined. This discussion is especially relevant in relation to the situation in Tibet which is included in this Chapter.

According to the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights\textsuperscript{219} violations of the ICESCR occur when there is a failure to meet the 'minimum core obligations' required to be provided to ensure the provision of the minimum essential level of the right in question. It is also to be remembered that these minimum core obligations apply irrespective of any argument which a State party may raise as to the availability of resources within the country concerned.\textsuperscript{220} This notion of availability of resources will be seen to be significant as the Case Studies in this Chapter will reveal.

\textsuperscript{219} Op.cit.

\textsuperscript{220} Paragraph 10 of the Guidelines provides: "In many cases, compliance with such obligations may be undertaken by most States with relative ease, and without significant resource implications. In other cases, however, full realisation of the rights may depend upon the availability of adequate financial and material resources. Nonetheless, as established by Limburg Principles 25-28, and confirmed by the developing jurisprudence of the Committee on Economic, Social and Cultural Rights, resource scarcity does not relieve States of certain minimum obligations in respect of the implementation of economic, social and cultural rights."
The *Guidelines* also refer to violations based upon the pursuit of policies or practices which deliberately contravene or ignore Covenant obligations, as well as to discrimination which has the effect or purpose of "...nullifying or impairing the equal enjoyment or exercise of economic, social and cultural rights constitutes a violation of the Covenant."\(^{221}\)

There are two types of violations that can occur — violations through acts of commission and violations through acts of omission. The Guidelines describe violations through acts of commission as "...the direct action of States or other entities insufficiently regulated by States..."\(^{222}\) - for example, *inter alia*:

"(a) the formal removal or suspension of legislation necessary for the continued enjoyment of an economic, social and cultural right that is currently enjoyed;

(b) the active denial of such rights to particular individuals or groups, whether through legislated or enforced discrimination;

(c) the adoption of legislation or policies which are manifestly incompatible with pre-existing legal obligations relating to these rights, unless it is done with the purpose and effect of increasing equality and improving the realisation of economic, social and cultural rights for the most vulnerable groups;

(d) the reduction or diversion of specific public expenditure, when such reduction or diversion results in the non-enjoyment of such rights and is not accompanied by adequate measures to ensure minimum subsistence rights for everyone."

In comparison, violations through acts of omission are described as violations which occur through the failure or omission of States to take those necessary measures which stem from legal obligations\(^{223}\), for example, *inter alia*:

\(^{221}\) Ibid, para.11

\(^{222}\) Ibid, para.14

\(^{223}\) Ibid, para.15
“(a) the failure to take appropriate steps as required under the Covenant;

(b) the failure to reform or repeal legislation which is manifestly inconsistent with an obligation of the Covenant;

(c) the failure to utilise the maximum of available resources towards the full realisation of the Covenant;

(d) the failure to monitor the realisation of economic, social and cultural rights, including the development and application of criteria and indicators for assessing compliance;

(e) the failure to remove promptly obstacles which it is under a duty to remove to permit the immediate fulfilment of a right guaranteed by the Covenant;

(f) the failure of a State to take into account its international legal obligations in the field of economic, social and cultural rights when entering into bilateral or multilateral agreements with other States, international obligations or multinational corporations.”

The Guidelines also provide clear statements with respect to the status of remedies and other responses to violations. The Guidelines clearly state that all individuals and groups who are victims of violations “...should have access to effective judicial or other appropriate remedies at both national and international levels”224 and that:

“In order to achieve effective judicial and other remedies for victims of violations of economic, social and cultural rights, lawyers, judges, adjudicators, bar associations and the legal community generally should pay far greater attention to these violations in the exercise of their professions...”225

Given these statements and the sentiment which they represent, it is to alleged violations that this thesis will now turn, by the use of various Case Studies. It should be noted at this point that it is not claimed that these Case Studies are comprehensive in content and scope – their purpose is illustrative of the varying ways in which economic, social and cultural rights, looked at from the perspective

224 Ibid, para.22
of the right to health and health care, may be violated and the avenues which may be open for redress.

Figure 25

MAJOR CASE STUDY 1 – The Right to Health Care in South Africa

The South African Constitution of 1996 in Chapter 2 (sections 7 through to 39) sets out a Bill of Rights. Section 7 states:

(e) This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values human dignity, equality and freedom.

(f) The State must respect, protect, promote, and fulfil the rights in the Bill of Rights.

(g) The rights in the Bill of Rights are subject to the limitations contained or referred to in section 36, or elsewhere in the Bill.

As previously identified in this thesis, Section 27 sets out the rights to health care, food, water and social security, while Section 28(1)(c) guarantees that every child has the right to “basic

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225 Ibid, para.28
226 Poster of Preamble of the Charter 7/83 – 161694 c UN/DP1/M.Grant retrieved from http://www.un.org/UN50/Photos/40s.html 27/04/04
nutrition, shelter, basic health care services (emphasis added), and social services” and 28(2) states that in every matter concerning a child “A child’s best interest in of paramount importance.”

Section 36 provides that:

The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including

a. the nature of the right;

b. the importance of the purpose of the limitation;

c. the nature and extent of the limitation;

d. the relation between the limitation and its purpose; and

e. less restrictive means to achieve the purpose.

(3) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

The significance of this provision will become clear as this case study is examined.

The Constitution also provides, in Section 167, for the establishment of a Constitutional Court, which is stated in subsection (3) to have the following jurisdiction:

(a) is the highest court in all constitutional matters;

(b) may decide only constitutional matters, and issues connected with decisions on constitutional matters; and

(c) makes the final decision whether a matter is a constitutional matter or whether an issue is connected with a decision on a constitutional matter.
Furthermore, the Constitutional Court is given the sole authority, under subsection (4) (c) to “decide that Parliament or the President has failed to comply with a constitutional duty.”

Section 167 (6) provides that:

National legislation or the rules of the Constitutional Court must allow a person, when it is in the interest of justice and with leave of the Constitutional Court –

(a) to bring a matter directly to the Constitutional Court; or

(b) to appeal directly to the Constitutional Court from any other court

while subsection (7) defines a constitutional matter as “..any issue involving the interpretation, protection or enforcement of the Constitution”.

Finally, Section 172 directs that any court, when deciding a constitutional matter, must declare any law or conduct that is inconsistent with the Constitution to be invalid “..to the extent of its inconsistency” (subsection (1)(a)) and then may make any order that is “..just and equitable.” (subsection (1)(b)).

Any person who wishes to bring a constitutional case before the Constitutional Court will usually be required to start in the High Court, which has the power to award relief which includes the invalidation of provincial or parliamentary legislation, a act which must be confirmed by the Constitutional Court before it has any effect. The Constitutional Court can also be approached on appeal, whereby the judges will decide if there is an important question of principle relating to the interpretation of the Constitution which has been raised and whether there is a reasonable prospect for the appeal to succeed. It is also important to note that when
interpreting the Constitution, the Constitutional Court is required to consider international human rights law and may also consider the law of other democratic countries.\textsuperscript{228}

The Constitution also provides for the establishment of a Human Rights Commission, in Section 184, which has extensive powers pursuant to subsection (2):

\begin{itemize}
  \item[(a)] to investigate and to report on the observance of human rights;
  \item[(b)] to take steps to secure appropriate redress where human rights have been violated;
  \item[(c)] to carry out research; and
  \item[(d)] to educate.
\end{itemize}

Subsection (3) provides that:

\begin{quote}
Each year, the Human Rights Commission must require relevant organs of state to provide the Commission with information on the measures that they have taken towards the realisation of the rights in the Bill of Rights concerning housing, health care, food, water, social security, education, and the environment.
\end{quote}

It can therefore be concluded that while South African citizens have a constitutional right of access to health care, reproductive health care and emergency medical treatment, and children are guaranteed a right to basic health care services, citizens also have a right to pursue any constitutional breach of these rights through either the Human Rights Commission or the Constitutional Court. This right is supplemented by the power of the Commission as set out in Section 187(3), as detailed above.

\textsuperscript{228} See http://www.concourt.gov.za/about.html retrieved 29/12/01
The key issue that will now be discussed is the effectiveness of these constitutional guarantees and the manner in which the courts have resolved relevant cases.\textsuperscript{229}

The first case in which a comprehensive discussion of these socio-economic rights occurred was the 1996 case \textit{Re Certification of the Constitution of the Republic of South Africa} [1996] S.A.J. No.19\textsuperscript{230}

The purpose of the judgment in this case was to pronounce whether or not the Constitutional Court certified that all the provisions of the proposed South African Constitution complied with certain principles in the existing Constitution. This process of certification was an agreed requirement of the acceptance of the Interim Constitution ("IC"), agreed to by the South African Parliament in 1994. This agreement was necessary given the fragmented and repressive historical and political history of South Africa\textsuperscript{231}, which the associated erosion of civil liberties, specifically

\textsuperscript{229} All cases referred to in this section were retrieved from: http://www.concourt.gov.za/about.html

\textsuperscript{230} Case No. CCT 23/96. The Court consisted of Chaskelison, P, Mahmoed DP, Ackermann J (who fell ill during proceedings and withdrew), Dadoo J, Goldstone J, Kriegler J, Langa J, Madala J, Mokgoro J, O'Regan J and Sachs J. The decision of their Honours was unanimous.

\textsuperscript{231} A succinct portrayal of the political history of South Africa is found in the judgment of the Constitutional Court in \textit{Executive Council, Western Cape Legislature and Others v President of the Republic of South Africa and Others} 1995 (4) SA 877 (CC); 1995 (10) BCLR 1289 (CC) at para 7 where it was stated: "The Constitution itself makes provision for the complex issues involved in bringing together again in one country, areas which had been separated under apartheid, and at the same time establishing a constitutional State based on respect for fundamental human rights, with a decentralised form of government in place of what had previously been authoritarian rule enforced by a strong central government. On the day the Constitution came into force 14 structures of government ceased to exist. They were the four provincial governments, which were non-elected bodies appointed by the central government, the six governments of what were known as self-governing territories, which had extensive legislative and executive competences but were part of the Republic of South Africa, and the legislative and executive structures of Transkei, Bophuthatswana, Venda and Ciskei, which, according to South African law, had been independent States. Two of these States were controlled by military regimes, and at the time of the coming into force of the new Constitution two were being administered by administrators appointed by the South African authorities. The legislative competences in these 14 areas were not the same. Laws differed from area to area, though there were similarities because at one time or another all had been part of South Africa. In addition the Constitution was required to make provision for certain functions which had previously been carried out by the national government to be transferred as part of the process of decentralisation to the nine new provinces which were established on the day the Constitution came into force, and simultaneously for functions that had previously been
with respect to the black and coloured population. This erosion and inequality was specifically recognised in the preamble to the IC, with an acknowledgment of the:

"...need to create a new order in which all South Africans will be entitled to a common South African citizenship in a sovereign and democratic constitutional state in which there is equality between men and women and people of all races so that all citizens shall be able to enjoy and exercise their fundamental rights and freedoms...[and therefore the Interim Constitution] provides a historic bridge between the past of a deeply divided society characterised by strife, conflict, untold suffering and injustice, and a future founded on the recognition of human rights, democracy and peaceful co-existence and development opportunities for all South Africans, irrespective of colour, race, class, belief or sex."  

Chapter 5 of the IC specifically addressed the issue of certification, and by virtue of IC 71(2), it was provided that:

"The new constitutional text passed by the Constitutional Assembly, or any provision thereof, shall not be of any force and effect unless the Constitutional Court has certified that all the provisions of such text comply with the Constitutional Principles referred to in subsection (1)(a)."

The 34 Constitutional Principles referred to in IC 71(2) were acknowledged as forming a 'solemn pact' between all the elected representatives of people of South Africa. These Principles are contained in IC Schedule 4, and while it is unnecessary to replicate them in this thesis, it is important to note that they were deemed to be foundational to the new Constitution and, importantly, crucial to the certification process. In respect to this latter issue, IC 71(3) provided a safeguard to the certification process, by ensuring

performed by the 14 executive structures which had ceased to exist to be transferred partly to national government and partly to the new provincial governments which were to be established. All this was done to ensure constitutional, legislative, executive, administrative and judicial continuity."

Re Certification, op cit, para.10
that no decision of the Constitutional Court with respect to certification was able to be challenged:

“A decision of the Constitutional Court in terms of subsection (2) certifying that the provisions of the new constitutional text comply with the Constitutional Principles, shall be final and binding, and no court of law shall have jurisdiction to enquire into or pronounce upon the validity of such text or any provision thereof.”

The Constitutional Court, in Chapter III of the judgment, addressed sections 26, 27 and 29 of the new Constitution – classified together as socio-economic rights – and the objections which had been raised in relation to their inclusion in the new Constitutional document. The first objection referred to the proposal that rights such as access to housing, health care, sufficient food and water, were not “...universally accepted fundamental rights” and that therefore they should not be included as they are not rights within the parameters of Constitutional Principle II. This argument was however rejected by the Court on the basis that the said same Principle allowed for the Constitution Act to supplement the universally accepted fundamental rights with other rights not universally accepted.

The second objection centred itself on the doctrine of the separation of powers, which essentially provides for a separation of powers and responsibilities between the three institutions of government:

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233 It should be noted that court decisions are not generally divided into Chapters, however, given the multiplicity of issues and the complexity of the task before the Court, the decision was taken to divide the judgment into separate Chapters, each dealing with a separate topic.

234 Ibid, para. 76

235 This approach is referred to in Australian Constitutional Law as the concept of connotation and denotation – that is, that a constitutional provision may be read in light of the circumstances prevailing at the time of its formulation (connotation) but may be amended in interpretation to ‘denote’ something additional in the future. For a discussion of this see Hanks, P. & Cass, D. Australian Constitutional Law: Materials and Commentary (6th Ed.) (Butterworths: Sydney, 1999) at Chap. 11
the legislature, the executive and the judiciary.\textsuperscript{236} Constitutional Principle VI required there to be such a separation of powers, and it was argued that the inclusion of such rights as justiciable would place the judiciary at risk of encroaching on the powers belonging to the legislature and executive, in that it would result in the judiciary essentially telling the government how the budget should be allocated.\textsuperscript{237} This objection was rejected by the Court on the basis that, even though the inclusion may result in the Court making orders with budgetary implications, this was no different to orders made pursuant to the enforcement of civil and political rights which would be contained in a Bill of Rights. The Court cited the example of orders by the Court requiring either the provision of legal aid or the extension of state benefits to a class of people formerly not beneficiaries of such benefits.

The third\textsuperscript{238}, and perhaps more significant objection for the purposes of this thesis, was based upon the premise that socio-economic rights, \textit{per se}, are not justiciable, primarily because of the budgetary implications arising from their enforcement. This argument was based on the wording of Constitutional Principle II, which specifically stated that all "\textit{...universally accepted fundamental rights}" shall be protected by "\textit{...entrenched and justiciable provisions in the Constitution}". In response to this objection, the Court was clear that the mere existence of budgetary implications was not a preclusion to justiciability.

\textquote{\textit{...It is clear...that the socio-economic rights entrenched in NT 26 to 29 are not universally accepted fundamental rights. For that reason, therefore, it cannot be said that their 'justiciability' is required by CP II. Nevertheless, we are of the view that these rights}}

\textsuperscript{236} See Hanks & Cass at p.350-351 for a definition of the doctrine under the Australian Constitution. See also \textit{Re Constitution} pars.105-113 for a discussion of the doctrine.
\textsuperscript{237} \textit{Re Certification}, op.cit para.77.
\textsuperscript{238} Ibid. para.78
are, at least to some extent, justiciable. As we have stated ... many of the civil and political rights entrenched in the NT will give rise to similar budgetary implications without compromising their justiciability. The fact that socio-economic rights will almost inevitably give rise to such implications does not seem to us to be a bar to their justiciability. At the very minimum, socio-economic rights can be negatively protected from improper invasion. In light of these considerations, it is our view that the inclusion of socio-economic rights in the NT does not result in a breach of the CPs.\textsuperscript{239}

This acknowledgement by the Constitutional Court of the justiciability of socio-economic rights, even given their budgetary implications, paved the way for the cases that will now be discussed. The significance of the recognition of the existence of budgetary implications in relation to socio-economic rights will become clearly evident as these cases are considered.

\textsuperscript{239} Ibid.
\textsuperscript{240} 43 yr old Loveness Mudaala of Zambia with some of her 18 children, which are not all hers by birth. She has taken n nephews and nieces as her own brothers and sisters have died
In *Soobramoney v Minister of Health* (KwaZulu Natal) 1997 (12) B.C.L.R. 1696 (CC), the South African Constitutional Court rejected an application by a terminally ill patient for an order directing Addington Hospital to provide him with dialysis treatment. The applicant to the Court was suffering from chronic irreversible renal failure, had diabetes and heart disease. His kidneys had failed and his condition was diagnosed as irreversible. The hospital had a policy of only providing renal dialysis to patients who could be cured or alternatively, were eligible for a kidney transplant. Specifically, the policy guidelines provided that an applicant was not eligible for a transplant unless they were ‘free of significant vascular or cardiac disease’ and also free of ‘significant disease elsewhere...’241 The applicant argued that the right to medical treatment could be inferred from s.27(3) which provides for that “No one may be refused emergency medical treatment”, and s.11 which provides the right to life, a non-derogable right under the Constitution.

In the opening judgment, Chaskalson P noted that this application was made at a time when South African society evidenced “...a high level of unemployment, inadequate social security...[and a lack of access by many] to clean water or to adequate health services” (emphasis added). These conditions, His Honour noted were not new, but the responsibility to address them, was central to the new constitutional order which aspired to the principles of ‘...human dignity, freedom and equality...’242

His Honour noted that this was the first time that the Constitutional Court had been called upon to pass judgment on the
'parameters of the right to life or its relevance to the positive obligations imposed on the state under various provisions of the bill of rights'.

In order to undertake this exercise, the Court, it was said would use a 'purposive' approach to Constitutional interpretation – that is, it would consider the rights in issue not in isolation "...but in [their] context, which includes the history and background to the adoption of the Constitution, other provisions of the Constitution itself and, in particular, the provisions [the bill of rights] of which [they are] part."  

It was held by the Court that the right to medical treatment did not have to be inferred from the right to life because it was dealt with expressly by section 27 of the Constitution. This section placed the state under an obligation to take 'reasonable legislative and other measures, within its available resources, to achieve the progressive realisation' of, inter alia, the right to access to health care services. As there were insufficient funds to provide patients such as the applicant with treatment, the failure to provide dialysis was not a breach of Constitutional rights. The arguments based upon the right to life were rejected. His Honour Judge Chaskalson stated:

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242 Para.8.
243 Para.15
244 This statement was taken from the decision of His Honour in S v Makwanyane and Another 1995 (3) SA 391 (CC) citing the decision of the Constitutional Court in S v Zuma and Two Others (5 April 1995) CCT5/94. In that decision, Kentridge AJ, in addressing the issue of what approach should be adopted in the interpretation of the fundamental rights enshrined in Chapter Three of the Constitution stated:

"The meaning of a right or freedom guaranteed by the Charter was to be ascertained by an analysis of the purpose of such a guarantee; it was to be understood, in other words, in the light of the interests it was meant to protect. In my view this analysis is to be undertaken, and the purpose of the right or freedom in question is to be sought by reference to the character and larger objects of the Charter itself, to the language chosen to articulate the specific right or freedom, to the historical origins of the concept enshrined, and where applicable, to the meaning and purpose of the other specific rights and freedoms with which it is associated within the text of the Charter. The interpretation should be..."
"In our Constitution the right to medical treatment does not have to be inferred from the nature of the state established by the Constitution or from the right to life which it guarantees. It is dealt with in section 27. If section 27(3) were to be construed in accordance with the appellant's contention it would make it substantially more difficult for the state to fulfil its primary obligations under sections 27(1) and (2) to provide health care services to 'everyone' within its available resources. It would also have the consequence of prioritizing the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for the purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening. In my view much clearer language than that used in section 27(3) would be required to justify such a conclusion."\textsuperscript{345}

Judge Madala set out his opinion as to the nature of constitutional rights by stating:

The Constitution is a forward-looking document and guarantees to every citizen fundamental rights in such a manner that the ordinary person-in-the-street, who is aware of these guarantees, immediately claims them without further ado – and assumes that every right so guaranteed is available to him or her on demand. Some rights in the Constitution are the ideal and something to be strived for. They amount to a promise, in some cases, and an indication of what a democratic society aiming to salvage lost dignity, freedom and equality should embark upon. They are values which the Constitution seeks to provide, nurture and protect for a future South Africa.

However, the guarantees of the Constitution are not absolute but may be limited in one way or another. In some instances, the Constitution states in so many words that the state must take reasonable legislative and other measures, within its available resources 'to achieve the progressive realisation of each of these rights'. In its language, the Constitution accepts that it cannot solve all of our society's woes overnight, but must go on trying to resolve these problems. One of the limiting factors to the attainment of the Constitution's guarantees is that of limited or scarce resources."\textsuperscript{346}

In another judgment, His Honour Judge Sachs linked health care rights to the notion of human interdependence. In other words,

\textsuperscript{345} Para.19

\textsuperscript{346}
health care rights had to be considered not just from the perspective of human autonomy "...but in a new analytical framework or human interdependence." Social interdependence means that there are shared and inter-dependent rights, and it is the responsibility of government to strike a balance between equally valid but competing entitlements or expectations in relation to these rights. His Honour went on to state that:

"...the provisions of the bill of rights should furthermore not be interpreted in a way which results in Courts feeling themselves unduly pressurised by the fear of gambling with the lives of claimants into ordering hospitals to furnish the most expensive and improbable procedures, thereby diverting scarce medical resources and prejudicing the claims of others. Unfortunately the resources are limited and I can find not reason to interfere with the allocation undertaken by those better equipped than I to deal with the agonising choices that have to be made."248

His Honour, in his concluding remarks, stated that however the right to life came to be defined under South African law, there could, in his opinion, never exist a meaningful way in which "...it can constitutionally be extended to encompass the right indefinitely to evade death."249 Death, according to His Honour, was part of life in that it was life's completion, and we need to come to terms with our mortality. The allocation of scarce expensive medical technologies requires the making of difficult medical choices and according to Judge Sachs, "...[C]ourts are not the proper place to resolve the agonizing personal and medical problems which underlie these choices..."250

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246 Pans 42 & 43
247 Pans.54.
248 Pans.58
249 Pans.57
250 Pans.58
It is also important to note that the court did not accept the argument that the treatment that the patient was seeking fell under the definition of emergency medical treatment – a right to which cannot be denied. The Court was of the opinion that while the words “emergency medical treatment” could possibly be interpreted in such a broad manner that they included “…ongoing treatment of chronic illnesses for the purpose of prolonging life”, this was not their ordinary meaning. For this to be the relevant interpretation for the purposes of section 27(3), it was necessary for it to have been expressed “…in positive and specific terms.”

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253 Para.13
In explaining the Court's approach to this issue, Chaskalson P referred to the 1996 decision of the Supreme Court of India in *Paschim Banga Khet Mazdoor Samity and others v State of West Bengal and another.* This case concerned a claim for damages for serious head injuries and brain haemorrhage following a train accident. The claimant was turned away from various state hospitals either because they did not have the necessary facilities for treatment or on the ground that there was no room to accommodate him. The Supreme Court in delivering its decision stated:

"The Constitution envisages the establishment of a welfare State at the federal level as well as at the State level. In a welfare State the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare State. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21."  

The Court indicated that this was clearly the sort of case which was intended to fall within the parameters of s.27(3) – "The occurrence was sudden, the patient had no opportunity of making arrangements in advance for the treatment that was required, and there was urgency in securing the treatment in order to stabilise his condition. The treatment was available but denied."  

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254 (1996) AIR SC 2426  
255 Ibid at p.2429  
By basing its decision on the rationality and good faith of budgetary decision-making and relating the provision of emergency medical treatment to the availability of health services, it could be argued that the court avoided the difficult task of defining what constitutes emergency medical treatment, unless one argues that the comments in the previous paragraph constitute a definition (a not unreasonable position) and that it could be expected that a similar approach would be taken in relation to the concept of "basic health care" as guaranteed to children in Section 28.

In the case Minister of Health and others v Treatment Action Campaign, Dr Harold Saloojee & Children's Right Centre CCT 8/02 July 2002, the Constitutional Court was asked to reverse a decision of the High Court which found that the government had not reasonably addressed the need to reduce the risk of HIV-positive mothers transmitting the disease to their children. The High Court also found that the government had acted unreasonably on two grounds — firstly, by refusing to make nevirapine (an antiviral) available in the public health sector where the attending doctor considered it medically indicated, and secondly, by not setting out a time frame for the introduction of a national program to prevent mother to child transmission of HIV.

It is interesting to note however, that in the unreported case of Biljon v Minister of Correctional Services 11778/96, C.P.D. (High Court), a case that dealt with the rights of prisoners living with HIV to adequate health care and access to antiretroviral therapy (ARV), the High Court dismissed the prison authorities' claim of budgetary constraints and upheld two of the four prisoners' rights to access ARV at the expense of the prison authorities. The Court held that although budgetary constraints will necessarily influence the type of treatment received by prisoners, prison authorities
could not simply rely upon this argument as a defence – that medical treatment is not affordable vis-à-vis their own budget. The Court did make it clear that although this case concerned the right to access to health care, it was specific to prison settings and that therefore it was the responsibility of the Department of Correctional Services and not the Department of Health that was responsible for the costs of the medical treatment.\textsuperscript{257}

Another case of interest is that of \textit{Applicant v Administrator, Transvaal} 1993 (4) S.A. 733, a case which was heard before the introduction of the interim Constitution of 1993 but could be argued as acting as a legal precedent in relation to the issues of access to health care and medical treatment. In this case, the applicant, a patient who had been prescribed the drug Gancyclovir and fitted with a special administering catheter, was informed that the drug would not be supplied because it was expensive. The drug had been previously supplied free of charge by the manufacturer. The hospital also argued that if the drug were made available to all AIDS patients, the costs would drain the financial resources of the hospital, adding that the drug was also toxic and not registered.

The court held that although the drug was not registered, it had obtained ‘ad hoc’ approval by the hospital authorities – the hospital had dispensed the drug to five other patients prior to the applicant. Furthermore, the drug was registered in most other countries and its registration was pending in South Africa. The court noted that although budgetary considerations are relevant in supplying medical treatment, in this case the cost would not drain hospital funds as was alleged. The court also stated that although the patient was terminally ill, the drug would improve his quality of

\textsuperscript{257} Ibid.
life and it was also noted that the patient had been led to believe that he would receive the drug. The hospital was ordered to begin supplying the applicant with the drug. The issue of the patient’s quality of life was not raised in Soobramoney’s case and one can only speculate why this was the case, although the debate surrounding the alleged subjective nature of quality of life determinations, both from an ethical and legal perspective, may have had a influence on the Court’s decision.

Figure 28

Following the decision of the Constitutional Court in Soobramoney’s case, it is difficult to see how a similar decision to that discussed above would again be reached, although the decision of the Constitutional Court in the case of The Government of the Republic of South Africa, The Premier and the Province of the Western Cape, Cape Metropolitan Council & Oostenberg Municipality v Irene Grootboom & Others (CCT 11/00 – heard 11

258 Ibid
259 There has been much written about the quality of life debate but this thesis does not present the opportunity to act as a forum for discussion. However, the following are references for those interested in reading more about this topic. Berglund, C.A. Ethics for Health Care (South Melbourne: Oxford University Press, 1998); Morton, J. (Ed) An Easeful Death? Perspectives on Death, Dying and Euthanasia (NSW: The Federation Press, 1996); Singleton, J. & McLaren, S. Ethical Foundations of Health Care – Responsibilities in Decision Making (London: Mosby, 1995)
260 Various pills used in treatment of HIV & AIDS retrieved from http://www.avert.org/photos.htm on 28/04/04
May, 2000 – decision 4 October, 2000) (‘Grootboom case’) provides useful and significant insight into the decision-making and interpretation processes of the Court – specifically in relation to the term “adequate” as set out in section 26 of the Constitution, which provides that everyone has right of access to adequate housing. The decision is also significant in that in delivering their judgments, their Honours referred authoritatively to the decision in Soobramoney’s case and therefore provides guidance as to the role of precedent in the Constitutional Court.

The Grootboom case, an appeal to the Constitutional Court against a decision of the High Court, concerned a group of 510 children and 390 adults who were rendered homeless as a result of their eviction from their informal ‘squatter’ homes which were located on private land previously earmarked for formal low-cost housing. Mrs Irene Grootboom, on behalf of all the applicants brought an application to the Cape of Good Hope High Court seeking an order requiring the government to provide them with adequate basic temporary shelter or housing until they obtained permanent accommodation and were granted certain other forms of relief or alternatively, basic nutrition, shelter, healthcare and social services to the respondents who were children. The applicants based their claim on two constitutional provisions – firstly, the right of access to adequate housing as guaranteed under section 26 of the Constitution and the obligation imposed on the state to take all reasonable legislative and other measures to ensure the progressive realisation of this right within its available resources pursuant to section 26(2), and secondly, the right of children to shelter as guaranteed by section 28(1)(c). The respondents argued

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261 Irene Grootboom & Others v Oostenberg Municipality, Cape Metropolitan Council, The Premier of the Province of the Western Cape, National Housing Board, & The Government of the Republic of South Africa 2000 (3) BCLR 777/ Case No. 6826/99
that their constitutional obligations had been complied with due to the implementation of the state housing programme, under which there was an acknowledged long waiting list.

The High Court qualifiedly granted the application and ordered the respondents to provide shelter to the children and their parents, stating that "...tents, portable latrines and a regular supply of water (albeit transported) would constitute the bare minimum". In making the order, the High Court, in relation to the claim based upon section 26 concluded that:

"In short, respondents are faced with a massive shortage in available housing and an extremely constrained budget. Furthermore in terms of the pressing demands and scarce resources respondents had implemented a housing programme in an attempt to maximise available resources to redress the housing shortage. For this reason it could not be said that respondents had not taken reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right to have access to adequate housing."

The High Court specifically referred to the judgement of the Constitutional Court in the Soobramoney case when discussing the relationship between section 26(1) and (2), specifically referring to the comments of Chaskalson P:

"What is apparent form these provisions is that the obligations imposed on the State... are dependant upon the resources available for such purposes, that the corresponding rights themselves are limited by reason of the 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."

and concluded that

263 Ibid per Davis J at 293A
"...Given the express wording of section 26(1) and (2) and the interpretation of the court in Soobramoney to the concept of 'progressive implementation' applicants have not shown that they are entitled to the relief sought in the notice of motion based upon the rights contained in section 26(1) and (2) read together."

In relation to the arguments presented concerning section 28, the High Court held that although the primary obligation to maintain a child rests with a parent, and that primary obligation includes the provision of shelter, in the absence of the ability of parents to provide shelter for their children, then

"...section 28(1)(c) imposes an obligation on the State to do so, albeit that by the use of the word shelter the constitution envisaged that such an obligation falls far short of adequate housing. Although the section does not employ the adjective 'basic' to qualify the concept 'shelter' as is the case with 'nutrition' and 'health care', it follows from the dictionary definition that shelter is a significantly more rudimentary form of protection from the elements than is provided by a house."

The Court also made some useful comments in relation to the use of definitions in a constitutional context, warning against the use of definitions that do not promote the essential purpose of the designated constitutional right. In this case, the Court was of the opinion that it was not within the essential constitutional purpose of the right to shelter to extend the definition to include an obligation on the state to provide housing to the parents of the respondent children, as this would impose "...impossible financial demands upon the State." Here, the Court had accepted the definition of shelter as found in the Shorter Oxford English Dictionary.

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264 Ibid at 285-A-B
265 Ibid
266 a structure affording protection from rain, wind or sun; any screen or place of refuge from the weather. A place of temporary lodging for the homeless poor..."
The High Court also made some important obiter dicta\textsuperscript{267} comments with respect to the justiciability of socio economic rights, specifically in relation to justiciability and budgetary implications. \textsuperscript{268} The Court noted that the right conferred by section 28(1)(c) was an unqualified constitutional right, that is, it is a right to which no qualifications are attached, as compared with the rights conferred by section 26, which are subject to the qualifications of available resources and progressive realisation.

\textsuperscript{267} The term ‘obiter dicta’ is a term used to describe those observations made by judges that do not form part of the reasoning of a case. Such observations are not binding on lower courts nor subsequently on the court that makes them. They are however useful in illustrating key points and can be used as persuasive argument before a court.

\textsuperscript{268} These comments were made in the context of the claim to an unqualified right to shelter and may be of limited use, but it is significant that the court at least addressed this issue.

\textsuperscript{269} A baby, one of 2.5 million people facing famine in Sudan, given oral rehydration solution by nurse. UN\#187754C UN/DP1/E.Debebe retrieved from http://www.un.org/UN50/Photos/90s.html on 27.04.04
In referring to these relevant qualifications is important to note that the High Court referred both to the submissions made with respect to General Comment No.3 of the Committee on Economic, Social and Cultural Rights\textsuperscript{270} ("General Comment"), and also to the implementation of the Limburg Principles.\textsuperscript{271}

The High Court noted the argument of Counsel that the General Comment was of persuasive force because article 2 para 1 of the ICESCR, the subject of the General Comment, bears similar wording to section 26(2) of the Constitution. The Court noted that paragraph 9 of the General Comment states, \textit{inter alia}, that

\begin{quote}
"...The concept of progressive realization institutes a recognition of the fact that full realization of all economic, social and cultural rights will generally not be able to be achieved in a short period of time. In this sense the obligation differs significantly from that contained in article 2 of the International Covenant on Civil and Political Rights which embodies an immediate obligation to respect and ensure all of the relevant rights. Nevertheless, the fact that realization over time, or in other words progressively, is foreseen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realization of economic, social and cultural rights...It thus imposes an obligation to move as expeditiously as possible towards that goal..."
\end{quote}

Further, the Court noted that in paragraph 10, the Committee on Economic, Social and Cultural Rights stated the view that,

\begin{quote}
"...a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is
\end{quote}

\textsuperscript{270} Office of the High Commissioner for Human Rights, \textit{The nature of States parties obligations (Art.2.par.1): 14/12/90}. CESC General Comment 3. (General Comments) at http://www.ohchr.org/EN/HRBodies/CESCR/Pages /GeneralComment3En.aspx

incumbent upon every State party. Thus, for example, a State party in which any significant number of individuals is deprived of...essential primary health care, of basic shelter and housing...is, **prima facie**, failing to discharge its obligations under the Covenant."

The Court then turned its attention to the relevant content of the Limburg principles, and specifically to the concept of “...to achieve progressively the full realization of the rights” as contained in the ICESCR, these being:

> “21. The obligation...requires States parties to move as expeditiously as possible towards the realization of the rights. Under no circumstances shall this be interpreted as implying for States the right to deter indefinitely efforts to ensure full realization. On the contrary all States parties have the obligation to begin immediately to take steps to fulfil their obligations under the Covenant.

> 22. Some obligations under the Covenant require immediate implementation in full by all State parties such as the prohibition of discrimination in article 2(2) of the Covenant.

> 23. The obligation of progressive achievement exists independently of the increase in resources; it requires effective use of resources available.

> 24. Progressive realization can be effected not only by increasing resources but also by the development of societal resources necessary for the realization by everyone of the rights recognized in the Covenant.”
In highlighting these issues, the Court referred to the Certification case\textsuperscript{272} wherein, as has been previously discussed, it was argued that the courts should not, within the context of interpreting the rights conferred by a bill of rights, especially socio economic rights, be able to dictate to the government on how the budget should be allocated – to allow the courts to do so would be inconsistent with the doctrine of separation of powers and must by necessity compromise the justiciability of the said rights. The Constitutional Court in that case however, concluded that the existence of budgetary implications did not compromise or preclude justiciability.\textsuperscript{273}

The importance of this acknowledgement lies in its value when considering the right to health care – that although under the Constitution of South Africa, the right of access to health care is a qualified one, the right is still a justiciable one, and each case must be evaluated in terms of its own particular facts. Therefore, the fact that budgetary implications will, by necessity, be a consideration when determining the extent of the right of access to health care in any one particular case, does not preclude the Constitutional Court from hearing the case on the basis of lack of justiciability.

In the Grootboom case, the appellants\textsuperscript{274} challenged the correctness of the order made by the High Court. Pursuant to the procedure of the Constitutional Court, all parties submitted written argument, as did the Human Rights Commission and the Community Law Centre of the University of the Western Cape both of whom were

\textsuperscript{272} Op. cit
\textsuperscript{273} Ibid at
\textsuperscript{274} The Government of the Republic of South Africa, The Premier of the Province of the Western Cape, Cape Metropolitan Council and Oostenberg Municipality
admitted as amici curiae275 and permitted to present written and oral argument.

The decision of the Constitutional Court covered several important areas but specifically, the issue of the justiciability of socio economic rights, the meaning of section 26 and the obligations imposed by it and relevant international law and its impact on South African national law. It is these issues that will now be addressed in turn. It should be noted that the decision of the Constitutional Court was delivered by His Honour Mr Justice Yacoob, with all other 9 judges concurring.

(i) Justiciability of socio economic rights

The Court stated that both section 26 and section 28(1)(c) of the Constitution -

26. (1) Everyone has the right to have access to adequate housing.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progression realisation of this right.

(3) No one may be evicted from their home, or have their home demolished, without an order of the court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.

28 (1) Every child has the right -

... (c) to basic nutrition, shelter, basic health care services and social services.

275 “amici curiae” is the Latin term for ‘friend of the court’. That is, a person, usually a barrister who, with the court’s permission, may advise the court on a point of law or on a matter of practice. Amici curiae have no personal interest in the case as a party and do not advocate a point of view in support of one party of another. The court may hear an amici curiae if it considers it is in the interests of justice to do so. See Butterworths Australian Legal Dictionary, 1997 for this definition. Note also the comments in para 17 of the judgment where the court thanked the representative of the amici curiae for “...a detailed, helpful and creative approach to the difficult and sensitive issues involved in this case.”
needed to be considered in the context of all the socio economic rights enshrined in the Constitution, for it is these rights that:

..entrench the right of access to land [section 25(5)], to adequate housing and to health care, food, water and social security [section 27]...protect the rights of the child [section 28] and the right to education [section 29]

His Honour was clear that the issue of whether socio economic rights were justiciable had been been settled by the judgement in the Certification case and that accordingly, the courts are constitutionally bound to protect and fulfil them. Therefore:

..The question is ...not whether socio economic rights are justiciable under our Constitution, but how to enforce them in a given case276. This is a very difficult issue which must be carefully explored on a case-by-case basis.277

Having established the justiciability of socio economic rights, His Honour Justice Yacoob turned then to the issue of enforcement and how the obligations imposed by section 26 ought to be interpreted. The comments of His Honour, reflective of the opinion of the Court as a whole, require close examination as they provide a clear indication about how socio economic rights enshrined in a Constitution can expect to be interpreted. In making this comment however, it needs to be remember that the 1996 Constitution had its foundation in a state that was based on an ideology of white racial superiority, in which all indigenous peoples, peoples of mixed race- 'colored people' – and Indians were considered inferior

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276 Section 38 of the Constitution of South Africa empowers the Court to grant appropriate relief for the infringement of any right entrenched in the Bill of Rights.
277 Para.20
and therefore had no role to play in mainstream economic or political life.\textsuperscript{278}

(ii) **Obligations Imposed by Section 26**

Justice Yacoob indicated that any interpretation of rights needed to be done in context and that there was two relevant types of context – textual and social/historical. In this case, the textual context required consideration of both Chapter 2 of the Constitution (which contains the Bill of Rights), and the Constitution as a whole. His Honour stated:

\begin{quote}
\textit{"Our Constitution entrenches both civil and political rights and social and economic rights. All the rights in our Bill of Rights are inter-related and mutually supporting. There can be no doubt that human dignity, freedom and equality, the foundational values of our society, are denied those who have no food, clothing or shelter. Affording socio-economic rights to all people therefore enables them to enjoy the other rights enshrined in Chapter 2. The realisation of these rights is also key to the advancement of race and gender equality and the evolution of a society in which men and women are equally able to achieve their full potential."}\textsuperscript{279}
\end{quote}

According to His Honour, it is the interrelatedness of these rights which assists in determining whether or not the state has met its relevant obligations.

\textsuperscript{278} Pillay, Y. *The impact of South Africa's new constitution on the organisation of health services in the post-apartheid era.* Journal of Health Politics, Policy and Law, 2001, Vol.26, No.4, pp.747-766 at \url{http://library.northernlight.com/AA20010910010001881.html} retrieved 29/12/01

\textsuperscript{279} Para.23
The social/historical context of the rights contained in Chapter 2, according to His Honour, could be found in South Africa’s “...legacy of deep social inequality...” as identified by the Court in *Soobramoney*, The race and gender inequality represented by the policies of apartheid could only be overcome by the full realisation of the socio-economic rights contained in Chapter 2.

It should be noted that this dual contextual approach is identical in intent, albeit different in mode of expression, to that of the Constitutional Court in *Soobramoney*, when the Court indicated it would undertake a ‘purposive approach’ to Constitutional interpretation.

(iii) The relevance of international law

The Court then turned its attention to the value of international law as an interpretative tool. It was noted that s.39(1) of the

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280 Young African boy cares for his younger sibling while his mother is in hospital being treated for AIDS retrieved from http://www.time.com/time/europe/photessays/aids on 28/04/04
281 Para.25
282 See #175
283 See #177
284 Section 39 of the Constitution provides:
“(1) When interpreting the Bill of Rights, a court, tribunal or forum –
Constitution places an obligation on a court to consider not only international law but that it may also consider foreign law, when interpreting a Bill of Rights.

The Court addressed the significance of the ICESCR, and specifically, considered the obligations on states parties to meet, what the United Nations Committee on Economic, Social and Cultural Rights calls "...that minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights..." contained in the ICESCR.

Justice Yacoob referred to argument presented to the Court regarding the concept of 'minimum core obligations' as set out by the Committee on Economic, Social and Cultural Rights, as previously referred to in this Thesis. His Honour described the significance of this concept in the following terms:

"The concept of minimum core obligation was developed by the committee to describe the minimum expected of a state in order to comply with its obligation under the Covenant. It is the floor beneath which the conduct of the state must not drop if there is to be compliance with the obligation. Each right has 'a minimum essential level' that must be satisfied by the states parties...Minimum core obligation is determined generally by having regard to the needs of the most vulnerable group that is entitled to the protection of the right in question. It is in this context that the concept of minimum core obligation must be understood in international law."\(^{285}\)

\(^{285}\) Ibid, para.31
His Honour stated that in order to identify what the specific needs and opportunities for the enjoyment of an economic, social and cultural right were in any one circumstance, it was necessary to consider such factors as "...income, unemployment, availability of land and poverty...[as well as] [t]he differences between city and rural communities...[and] the economic, social history and circumstances of a country."

"All this illustrates the complexity of the task of determining a minimum core obligation for the progressive realisation of the right of access to adequate housing without having the requisite information on the needs and opportunities for the enjoyment of this right. The committee developed the concept of minimum core over many years of examining reports by reporting states. This Court does not have comparable information."

It was this lack of ‘comparable information’ which His Honour identified as the key difficulty which a court faced in determining what the ‘minimum core’ would be in any given context.

"...the real question in terms of our Constitution is whether the measures taken by the state to realise the right afforded by section 26 are reasonable. There may be cases where it may be possible and appropriate to have regard to the content of a minimum core obligation to determine whether the measures taken by the state are reasonable. However, even if it were appropriate to do so, it could not be done unless sufficient information is placed before a court to enable it to determine the minimum core in any given context. In this case, we do not have sufficient information to determine what would comprise the minimum core obligation in the context of our Constitution." \[286\]

The implications of this statement for the right to health care arises from this notion of a lack of ‘sufficient information’ – if there is no substantive definition of what constitutes ‘basic or adequate health care’ and the court is indicating that it does not have the sufficient information before it to determine its extent, then it would appear that the court will not make a determination

\[286\] Ibid, para.33
of 'unreasonableness' if the issue comes down to one of budgetary considerations.

In relation to this issue of budgetary considerations when making decisions regarding socio economic rights, it has been argued that the will and ability of such countries as South Africa to "develop and sustain equitable access to health care" is being undermined by the type of market-driven health care that exists in such countries as the United States, the U.K. and, logically, Australia. Benatar argues that what he calls the "the progressively dominating influence of 'economic rationality' (with money as the bottom line) in medical care...[is] impoverishing the concept of medicine as a caring profession..." with the result that health care is seen as a saleable commodity in an aggressive and adversarial marketplace rather than the provision of patient care. He is critical of the roles played by multinational drug companies, insurance companies and bureaucrats in the increasing global disparity in health and health care provision and claims that human rights are most at risk when governments become pre-occupied with political, military or economic considerations.

Research has revealed that there is some consensus of opinion with the type of views espoused by Benatar, with criticism of the European Union's opposition to a proposal by South Africa to give priority to the right to the highest attainable standard of health ahead of the intellectual property rights of certain pharmaceutical companies. It has also be claimed that organisations such as

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the World Bank, the International Monetary Fund and other major international donors have pushed through structural adjustment policies in the fields of health care and economics in less-developed countries, such as the new South Africa, over-riding the wishes of national governments and internationally agreed human rights in health and health care. A further warning came from in this regard came from Dr Boutros Boutros-Ghali shortly before his election as Secretary-General of the UN, with research revealing that he warned the International Monetary Fund and other aid agencies that the making of loans and grants dependent on increased democracy and freer economies could become a pretext for interference in internal politics. More recently, the U.N. Economic and Social Council Sub-Commission on Human Rights has reminded international economic policy forums and governments that they should be taking human rights, including the right to health, into account when making economic policies and agreements.

A clear example of Benetar's argument in relation to South Africa, can be seen in the recent controversy regarding the pharmaceutical pricing of HIV/AIDS drugs and South African health policy and it is this issue that will now be addressed, for the provision of antiretroviral drugs has received the attention of both government and, more importantly for the purposes of this paper, the courts. In the case of the latter, the focus has been on the enforcement and justiciability of socio-economic rights.

http://global.umi.com/pqdweb?TS=992490844&RQT=309&CC=1&Dtp=1&Did=0000000
retrieved 14/6/01

Ibid.

South Africa has the world's fastest-growing HIV infection rates with research revealing that some 4.2 million of South Africa's 43 million citizens are infected. It is estimated that at least 16% of the adult population are infected, with 20% of pregnant women carrying the virus and black South Africans recognised as being predominantly at risk of dying early from AIDS. Significantly, from a human rights perspective, HIV/AIDS has been described as "a silent emergency whose effect threatens to violate all the tenets

293 Hink, R. Intellectual Property and AIDS Medication in South Africa at http://www.american.edu/TED/aidstrip.htm retrieved 10/01/02
of the Convention on the Rights of the Child" and is projected to account for a 100 per cent increase in child mortality in South Africa.

Pursuant to the new public health policy objectives of the Department of Health in South Africa in compliance with the provisions of the Constitution, there has been a move away from funding large secondary and tertiary facilities to the provision of primary health care (PHC) clinics. In 1994, under the interim Constitution, free primary care was offered nationally to all pregnant women and children under the age of six and by 1996, this was expanded to all "..all personal consultation services, and all non-personal services provided by the publicly-funded PHC system". Implementation however, has been uneven at provincial levels and according to some sources, has been significantly hindered by budgetary constraints, constraints that could be eased by the use of generic pharmaceutical products, including generic versions of anti-virals to treat HIV.

In 1999 in response to growing criticism that the government was doing little in the field of HIV/AIDS treatment or education, Health Minister Nkosazana Dlamini-Zuma (Zuma) claimed that budget shortfalls prevented her from providing HIV-positive women with the anti-viral zidovudine at several anti-natal pilot projects. The estimate was that approximately 30,000 lives would be saved annually with the universal availability of this anti-viral for pregnant women, with the cost put at some $13 million per

[296] Ibid.
year. While there was some debate over the accuracy of the figures and how the use of the drug may limit transmission, the key issue was the budgetary one – the anti-viral drug could not be funded, given its cost and the broader budgetary implications, as a result of increased healthcare entitlements, increased coverage and increased clinic construction – estimated at $50 million per annum.

In 1997, Minister Zuma secured the passage of the *Medicines and Related Substances Control Amendment Act*\(^{299}\) ("Medicines Act"), which provided for generic substitution by pharmacists of prescription medicine, the scheduling of medicines, the licensing of dispensers, the establishment of a pricing committee, and the prohibition of pharmaceutical bonusing and rebates for favoured bulk buyers. The most significant clause in the Medicines Act is Clause 15 which allows, inter alia, for the Minister to prescribe conditions for "*...the supply of more affordable medicines in certain circumstances so as to protect the health of the public*" and furthermore "*...may...prescribe the conditions on which any medicine which is identical in composition meets the same quality of standard and is intended to have the same proprietary name as that of another medicine already registered in the Republic...may be imported*". In other words, the legislation allowed for South Africa to seek the cheapest world price for a drug and for the Minister to allow parallel importing. Also, the Minister could, under certain conditions, grant rights for the manufacture of copies of patented drugs without the approval of the patent holder. According to research\(^{300}\), this had the potential to reduce the price of some drugs by 70 to 95 percent and would allow for such drugs

\(^{298}\) Bond op.cit at p. 2
as AZT and other AIDS related drugs to be copied and manufactured under the terms of the legislation.

It is useful at this point to return to, in some detail, the case of Minister of Health and others v Treatment Action Campaign, Dr Haroon Saloojee and Children’s Rights Centre301 a Constitutional Court case concerning the availability of an antiretroviral drug called nevirapine. The case began as an application in the South African High Court in August of 2001, whereby a number of applicants, primarily the Treatment Action Campaign (TAC) brought an action against the national Minister for Health as well as the respective members of the executive councils responsible for the provision of health in all provinces save the Western Cape.

The South African Government had devised a programme to contend with mother-to-child transmission of HIV at birth and in doing so, had identified the drug ‘nevirapine’ as the preferred drug of choice for treatment. However, the programme restricted the availability of nevirapine in the public health sector to specific research sites and the applicants contended that the restrictions were unreasonable when measured against the Constitution, specifically:

"7(2) The state must respect, promote and fulfil the rights in the Bill of Rights.

...

301 Constitutional Case CCT8/02, heard 2,3 & 6 May, 2002; [2002] S.A.J. No.48
The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state."

The central arguments concerned, firstly, the right of everyone to have access to public health care services and, furthermore, the right of children to be afforded special protection, under s.27(1), (2) and s.28(1), and secondly, whether the Government is constitutionally obliged and therefore could be ordered to implement an effective and comprehensive plan for the prevention of mother-to-child transmission of HIV throughout the country. The High Court, in December 2001 made four significant orders and it is of value to include these orders in full, as they have a bearing on the comments that will follow in relation to the Constitutional Court hearing.

The orders read:

"(1). It is declared that the Government is obliged to make Nevirapine available to pregnant women with HIV who give birth in the public health sector, and to their babies, in public health facilities to which the respondents' present programme for the prevention of mother-to-child transmission of HIV has not yet been extended, where in the judgment of the attending medical officer, acting in consultation with the medical superintendent of the facility concerned, this is medically indicated, which shall at least include that the woman concerned has been appropriately tested and counselled.

(2) The Government is ordered to make Nevirapine available to pregnant woman with HIV who give birth in the public sector, and to their babies, in public health facilities to which the respondents' present programme for the prevention of mother-to-child transmission of HIV has
not yet been extended, where in the opinion of the attending medical practitioner, acting in consultation with the medical superintendent of the facility concerned, this is medically indicated, which shall at least include that the woman concerned has been appropriately tested and counselled.

(3) It is declared that the [Government] is under a duty to forthwith plan an effective comprehensive national programme to prevent or reduce the mother-to-child transmission of HIV, including the provision of voluntary counseling and testing, and where appropriate, Nevirapine or other appropriate medicine, and formula milk for feeding, which programme must provide for its progressive implementation to the whole of the Republic, and to implement it in a reasonable manner.

(4) The [Government is] ordered forthwith to plan an effective comprehensive national programme to prevent or reduce the mother-to-child transmission of HIV, including the provision of voluntary counseling and testing, and where appropriate, Nevirapine or other appropriate medicine, and formula milk for feeding, which programme must provide for its progressive implementation to the whole of the Republic, and to implement it in a reasonable manner.

The hearing before the Constitutional Court was an attempt to reverse these orders.

According to evidence presented to the Court, the Government’s decision to restrict the availability of nevirapine to research sites was based upon concerns about its safety and efficacy. However, nevirapine had been registered by the Medicines Control Council in 1998 and under the provisions of the Medicines and Related Substances Control Act 101 of 1965, registration of a drug by

302 Ibid, para.8
definition entailed a positive finding as to its quality, safety and efficacy. Furthermore, following the decision of the World Health Organisation, in January 2001, to recommend the administration of nevirapine to mother and infant at the time of birth to combat HIV, the Medicines Control Council formally approved the drug for the prevention of mother-to-child transmission of HIV.

The Government had, in April of 2001, issued a Protocol for providing a comprehensive package of care in relation to the prevention of mother-to-child transmission of HIV in South Africa. Part of this Protocol was the establishment of two research sites in each of the nine provinces which would operate for a period of two years for the purposes of gaining "...a better understanding of the

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303 Retrieved from http://www.dec.org/partners/afr/photogallery/search_results.cfm on 27/04/04
operational challenges of introducing [antiretroviral interventions] on a wider scale...

The TAC argued that the result of the Protocol was that doctors in the public sector who did not work at one of these research sites would not be able to prescribe nevirapine for their patients. As the prescribing of nevirapine was one of medical judgment, it was neither lawful or rational to preclude doctors in the public sector from exercising their professional judgment in relation to its prescription, while allowing doctors in the private sector to continue to prescribe. The lack of availability of the drug, combined with the failure to implement a comprehensive programme addressing the needs of mother and child was, according to the TAC evidence of government conduct that was "...irrational, in breach of the Bill of Rights, contrary to the values and principles prescribed for public administration in section 195 of the Constitution ...[as well as being] in breach of ...international obligations as contained in a number of conventions ...signed and ratified."

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301 Ibid, para.16
305 Ibid, para 19. Section 195(1) of the Constitution states:

195. (1) Public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:

a. A high standard of professional ethics must be promoted and maintained.

b. Efficient, economic and effective use of resources must be promoted.

c. Public administration must be development-oriented.

d. Services must be provided impartially, fairly, equitably and without bias.

e. People's needs must be responded to, and the public must be encouraged to participate in policy-making.

f. Public administration must be accountable.

g. Transparency must be fostered by providing the public with timely, accessible and accurate information.

h. Good human-resource management and career-development practices, to maximise human potential, must be cultivated.
The Constitutional Court, in determining whether the orders as handed down by the High Court should stand, addressed the issue of the enforcement of socio-economic rights and referred to both Soobramoney and Grootboom. In doing so, the Court was definitive in its assessment that socio-economic rights were justiciable and quoted Yacoob, J. in Grootboom when he stated:

"...The [Constitutional] obligation is to provide access to housing, health care, sufficient food and water, and social security ...these are rights, and the Constitution obliges the State to give effect to them. This is an obligation that Courts can, and in appropriate circumstances, must enforce." 306

Therefore, given this justiciability307, the only question that the Constitutional Court regarded as being before it was whether the measures adopted by the South African government in relation to the provision of health care services HIV infected mothers and their newborns fell short of its constitutional obligations.

In addressing this issue, the court turned first to a consideration of argument presented to it that s27(1) of the Constitution vests in everyone an individual right, which has a ‘minimum core’ to which every person is entitled. The Court noted that this concept of ‘minimum core’ was developed by the United Nations Committee on Economic, Social and Cultural Rights, when it stated:

"...a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education.

i. Public administration must be broadly representative of the South African people, with employment and personnel management practices based on ability, objectivity, fairness, and the need to redress the imbalances of the past to achieve broad representation.

307 It is also useful at this
is, prima facie, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its raison d’être. By the same token, it must be noted that any assessment as to whether a State has discharged its minimum core obligations must also take account of resource constraints applying within the country concerned. Article 2(1) obligates each State party to take the necessary steps ‘to the maximum of its available resources’. In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.”

Argument had been presented to the Court that the Constitution specifically recognized the notion of a ‘minimum core’ in several sections, namely:

“s.9(2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories or persons, disadvantaged by unfair discrimination may be taken.”

“s.24(b) Everyone has the right...

to have the environment protected...through reasonable legislative and other measures...

“s.25(5) The State must take reasonable legislative and other measures, within its available resources, to foster conditions which enable citizens to gain access to land on an equitable basis.”

“s.25(8) No provision of this section may impede the state from taking legislative and other measures to achieve land, water and related reform, in order to redress the results of past racial

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308 CESC R General Comment No.3 “The nature of States parties obligations (Art.2, par.1) 14/12/90 para 10 as quoted at ibid, para.26.
discrimination provided that any departure from the provisions of this section is in accordance with the provisions of section 36(1)."\(^{309}\)

It was argued that there is a significant distinction between these sections for while s.25(5) obligates (emphasis added) the State in relation to access to land, s.24(b) confers on everyone the right to have a protected environment through 'reasonable legislative and other measures' but without a corresponding separate duty imposed on the state to take such measures. Furthermore ss.9(2) and 25(8) contain only permissive powers to take reasonable measures, with again no obligation on the State to do so. The relevance of identifying such distinctions could be seen when a comparison of these sections is drawn with ss.26 and 27.\(^{310}\)

\(^{309}\) Section 36(1) reads:

**Limitation of rights**

36. (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including

a. the nature of the right;

b. the importance of the purpose of the limitation;

c. the nature and extent of the limitation;

d. the relation between the limitation and its purpose; and

e. less restrictive means to achieve the purpose.

\(^{310}\) These sections provide:

**Housing**

26. (1) Everyone has the right to have access to adequate housing.

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

(3) No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.

**Health care, food, water and social security**

27. (1) Everyone has the right to have access to
Sections 26(1) and 27(1) were identified as 'self-standing rights’ to which everyone was entitled, in other words, they were rights which stood independently of any corresponding duty or obligation which may be imposed on a State in relation to their realization. The imposition of obligations in relation to these rights, it was argued, were imposed by sections 26(2) and 27(2) respectively. Thus, on this basis, the content of the ‘right’ was different from the content of the ‘obligation’.

This argument was firmly rejected by the Court based on the linkage and interpretation of these sections as identified in both Soobramoney and Grootboom. Both section 26(1) and section 27(1) refer to the ‘right’ of access, while sections 26(2) and 27(2) refer to obligation on the state to take ‘reasonable legislative and other measures within its available resources, to achieve the progressive realization of each of these rights’ – the rights and obligations are therefore corresponding, and therefore, as was stated by Yacoob J in Grootboom, they “... are related and must be read together.”

Given this recognition that there exists a linkage between rights and obligations, the Court turned it attention to the notion of a ‘minimum core’ of services which could be said to exist in relation to such rights.

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

(3) No one may be refused emergency medical treatment.

311 OP.cit., para.34
In the opinion of the Court, while the notion of 'minimum core' of a particular service could be useful in determining in any particular circumstance whether the measures adopted by the state in relation to the provision of a particular service, could be said to be 'reasonable', it was not appropriate to read the socio-economic rights of the Constitution as entitling everyone to demand that 'minimum core' be provided to them. Accordingly therefore, what constituted a minimum core related only to 'reasonableness' under s.26(2), not a self-standing right under s.26(1).

"A purposive reading of sections 26 and 27 does not lead to any other conclusion. It is impossible to give everyone access even to a "core" service immediately. 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 and 27 on a progressive basis..."\(^{312}\)

The Court also proposed a limited role for itself in this debate, when it stated:

"Courts are ill-suited to adjudicate upon issues where court orders could have multiple social and economic consequences for the community. The Constitution contemplates rather a restrained and focused role for the courts, namely to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets. In this way, judicial, legislative and executive functions achieve constitutional balance."\(^{313}\)

This recognition of the importance of constitutional balance as established by the separation of powers, was, as previously mentioned, noted in the Certification case and was reinforced by the Court here when it stated:

\(^{312}\) Ibid, para.35
\(^{313}\) Ibid, para.38
"This Court has made it clear on more than one occasion that although there are no bright lines that separate the roles of the legislature, the executive and the courts from one another, there are certain matters that are pre-eminently within the domain of one or other of the arms of government and not the others. All arms of government should be sensitive to and respect this separation."\textsuperscript{314}

However, even given the importance of this separation, the Court identified that the courts had a primary duty "...to the Constitution and the law..." which, pursuant to s.165(2) of the Constitution, "...they must apply impartially and without fear, favour or prejudice." Accordingly therefore because the state has an obligation, under s.7(2) of the Constitution to "...respect, protect, promote, and fulfil the rights in the Bill of Rights...",

"...where state policy is challenged as inconsistent with the Constitution, courts have to consider whether in formulating and implementing such policy the state has given effect to its constitutional obligations. If it should hold in any given case that the state has failed to do so, it is obliged by the Constitution to say so. In so far as that constitutes an intrusion into the domain of the executive, that is an intrusion mandated by the Constitution itself..."

As Mr Justice Ackermann in \textit{Fose v Minister of Safety and Security}\textsuperscript{315}

"I have no doubt that this Court has a particular duty to ensure that, within the bounds of the Constitution, effective relief be granted for the infringement of any of the rights entrenched in it. In our context an appropriate remedy must mean an effective remedy, for without effective remedies for breach, the values underlying and the right entrenched in the Constitution cannot properly be upheld or enhanced. Particularly in a country where so few have the means to enforce their rights through the courts, it is essential that on those occasions when the legal process does establish that an infringement of an entrenched right has occurred, it be effectively vindicated. The courts have a particular responsibility in this regard and are obliged to 'forge new tools' and shape innovative remedies, if needs be, to achieve this goal."

The Court when on to state that in a dispute concerning socio-economic rights, it is probable that a court will be called upon to

\textsuperscript{314} Ibid, para.98.
determine whether or not state policy is consistent with the Constitution, and if it is not, to so declare that inconsistency.

The approach of the Court as detailed in the above comments, specifically in relation to state policy and the forging of innovative remedies, is reflective of the type of comments that have resulted in the Court being criticized for what has been called 'judicial elitism' or 'judicial activism', while recognising that the Court is one of the most progressive constitutional courts in existence.\textsuperscript{316}

The argument is proffered that when judges take it upon themselves to make decisions to criticise state policy and allocate significant social resources in a manner that may be contrary to state policy, thus "..spending tax payers' money on their behalf"\textsuperscript{317} they are taking on the role of legislators, determining the values and policies that must be embraced by society, values sourced from natural law rather than common law. There is the suggestion that decision-making based upon natural law principles is undemocratic, for as any judicial interpretation of constitutional law must be accepted as final and the possibility of constitutional amendment is marginal, then such judicial decision-making has the potential to conflict with the will of the people, as reflected in the legislature.

It is useful to also note that it has also been proposed\textsuperscript{318} that there may be good reasons to entrust the interpretation of a new "..socially progressive constitution to a South African judiciary that

\textsuperscript{315} 1997 (3) SA 786 (CC); 1997 (7) BCLR 851 (CC) at para.69
\textsuperscript{316} Tucker, D.F.B. "Natural Law or Common Law: Human Rights in Australia" in Galligan & Sumpford pp.120-143.
\textsuperscript{317} Ibid p.134
historically has practiced and tolerated racism in its courtroom" even though the risk of having the process of constitutional interpretation undertaken by such an elite body of individuals may result in the imposition of the political and ideological views of the judiciary on South African society.

There will always be critics of the judicial process, especially that undertaken by a 'progressive' Constitutional Court burdened with the responsibility of interpreting a complex and newly introduced Constitution which contains a Bill of Rights. As Sir Henry Gibbs once stated\textsuperscript{319}:

"[In] this cynical age, when critics are more inclined to look for the canker in the rose rather than to admire the rose itself, it is not surprising that there are some academic lawyers who regard it as unrealistic to take what the judges say at its face value. The real reasons for the decisions, they say, are not those given by the judges; there is a hidden agenda. The decisions are to be explained by the beliefs (or prejudices) of the judges on social, political and economic questions. Since this so-called realist theory is quite at variance with the reasons published by the judges, the natural inference,...is that the judges are deliberately deceitful in professing to act in a strictly legal way. Other writers.....suggest that the influence of the values or prejudices of the judges is an unconscious one and that the judges are naively unaware of it and really believe that they are strictly guided by legal rules and principles. Another suggestion is that the judges adopt legalism as a valuable strategy that enables them to perform a political function without appearing to act politically."

It is also argued\textsuperscript{320} that as judges are not politicians, any decision regarding the allocation of scarce resources made within the parameters of a Constitutional Court, such as that in South Africa, is incapable of securing a political consensus to advance the rights identified by the Court. The reasoning behind this argument is

\textsuperscript{319} Sir Harry Gibbs, 'Law and Government', Quadrant October 1990, p.25 at pp.26-7
\textsuperscript{320} Ibid p.135
that the decisions of the Constitutional Court are narrowly focused on the particular issues of case in question and not on the broader social implications. One might agree with the arguably cynical comment that because judges enjoy tenured positions and therefore have no need for 'supporters', they have no need to make sensitive judgments\textsuperscript{321} – judgments made in consideration of the broader social policy implications.

A further argument related to that mentioned above concerns the role of judges as moral educators. Justice Michael Kirby\textsuperscript{322} has argued that judges must act as the moral conscience of a nation, providing reasoned judgments which elaborate the meaning of human rights, providing a sound moral foundation for society. The opposing argument stems from the proposition that people only agree about a listing of human rights, as in a Bill of Rights, because of self-interest which they see as being served by recognition of these rights. Therefore, although in deeply divided societies such as that existing in South Africa, there may be the appearance of national consensus in relation to the recognition of human rights, it is proposed that this does not mean that there is any consensus about the place that such rights have in determining the fundamental values of society.\textsuperscript{323}

In conclusion therefore, the Constitutional Court in South Africa being charged with the responsibility of interpreting the Constitution and its Bill of Rights, is obliged by section 172(1) of the Constitution to 'make any order which is just and equitable' to ensure the rights contained therein are adequately protected. Given the justiciability that has been ascribed to socio-economic

\textsuperscript{321} Ibid
\textsuperscript{322} M. Kirby (1995) 'Mechanism for the Recognition and Protection of Rights of Australia' 4(1) Constitutional Centenary 8
rights by the Court, it is on therefore encumbent on the Court to, as was stated by Justice Ackermann in Fose,\textsuperscript{324} shape innovative tools to ensure the remedies intended by the Constitution and the ICESCR are available to all.

On this basis, it is the opinion of this writer that any criticism of the decision-making of the Constitutional Court should be circumspect, respecting the need for the Court to pronouncement judgments that show the necessary willingness to engage in the development of new remedies that "... secure the protection and enforcement of these all- important rights."\textsuperscript{325}

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\textsuperscript{323} Tucker in Galligan & Sampford, op.cit. p.137
\textsuperscript{324} Op.cit
\textsuperscript{325} Ibid, para.19
\textsuperscript{326} Retrieved from \url{http://www.dec.org/partners/afr/photogallery/search_results.cfm} on 27/04/04
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MAJOR CASE STUDY 2 – The Right to Health care in Tibet

The relationship between Tibet and China and the issue of human rights violations has long been a concern of the International Commission of Jurists (ICJ).\textsuperscript{327} In a 1960 report\textsuperscript{328}, the ICJ found that there were widespread violations of not only civil and political rights, but also of economic and social rights. The 1997 report of the ICJ identified that the Tibetan people were "...entitled to but denied the right of self-determination" and that part of this denial related to the right to health. It is therefore useful to examine how the ICJ has determined that the right to health care in Tibet has been violated by the Chinese People’s Republic. Whilst a detailed historical narrative of the relationship between Tibet and China serves no constructive purpose here, it is beneficial to note some key historical issues which place the case study in perspective.

In 1950, the People’s Republic of China (PRC) invaded Central Tibet and began a systematic repression of the Tibetan people, including the forced exile of the leading figure in Tibetan Buddhism, the Dalai Lama. In 1955, the Chinese government established the Preparatory Committee for the Tibet Autonomous Region, which effectively transferred political power from the Tibetan government to this Preparatory Committee. In 1965, China inaugurated the Tibet Autonomous Region (TAR), which was presented to the world as instituting national regional autonomy – Tibetan self-rule – while maintaining complete Chinese control over all Tibetan affairs. In 1994, the Third

\textsuperscript{328} International Commission of Jurists, Tibet and the Chinese People’s Republic: A Report to the International Commission of Jurists by its Legal Inquiry Committee on Tibet - 1960
National Forum on Work in Tibet, saw senior Chinese officials map out a new strategy for the region, which strategy included, "...heightened control on religious activity and a denunciation campaign against the Dalai Lama...; an increase in political arrests; stepped up surveillance of potential dissidents; and increased repression of even non-political protest." Since the beginning of 1996, research has shown that a number of organisations have alleged that repression has escalated with even certain aspects of Tibetan culture being regarded as obstacles to development and Buddhism a 'foreign culture'.

Figure 34

In addressing the issue of the right to health in Tibet, the ICJ quotes the WHO's statement of the 'enjoyment of the highest attainable standard of health' and the Universal Declaration of Human Rights statement that 'everyone has the right to a standard

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330 Tibet Justice Centre (http://www.tibeticlt.org), Tibetan Centre for Human Rights and Democracy (http://www.tibet.com) and Lawyer for Tibet are three such organisations.
331 Map of Tibet retrieved from http://www.travelchinaguide.com/picture/tibet on 27/04/04
of living adequate for the health and well-being of himself and his family, including...medical care and necessary social services' as the fundamental principles against which health in Tibet, as provided by the Chinese, should be measured.

The ICJ points out that while the Constitution of the PRC does not mention the right to health, treaties ratified by the PRC include the International Convention on the Elimination of All Forms of Racial Discrimination, a document that prohibits discrimination in the enjoyment of the right to public health and medical care\textsuperscript{332}; the Convention on the Rights of the Child,\textsuperscript{333} thus requiring the State to take appropriate measures to, inter alia, diminish infant and child mortality and provide necessary medical assistance and health care to all children and the Convention on the Elimination of Discrimination Against Women\textsuperscript{334} which specifically mentions the right of rural women to access adequate health care facilities.\textsuperscript{335}

The ICESCR list four specific steps that are required to be taken by states in fulfillment of the right to health and these steps have equal application to those treaties mentioned above as being ratified by the PRC. These steps are: those necessary for (i) the reduction of the still-birth rate and of infant mortality, as well as for the development of the child, (ii) the improvement of all aspects of environmental and industrial hygiene, (iii) the prevention, treatment and control of epidemic, endemic, occupational and other diseases, and, (iv) the creation of conditions which would assure to

\textsuperscript{332} Article 5(e)(iv)
\textsuperscript{333} Article 24
\textsuperscript{334} Article 12(1)
\textsuperscript{335} Article 14(2)(b)
all medical services and medical attention in the event of illness/sickness.\textsuperscript{336}

In light of the above information, it is important to note however, that both the government of the PRC and the Chinese Communist Party regard health as an important component of socialist modernisation\textsuperscript{337} and that in 1996, Li Peng stated in relation to Tibet that: "by the year 2000, we should initially establish a health care system with Chinese characteristics, whereby everyone can enjoy basic health care, and further raise people's health level."\textsuperscript{338}

While research has shown that official statistics and statements of the PRC\textsuperscript{339} show that there have been significant improvements in the availability and quality of health care, specifically to women and children, in the TAR, there is research that calls these claims into question and research undertaken by the World Bank further indicates the questionable validity of this information. According to the World Bank's May 2002 report China: National Development and Sub-National Finance\textsuperscript{340}

"More than 90 percent of the rural populace or 700 million people...are now without any coverage from risk pooling [medical insurance] schemes. During this period the government's share of the total health spending has fallen and the personal out-of-pocket portion has risen rapidly. The Government finances a small proportion of the total health expenditure – very low compared to other countries".

\textsuperscript{336} Article 12 (2), ICESCR
\textsuperscript{337} As referred to in Tibet, op.cit : Speech by Li Peng at the National Conference on Health Work, Beijing, 9 Dec. 1996, SWB FE/2794 G/5, 13 Dec. 1996
\textsuperscript{338} Ibid, p.225
\textsuperscript{339} Tibet, op.cit , p.227 and see also Information Office of the State Council of the People's Republic of China, New Progress in Human Rights in the Tibet Autonomous Region (Beijing, February 1998) as found at http://www.chinaguide.org/e-white/fast/index.htm retrieved 15/11/01
\textsuperscript{340} A full copy of this report is available at http://www.worldbank.org.cn/English/Content/fiscal.org - retrieved 16/06/2003
The TCHRD\textsuperscript{341} states that personal health care costs in Tibet have escalated over recent years, with an increase from barely 10 yuan in 1990 to 265 yuan in 2000, placing health care and medical services well beyond the reach of the Tibetan people, especially those in rural areas.

In light of this research, the specific treaty obligations will now be addressed, with a focus on the provision of health and medical care to women and children.

![Figure 35\textsuperscript{342}]

**Convention on the Elimination of Discrimination Against Women (CEDAW)**

There are three Articles of the CEDAW that are of relevance to this discussion and these are:


\textsuperscript{342} Old woman with child retrieved from \url{http://www.historylink101.net/china/tibet-1.htm} on 27/04/04
Article 1 which declares that:

"...the term 'discrimination against women' shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality of men and women of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

Article 12 which declares that:

"States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including to those related to family planning."

Article 16(e) which obliges States parties to ensure, on the basis of the equality set out in Article 12 that men and women have:

"The same rights to decide freely and responsibly on the number of children and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."

In 1998, according to the Tibet Justice Centre\textsuperscript{343}, Lawyers for Tibet submitted a report to the Committee on the Elimination of Discrimination Against Women documenting extensive and pervasive discrimination and violence against women. The report identified coerced or forced abortions and sterilizations, with the general limiting of Tibetan families to two or three children, depending on occupation and location. The 1997 Annual Report of Human Rights Violations in Tibet by the Tibetan Centre for Human Rights and Democracy\textsuperscript{344} (TCHRD) reported that 833 known cases of forced abortion and sterilisation of Tibetan women were received in that year.

Research\textsuperscript{345} has also revealed that according to the Tibetan Women’s Association\textsuperscript{346}, between four and twenty percent of the Tibetan population inside Tibet are no longer able to reproduce as a result of forced sterilisations. It has been estimated that between 1995 and 1998, in excess of 1,230 Tibetan women were forceably sterilised, with a report that in one town 90 per cent of all married women were forceably sterilised.\textsuperscript{347}

Chinese health authorities are reported to have banned the official use of words relating to birth control with terms such as ‘drug induced abortion’ and ‘surgical abortion’ being replaced with terms such as ‘out patient operation clinics’, ‘family planning centres’ and ‘operation hospitals’. Tibetan couples are required to seek reproductive rights from officials and those couples that fail to keep within the limited quotas set by the relevant officials are liable to be punished with heavy fines, which often exceed the family’s yearly income.

In 1995, China introduced the \textit{Maternal and Infant Child Health Care Law} that entitles the Chinese government to control marriages and births according to the government’s perception of the health of the parents and their suitability for reproduction. The law specifically mentions that it is legal to use methods of sterilisation, abortion and marriage to prevent couples from

\footnotesize{\textsuperscript{344} See \url{http://www.tibet.com/Humanrights/HumanRights97/hr97.html} for this report. 
\textsuperscript{346} The Tibetan Women’s Association is a non-governmental organisation founded in Tibet in 1959 by a group of Tibetan women to protest the forceful occupation of their homeland. In 1984, the Association was re-established by Tibetan women living in exile in India, and currently has over 10,000 members and 40 world-wide branches. The main objective of the Association is to alert communities to the human rights abuses faced by Tibetan women in Chinese-occupied Tibet.}
passing on diseases and mental illness to their children. Furthermore, the permission to marry is only granted to couples who are deemed unsuitable for reproduction if they either agree to take long-lasting contraception or give up a child born to them.348 According to the Tibetan Centre for Human Rights and Democracy,

"The Chinese government has stated that, 'The family planning policy as in place in Tibet is as a matter of fact the policy of encouraging few and healthy birth.' The potential for misapplication of such policies is extremely dangerous in light of the coercive birth control policies of the Chinese government in Tibet. 'In May 1990, the Chinese authorities announced without any evidence that there were 10,000 mentally handicapped people in Tibet, and that this was a sign of inferior population quality.' It should also be remembered that international human rights law guarantees that persons with mental illnesses shall not be discriminated against or denied any of the rights accorded the general population. Specifically, in Principle 1 (5) of The Protection of Persons with Mental Illness and the improvement of Mental Health Care, adopted by the United Nations on December 17, 1991, it is stated that:

"Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment."

According to research, under international human rights law, coercive birth control practices, such as abortions and large-scale

347 Ibid. The report cites that in Nyandgren town, 342 of 379 married women were sterilised. The report also states that between September and October 1996, 308 women in the district of Takar were sterilised over a period of 22 days.
sterilization, constitute a violation of women’s right to health.\textsuperscript{349} There is also substantive opinion\textsuperscript{350} that laws and policies that deliberately attempt to control women’s sexual and reproductive behaviour or obstruct women’s access to reproductive health services constitute fundamental violations.\textsuperscript{351} It is also important to note that these types of violations are classified as ‘acts of commission’, and as such, are most comparable to violations of civil and political rights\textsuperscript{352} which are generally seen to be the easier to monitor and prosecute.

![Figure 36](image)

With regards to general access to health care, research\textsuperscript{354} has shown that in its most recent report to the United Nations under the \textit{Convention on the Elimination of All Forms of Discrimination

\begin{flushleft}
\textsuperscript{350} See Chapman, A. \textit{Monitoring Women’s Right to Health under the International Convenant on Economic, Social and Cultural Rights} 44 American University Law Review 1157 as found at \url{http://www.law-lib.utoronto.ca/Diana/fulltext/chap.htm} retrieved 15/11/01
\textsuperscript{351} See also Cook, R.J. \textit{International Protection of Women’s Reproductive Rights} 24 N.Y.U.J. INT’L. & POL. 645 (1992)
\textsuperscript{352} Chapman, op.cit, p.1168.
\textsuperscript{353} Group of women and children in Shigatse street retrieved from \url{http://perso.wanadoo.fr/tibetmap/p14.html} on 27/04/04
\end{flushleft}
Against Women, China made no mention of health care in relation to women in Tibet. According to the same research, it is argued that despite China’s claims of increased health services to women, Tibetan women either have virtually no access to health care or that the health care that is available, is too expensive to use.\textsuperscript{355}

The Fourth World Conference on Women held in Beijing in 1995\textsuperscript{356} in its Platform for Action\textsuperscript{357} re-stated the right of women to “the highest attainable standard of physical and mental health” and that in addition in relation to health care, women have the right to privacy and the right to be educated about HIV/AIDS, and called upon all participating bodies to the CEDAW to remove conditions that may deter women from seeking health care. The Conference also stated that:

“Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.”\textsuperscript{358}

According to the Tibetan Women’s Association there is a void of information or training regarding HIV/AIDS, with reports of up to 50 hospital patients sharing one needle for injections. Furthermore, Tibet has a significantly higher maternal mortality rate than China, reported to be 20 per 10,000 as compared to 6 per 10,000.\textsuperscript{359}

\textsuperscript{356} The Beijing Women’s Conference, held in September 1995, was attended by representatives of 180 governments and had as its theme "Action for Equality, Development and Peace". The Platform for Action reaffirmed the fundamental principle set forth in the Vienna Declaration and Programme for Action, and adopted by the World Conference on Human Rights, that the human rights of woman and the girl child are an inalienable, integral and indivisible part of universal human rights.
\textsuperscript{357} See Appendix 3 for the relevant Extract from the Report of the Beijing Conference. A full copy of the Beijing Declaration and Platform for Action can be found at http://www1.umn.edu/humanrts/instree/e5dplw.htm#four
\textsuperscript{358} Beijing Declaration for Action, Strategic Objective C/92
\textsuperscript{359} Ibid
There are also concerns as to the health status of Tibetan women detainees, with reports of women detainees being denied basic health needs such as sanitary materials and facilities for bathing. This is in addition to being subjected to torture, hard labour, and forced exercise. The TCHRD reports that:

"Grossly inadequate medical care in detention – as well as the apparent collusion of medical personnel – are major problems to be addressed by international ethics organisations...[while] Many female political prisoners – most commonly nuns – have died due to a lack of medical care after being tortured."360

It is clear that Tibetan women suffer considerable discrimination in relation to both access to health care and in the provision of basic health care services. This discrimination occurs not only because of their gender, but also because of their 'minority' status. There are therefore clear violations by the Chinese government of its obligations under the UDHR, the CEDAW, the International Convention on the Elimination of All Forms of Racial Discrimination, and the ICESCR.

It should also be noted that Article II of the Convention on the Prevention and Punishment of the Crime of Genocide361, a convention ratified by the PRC, provides:

"In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such: (a) Killing members of the group; (b) Causing serious bodily or mental harm to members of the group; (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; (d) Imposing measures intended to prevent births within the group; [emphasis added]; (e) Forcibly transferring children of the group to another group".

360 Ibid. For further information on the status of female political prisoners, especially nuns see Marshall, S. Rukhag 3: The Nuns of Drapchi Prison, Tibet Information Network (TIN), September 2000
361 United Nations Treaty Series 277, entered into force 12 January 1951
Thus, it can be argued that, in addition to the violations mentioned above, the PRC is in violation of its obligations under this treaty.

Figure 37

Convention on the Rights of the Child

As previously set out in this thesis, the specific Article under this Convention in relation to health care is Article 24 and there are a number of aspects of this Article where it is alleged, China’s state obligations are not being met. Furthermore, there are a number of related issues involving violations of other Articles, that indicate an indirect violation of Article 24, and these will also be discussed.

Research has revealed that according to a report by the Western Consortium for Public Health,\textsuperscript{363} the survival of Tibetan children is under threat from malnutrition and disease, a violation of Article 24 (2)(c). The Report is quoted as saying:

\textsuperscript{362} Symbol of Kunphen, the first and only bilingual Tibetan Non-Government Organisation catering to the needs of substance abuse, HIV/AIDS & HRD based in Dharamshala retrieved from http://www.dharamsalanet.com/links/health.htm on 27/04/04

\textsuperscript{363} Tibet Child Nutrition and Collaborative Health Project, Annual Report, 1995/96, International Health Programs, Western Consortium for Public Health as cited in Tibet op.cit. p. 228
..many children within the TAR are extremely short for their age, so short that 60% fail drastically, accepted international growth reference values. Data indicates that this shortness is a result of 'nutritional stunting' – chronic malnutrition during the first three years of life – rather than as a result of genetics or altitude, as previously assumed. These findings should be cause for alarm. Nutritional stress at this critical period in a child's early growth affects neurological development and increases risk of acute illness and death. Chronic malnutrition renders children vulnerable to the common fatal diseases of childhood in the developing world: diarrhoea and pneumonia. Therefore, an entire generation of children is now at risk for irreversible compromise of intellectual potential, as well as increased likelihood of death before age seven.\textsuperscript{364} (Emphasis added).

According to the ICJ, research has revealed that the infant mortality rate in Tibet of over 90 per 1,000 live births is triple that of the overall mortality rates for infants in China in its entirety, while the under five mortality rate is 126.7.\textsuperscript{365} Official statistics from the PRC\textsuperscript{366} however, claim that in 1989, the infant mortality rate was 55.21 per thousand as a result of the carrying out of children's health projects. A further survey conducted in 1990 and reported by the ICJ\textsuperscript{367} noted that weight-for-age and height-for-age of Tibetan children were 'borderline unacceptable' and in some instances 'unacceptably low' by WHO standards. In relation to the WHO standards, the World Health Report 1998\textsuperscript{368} stated that the infant mortality rate target for 2000 was below 50 per 1000 live births, while the under-5 mortality rate target was 70 per 1,000 live births. It is also significant to note that in the same report, it was stated that 97% of the deaths of children under 5 occur in the

\textsuperscript{364} Ibid.
\textsuperscript{365} This information quoted by the ICI is extracted from Yangsun, J. Li, Su, Pei, C. & Husheng, W. "A Study on Patterns in the Average Life Expectancies and Mortality Rates of 56 Nationalities in China in 1990," Chinese Journal of Population Science, vo.6., no.3, 1994, 263 at 268
\textsuperscript{366} See http://www.chinaguide.org/e-white/ast/1-3.htm opcit.
\textsuperscript{367} Nutrition, Health, Water and Sanitation Assessment in the Lhasa Valley, May-July 1990, Tibet Information Network
developing world with most deaths due to infectious diseases such as pneumonia and diarrhoea, combined with malnutrition.

Another key issue that requires discussion, is that of discrimination against children in respect to their ability to access health care. In Tibet, a child born out of the quota – ‘out of plan’ - does not have their name registered, (a clear violation of Articles 7 and 8\textsuperscript{369}) and is therefore denied facilities such as education and medical care\textsuperscript{370} and specific employment opportunities.\textsuperscript{371} Furthermore, because the child’s name is not registered, the family do not receive a ration card for the additional family member thus denying the child, and the family in general, of the necessary nutrition.

Article 2 identifies clearly that states shall ensure to each child the rights set out in the Convention without discrimination and according to research, The Tibet Justice Center cites Timothy Fitzgibbon, a legal commentator, who has argued that to deny children health care and other forms of assistance on the basis of their unauthorized status violates China’s obligations:

(1) not to discriminate against children on the ‘basis of status,’ (2) to ‘ensure that no child is deprived of his or her right of access to ... health care services,’ and (3) to provide ‘a standard of living adequate

\textsuperscript{369} Article 7 states: (1) The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his parents. (2) States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in their field, in particular where the child would otherwise be stateless.

Article 8 states: (1) States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognised by law without unlawful interference. (2) Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to speedily re-establishing his or her identity.

\textsuperscript{370} See http://www.tibetjlt.org/reports/un/unint3.html

\textsuperscript{371} See http://www.tibet.com/op.cit
for the child’s physical, mental, spiritual, moral and social development.’

It should be noted that China\textsuperscript{372} has validated its birth control practices by claiming that its ‘family planning’ policies take precedence over Article 6 of the Convention on the Rights of the Child which clearly instructs states to ‘...ensure to the maximum extent possible the survival and development of the child’. However, research\textsuperscript{373} has shown that the word ‘survival’ is unusual in human rights treaties being ‘borrowed’ from the terminology used in development discussions and originating in a proposal by UNICEF, specifically ‘...introduce a dynamic aspect to the right to life, including the need for preventative action such as immunization.’\textsuperscript{374} It is further argued that Article 6 can be seen as the platform for all the other Articles in this Convention that deal with economic, social and cultural rights, therefore Article 24, and that even though the Article refers to the ‘maximum extent possible’ thus implying an economic element, the formulation of this Article indicates that priority should be given to implementation of this requirement.\textsuperscript{375}

**Violations and Enforcement**

The Constitution of the People’s Republic of China does not provide for the establishment of a Constitutional Court or for any other mechanism to which violations of human rights can be addressed. However, there are a number of provisions within the Constitution that are relevant in relation to the provision of health care to the Tibetan people.

\textsuperscript{373} See Hammarberg, T. “Children” in Eide, Krause & Rosas op.cit. pp.289-207
\textsuperscript{374} Ibid, p.292.
\textsuperscript{375} Ibid, p.293.
Article 4 of the Constitution provides for equality of all nationalities within the People's Republic, specifically stating that "...discrimination against and oppression of any nationality are prohibited." and "...The state helps the areas inhabited by minority nationalities speed up their economic and cultural development in accordance with the peculiarities and needs of the different minority nationalities."

Furthermore, subsection (2) refers to the issue of regional autonomy, stating that all national autonomous regions, as Tibet is characterised, are "...inalienable parts of the People's Republic of China" and therefore subject to the provisions of the Constitution.

Section VI of the Constitution sets out the Articles dealing with Self-Government of National Autonomous Regions, with Article 119 clearly stating that the organs of self-government are responsible for the independent administration of, inter alia, public health affairs and for the "...development and flourishing of their cultures."

The Chinese Government became a signatory to the International Covenant on Economic, Social and Cultural Rights in 1997 and the International Covenant on Civil and Political Rights in 1998 and in February 2001, the ICESCR was deliberated and ratified at the 20th meeting of the Ninth National People's Congress. According to the White Paper on China's Human Rights378, this latter act demonstrates "...the Chinese government’s positive attitude toward carrying out international cooperation in human rights as well as China's firm determination and confidence in promoting and

protecting human rights. ³⁷⁷ The White Paper also highlights that in 2000, the Chinese Government submitted its eighth and ninth reports on the implementation of the ICESCR and the ICCPR as well as signing the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography.

Despite these apparent commitments, research carried out by both the World Bank and the TCHRD, to name but two organizations, reveals a systemic failure by the PRC to deliver the basic requirements for health care development to the Tibetan people. Infant and maternal mortality remain critically high, significant numbers of children suffer from malnutrition, and there has been a decline in the development and provision of health institutions. ³⁷⁸

"Tibetans in Tibet have very limited or no access to health care facilities. Health provisions for Tibetans continue to lag far behind China’s national averages, and fall short of international standards of adequate healthcare. The increasing cost of hospital care, and the shortage of trained village-level health professionals, contribute to a worsening health situation for Tibetans. Health care is no longer a right. It is a privilege of those who can pay and have the right connections" ³⁷⁹

The Tibetan people have no independent voice in the international community due to their occupied status. China, with its ratification of the ICESCR, has claimed that this act

"...fully demonstrates the Chinese government’s positive attitude toward carrying out international cooperation in human rights as well as China’s firm determination and confidence in promoting and protecting human rights." ³⁸⁰

³⁷⁷ Ibid at p.11
³⁷⁸ TCHRD reports a decline from a high of 1,324 in 1997 to 1,237 in 2000.
³⁷⁹ Tibetan Centre Annual Report 2002, op.cit at p.5
Given the ratification by the PRC of international treaties and conventions together with its claims of its ‘firm determination and confidence in promoting and protecting human rights’, the prevailing situation in Tibet with respect to health care requires immediate proactive attention by the PRC. Failure to meet its clear obligations leave the PRC at risk of ongoing international scrutiny and criticism. Whilst this may not be a satisfactory method of enforcement for the Tibetan people of violations of basic human rights, given their occupied status and the lack of official international recognition, scrutiny and criticism by international organizations is preferable to nothing at all.

Figure 38

MAJOR CASE STUDY 3 – The United Kingdom and the NHS

In 1941, the British Government appointed Sir William Beveridge to head an inquiry into Social Insurance and Allied Services in Britain. Beveridge had a long history of involvement with issues

381 Staff at Sershul County Hospital in Gyurga Town retrieved from http://www.tibetfoundation.org/aid/att/proj-SCHIIntro.html on 27/04/04
such as unemployment and social insurance including his role as chairman of the Unemployment Insurance Statutory Committee, a 1937 committee established to look into the impact of unemployment on individuals and families and was deemed to be the most suitable person to review and make recommendations in relation to social insurance.

The Beveridge Report was presented to the British government in 1942 and formed the basis for welfare state reforms established by the Labour Government in the period immediately post World War 2. In his report, Beveridge identified a number of key areas for reform, one of which was the establishment of a comprehensive national health service that would ensure for “every citizen...whatever medical treatment he requires, in whatever form he requires it.”

Following the defeat of Churchill’s Conservative Party in the 1945 General Election, the new Prime Minister, Clement Attlee introduced the Welfare State as outlined in the Beveridge Report. Accordingly, the National Health Service (“NHS”) was established in the United Kingdom in 1946 and introduced by the passing of the National Health Service Act 1948. This legislation provided people in Britain with free diagnosis, the treatment of illness at home or in hospital, as well as dental and ophthalmic services.

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382 See http://library-2.lsc.ac.uk/collections/pamphlets/document_service/HD7/00000145/doc.pdf (retrieved 09/05/02) for the complete report of this Committee.
384 See http://www.bbc.co.uk/education/medicine/nonint/modern/ph/mophbi2.shtml retrieved 9/05/02
The legal framework for the NHS is now contained in the *National Health Service Act 1977*, together with other statutes governing the provision of health related services.\(^{365}\) This legislation imposes on the Secretary of State a broad general duty to continue the promotion in England and Wales of a comprehensive health service. In particular, section 1 requires the Secretary of State to secure improvement in the physical and mental health of the citizens of England and Wales as well as in the prevention, diagnosis and treatment of illness, with the provision of services being 'free of charge' unless otherwise provided.

The most significant section of the legislation is section 3, which states:

3. – (1) It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements –

(a) hospital accommodation;

(b) other accommodation for the purpose of any service provided under this Act;

(c) medical, dental, nursing and ambulance service;

(d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;

(e) such facilities for the prevention of illness, the care of persons suffering from illness and after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;

(f) such other services as are required for the diagnosis and treatment of illness.

\(^{365}\) These statutes include the *National Health Service and Community Care Act 1990* and the *Chronically Sick and Disabled Persons Act 1970*. 

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In turn, this duty is delegated to the health authorities created by the legislation, with Paragraph 15(1) of Schedule 5 of the Act making it clear that in any case for a failure to perform the duty under section 3, it is the health authorities and not the Secretary of State who is to be sued. Section 15 (1) states:

"An authority shall, notwithstanding that it is exercising any function on behalf of the Secretary of State or another authority, be entitled to enforce any rights acquired in the exercise of that function, and be liable in respect of any liabilities incurred (including liabilities in tort) in the exercise of that function, in all respects as it is were acting as a principal. Proceedings for the enforcement of such rights and liabilities shall be brought, and brought only, by or, as the case may be, against the authority in question in its own name."

Section 5 of the Act regulates the provision of medical and dental examinations for state school children and family planning services. Other statutes governing the provision of other health related services include the Chronically Sick and Disabled Persons Act 1970 and the National Health Service and Community Care Act 1990.

While the provisions of the National Health Service Act 1997 would appear to be comprehensive, the Secretary of State only has to provide the services ‘to the extent that (he/she) considers necessary to meet all reasonable requirements.’ In other words, there is considerable discretion allowed to those exercising the duties delegated under the legislation as to how those duties are implemented. Therefore, although such legislation may appear to recognize a legal right to health care, there are significant problems in realizing the right if the courts are relied upon as the
ultimate arbiters as to how scarce health care resources are to be allocated.\textsuperscript{386}

The courts in Britain have been used by patients aggrieved by their alleged inability to access health care and who therefore claim that the duties imposed under the legislation have not been performed in the manner which is required by law. There are two types of legal action that can be used by patients - the first, judicial review, enables an allegation of a failure by denial to provide a particular service, to be judicially considered and an order sought that the service be provided. This avenue is also available to challenge the manner in which clinical priorities are set within a health service. This judicial review of administrative action is not based upon the merits of the case, but instead focuses on the legality of the decision-making process. In other words, the concern of the court is not with the outcome of the decision in the first instance, rather with the exercise of the power of the decision-maker and the decision-making process itself. Accordingly therefore, when undertaking judicial review, a court cannot examine the merit of the policy or policies behind the decision made the administrative body (although it can find that the rigid application of departmental or government policy is \textit{ultra vires}) – it must confine its determination to the legality of the decision-making process.\textsuperscript{387}

Once a court has found that a decision has breached the requirements of administrative law, the court has three options: to ‘quash’ the decision and force the decision-maker to reconsider

\textsuperscript{386} See comments by Hendrick, \textit{J. Law and Ethics in Nursing and Health Care} (Cheltenham, U.K.: Stanley Thornes (Publishers) Ltd at p.133.
his/her decision; to compel the decision-maker to act in accordance with the rules of administrative law; or, to prevent the decision-maker from acting in a manner specifically proscribed by the court. The types of administrative orders granted by a court to effect these options are fall into three categories – injunction, writ of mandamus and writ of prohibition.388

The second type of legal action that can be brought is one based upon a breach of statutory duty or common law negligence. The purpose of instituting such legal action is to obtain compensation, based upon the principle that either as a result of the breach of the statutory duty the patient has suffered damage, or that the health service has been negligent in failing to provide the service and that as a result, the patient suffered damage. The four key principles for an action in negligence are: (i) the defendant owes a duty of care to the plaintiff; (ii) the defendant has breached this duty of care; (iii) the plaintiff has suffered damage or loss as a result of the breach of the duty of care; and (iv) the damage or loss suffered by the plaintiff is a reasonably foreseeable consequence of the breach of the duty of care. A failure by the plaintiff to prove any one of these four principles will mean that the action in negligence will fail and the defendant will not be required to compensate the plaintiff.389

The first case involving a challenge under section 3 of the National Health Service Act 1977 was R v Secretary of State for Social Services ex parte Hincks (Unreported) (1980) I BLMR 93. The case

389 See Wallace, M. Health care and the law (3rd Ed) (Sydney: Lawbook Co., 2001) for a discussion of the principles of negligence in relation to the health care professions.
concerned four orthopaedic patients who alleged they had all waited too long for hip-replacement surgery. The patients based their claim on an allegation that they had not been provided with the comprehensive health service (orthopaedic surgery) within their area, as guaranteed by section 3 of the Act. The district hospital concerned had planned and received approval for an extension of orthopaedic services, but these could not be put into place because the lowest tender for the project was far higher than the funds which had been put aside to fund the project. As time passed, the differential between the funds set aside and the lowest tender increased, with the result that by 1978, the scheme for increased services was virtually abandoned, with nothing to be done for at least 10 years.

The four patients who brought the action all lived within the local hospital’s area, and each had been on the hospital’s waiting list for orthopaedic surgery for many years. The argument presented on behalf of these patients centred on the fact that as the Secretary of State had approved the plan for the extension of services, the Act required that he set aside the necessary funds to allow the extensions to take place.

In its decision, the Court of Appeal held that the Act did not impose an absolute duty on the Secretary of State to provide health services irrespective of the government’s economic policy. In making this decision, Lord Denning however, did identify one area of which had not been addressed by the legislation when he stated:

“If the Secretary of State needs money to do it, then he must see that Parliament gives it to him. Alternatively, if Parliament does not give it to him, then a provision should be put in the statute to excuse from his duty”.

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Even so, the fact that section 3(1) of the Act only required the Secretary of State to provide services 'to such an extent as he considers necessary to meet all reasonable requirements' meant that the decision-making of the Secretary of State was constrained by economic decisions taken at a national level. Therefore, although the purpose of the Act was to guarantee the provision of a comprehensive health service, the duty imposed on the Secretary of State was not absolute:

"The provision [in the 1977 Act] has to be read subject to the implied qualification that the Secretary of State’s duty was to ‘meet all reasonable requirements such as can be provided within the resources available’, which ‘must be determined in the light of current Government economic policy’.\(^{380}\)

In finding that the Secretary of State had a discretion in the allocation of health service resources, the court indicated that judicial interference was only justified where it could be shown that he had acted ‘unreasonably’ – thus subjecting his decision-making to judicial review. Lord Denning concluded:

"It cannot be supposed that the Secretary of State has to provide all the latest equipment... all the kidney machines which are asked for... or heart transplants in every case where people would benefit from them... it cannot be said that [he] has to provide everything that is asked for in the changed circumstances, which have come about. That includes the numerous pills that people take nowadays: it cannot be said that he has to provide all these free for everybody."

In other words, no matter how comprehensive the health service guaranteed by legislation, the services provided are discretionary, the dictate of national health economic policy, and providing the decision-making process in the exercise of this discretion in reasonable, there exist no grounds for judicial intervention. Therefore, the rights which are deemed to accrue from such a

guarantee will only be deemed to have not been met, where the
discretionary exercise of the correlative duty is deemed to be
unreasonable.

A similar decision was reached in the case *R v Central
Birmingham HA* ex parte *Walker* (1987) 3 BLMR 32, which
concerned a premature baby needing heart surgery. While surgery
had been scheduled on five separate occasions, the health
authority had postponed it on each of those occasions, alleging it
was unable to carry out the surgery to correct the defect because of
the nursing shortages in a neonatal intensive care unit. Even when
beds did become available, they were allocated to more urgent
cases. The baby’s mother claimed that this was unlawful, under
section 3 of the Act, and sought an order from the court that the
operation be performed. The mother’s application was dismissed by
MacPherson J and an appeal was lodged in the Court of Appeal.

In rejecting the mother’s appeal, Sir John Donaldson in his
decision stated:

“It is not for this court, or indeed any court, to substitute its own
judgment for the judgment of those who are responsible for the
allocation of resources. This court could only intervene where it
was satisfied that there was a prima facie case, not only of failing
to allocate resources in the way that others would think that
resources should be allocated, but of a failure to allocate resources
to an extent which was Wednesbury (*Associated Provincial Picture
Houses v Wednesbury Corp* [1948] 1 KB 233) unreasonable301, if

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301 It was Lord Greene MR who firmly introduced the concept of unreasonableness as a
ground of review in *Associated Provincial Picture Houses v Wednesbury*. It was in this case
that a regulation preventing the admission of any child under the age of 15 into the local
picture house was castigated as unreasonable. In arriving at his conclusion Lord Greene
presented unreasonableness as having two meanings. The first was merely as a general rubric
containing the other grounds of review, such as relevancy and impropriety of purpose.
However, it is evident from his proposition that “if a decision on a competent matter is so
unreasonable that no reasonable authority could ever come to it then the court can interfere,”
that he envisaged a second meaning of unreasonableness, that is, as an independent
substantive ground of review. He emphasised that to prove unreasonableness in this sense
would require something overwhelming. It was intended only as a safety net to catch those
one likes to use lawyers' jargon, or, in simpler words, which involves a breach of public law duty. Even then, of course, the court has to exercise a judicial discretion. It has to take account of all the circumstances of the particular case with which it is concerned.\textsuperscript{392}

His Honour also made the comment that for the court to grant leave in most cases where patients were disturbed about what the NHS was doing, would result in the NHS stop providing services and instead use up its resources to meet the complaints of its patients. Therefore, while it was acknowledged the court had the jurisdiction to hear such cases, the jurisdiction must be "used extremely sparingly."\textsuperscript{393} It should be noted that it was accepted that although the baby required the surgery, there was no immediate danger from delaying the surgery. The question therefore needs to be asked as to whether the decision would have been different had there been immediate danger – that a failure to allocate resources in those circumstances would have indeed been regarded as unreasonable.

However, the issue of 'immediate danger to health' would appear to have no significance under the discretion granted to a Health Authority under the provisions of the National Health Service Act 1977 and therefore provide no greater 'right' to access guaranteed health care services, as is illustrated by the case of \textit{R v Central Birmingham Health Authority, ex parte Collier}, 6 January 1988

decisions that were manifestly absurd but may escape review on any of the more specific grounds of attack. Hence as a substantive ground of review unreasonableness would have only very limited applicatio. From here unreasonableness has continued to develop as a legitimate basis upon which to challenge an exercise of administrative discretion. In the fifty years that have passed since its emergence there has been much debate, both academic and judicial, over the definition and appropriate scope of unreasonableness as a ground of review.\textsuperscript{392} \textit{R v Central Birmingham Health Authority, ex parte Walker} 3 BMLR 32 at 33. A copy of this judgment is available at http://www.lexis.com/research/retrieve/frames?_m=de2b3a4af23b4b779afec1a7a4570017&
csvc=bl&form=bool&fnstr=XCITE&docnum=1&startdoc=1&wehttp=GLbVtb-
38KAB&_md5=d70a25c8e837c2a70af2334f380d9ed
\textsuperscript{393} Ibid
In this case, a 4 year old boy suffering from a 'hole in the heart' who was said by a consultant to be 'in desperate need' of life-saving surgery, without which he would die, had his surgery postponed three times. The Health Authority claimed that it lacked the necessary resources - intensive care beds - and therefore was unable to carry out the surgery until the resource became available.

Sir Stephen Brown LJ referred to the argument presented by the appellant's counsel that the issue of immediate danger to health required the court to distinguish this case from the circumstances of the Walker case and commented:

"We have no medical evidence before us, but, even assuming that it does establish that there is immediate danger to health, it seems to me that the legal principles to be applied do not differ from the case of Re Walker."

His Honour then proceeded to confirm the view taken by the Court in Re Walker that it was not the role of the court to interfere in or judge the allocation of resources by health authorities and that:

"This is not the forum in which a court can properly express opinions upon the way in which national resources are allocated or distributed. [There] may be very good reasons why the resources in this case do not allow all the beds in the hospital to be used at this particular time. We have no evidence of that, and indeed, as the Master of the Rolls has said [in the Walker case], it is not for this court, or any court to substitute its own judgment for the judgment of those who are responsible for the allocation of resources."

In sympathizing with the predicament of the Collier family, the court was of the opinion that the use of judicial review in these circumstances was 'unfortunate' and 'wholly misconceived'. In the

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394 A copy of the unreported judgment is available at http://www.lexis.com/research/retrieve/frames?_m=clc2b3a4af23b4b779afcc1a7a4570017&c
absence of unreasonableness in the allocation of resources, the
court could not intervene, Sir Stephen Brown LJ concluding:

"Having regard to the recent decision of Re Walker it seems to me
unfortunate that the step has been taken of bringing the matter to
the court again. It may be that it is hoped that the publicity will
assist in bringing pressure to bear upon the hospital: I do not know.
This court cannot be concerned with matters of that kind. But
simply upon the basis - which is purely a legal basis – that the
matter comes before this court I can see no ground upon which the
application can be granted".

In the case of Re J [1992] 3 WLR 507\textsuperscript{385}, the court was required to
consider the appropriateness of treatment and whether all-life
saving procedures should be instituted in a situation where it was
deemed clinically inappropriate. The action was brought by the
mother of a 16-month old profoundly handicapped baby. He was
microcephalic and suffered a severe form of cerebral palsy, as well
as cortical blindness and severe epilepsy. Although his clinical
prognosis could not determine his life expectation, it was
undoubtedly very short and the consultant paediatrician
considered that in the event of a life-threatening event, the use of
life-prolonging treatment would be futile, recommending only
ordinary resuscitation with suction, physiotherapy and antibiotics.
The mother was opposed to this treatment decision and requested
that all life-saving procedures be instituted, so as to save his life
for as long as possible.

Lord Justice Balcombe in his decision rejecting the mother’s claim
said:

\textsuperscript{385} Also at [1993] Fam 15, a copy of the judgment is available at
http://www.lexis.com/research/retrieve/frames?_m=244086ee5f8f32e67d5c9f2348ed27b1&c
svc=bl&cform=bool&_fmtstr=XCITE&docnum=1&_startdoc=1&wchp=dGLbVtb-
zSkA&B&_ndS=c70a25c8e837c2a70a12334f380d9ed
"[M]aking an order which may have the effect of compelling a
doctor or health authority to make available scarce resources...to a
particular child...might require the health authority to put J on a
ventilator in an intensive care unit, and thereby possibly to deny
the benefit of those limited resources to a child who was very much
more likely than J to benefit from them".

In addition, His Lordship stated, when discussing the inherent
jurisdiction of the court to make orders with respect to children:

"The court is not, or certainly should not be, in the habit of
making orders unless it is prepared to enforce them. If the court
orders a doctor to treat a child in a manner contrary to his or her
clinical judgment it would place a conscientious doctor in an
impossible position. To perform the court's order could require the
doctor to act in a manner which he or she genuinely believed not to
be in the patient's best interests; to fail to treat the child as ordered
would amount to a contempt of court, which seems to me to be a
very strong indication that such an order should not be made."396

Lord Donaldson referred to the difficulty which faced health
authorities when they found they had:

"...too few resources, either human or material, or both, to treat all
the patients whom they would like to treat in a way which they
would like to treat them..."397

His Lordship was also of the opinion that a court in considering
whether to make an order such as the one requested here, was
being asked to make it full knowledge of the competing claims
which face a Health Authority, claims such as the availability of
staff. His Lordship also identified difficulty with the terminology of
the order made by Mr Justice Waite at first instance, in that it
place the Health Authority at risk of a sanction for failing to carry

396 ibid at 519
397 [1992] 3 WLR 507 at 517
out an order that it was incapable of ascertaining the detail of.\textsuperscript{398} This was supported by Lord Justice Leggatt, when he stated:

"That was an order with which it was probably impossible for the health authority to comply because if has no power, contractual or otherwise, to require doctors to act in a way which they do not regard as medically appropriate. If it could comply, it would be obliged to accord to this baby a priority over other patients to whom the health authority owes the same duties, but about whose interests the court is ignorant."

It may therefore be reasonable to suggest that it was this unwillingness of the English courts to impose a blanket duty to provide statutorily guaranteed health care services where a discretion exists in the allocation of resources (which may also impact upon clinical decision-making), that resulted in the decision not to include a right to health care in the \textit{Human Rights Act 1998}.\textsuperscript{399}

There have been two more recent cases concerning the provision of health services under the \textit{National Health Service Act 1977}, and it is to these cases the focus will now turn, for both cases provide further insight into the role of judicial review of decisions in this context.

The first of these cases is \textit{R v North and East Devon Health Authority, ex parte Coughlan (Secretary of State for Health and another intervening)} [2000] 3 All ER 850\textsuperscript{400}. This case concerned the provision of nursing care and whether there could be a

\textsuperscript{398} Mr Justice Waite has ordered that the health authority "...were to cause such measures, including artificial ventilation to be applied to J, for so long as they were capable of prolonging his life".

\textsuperscript{399} In fact, the only human rights covered by the \textit{Human Rights Act 1998} are those that are categorised as civil and political rights, thus one could argue, an indication in itself of the perceived difficulty of enforcing those rights categorised as social, economic and cultural.
distinction between general nursing care and specialist nursing care for the purposes of the National Health Service, thus affecting who should pay for the nursing care.

Figure 39

The facts of the case are not complex. Miss Coughlan was a tetraplegic, doubly incontinent requiring regular catheterisation, partially paralysed in the respiratory tract and suffered from severe and recurrent headaches as a result of an associated neurological condition. In 1993, she and seven other patients were transferred, by agreement, from Newcourt Hospital, which was due to close, to a new purpose built facility, Mardon House. However, in 1998, the North and East Devon Health Authority (‘the Authority’) decided to close the new facility, the result of which would be the transference of Miss Coughlan’s care to a local authority social services department. In making this decision, the Authority classified the type of nursing care required by Miss

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400 A copy of this judgment is available at http://www.butterworthsonline.com/lpBin20/lpext.dll?f=templates&fn=bwalmart-hit-j.htm&2.0
401 British ambulances with UNPROFOR, Vukovar, Croatia 7/92 (UN# 159206C UN/DPI/S.Whitehouse) retrieved from http://www.un.org/UN50/Photos90s.html on 29/04/04
Coughlan as ‘standard nursing care’ which had the effect of requiring Miss Coughlan, pursuant to National Health Service policy guidance, to pay for her nursing care. Should the nursing services she required been classified as being ‘specialist’, then they would have been provided free of charge by the National Health Service.

The Authority, in making its decision to close Mardon House, was guided in part by the National Health Service and Community Care Act 1990, which identified as its purposes ‘to make further provision about health authorities and other bodies constituted in accordance with the [1977 Act], to provide for the establishment of National Health Service Trusts; ... to make further provision concerning the provision of accommodation and other welfare services by local authorities’. This Act was accompanied by the guideline document\textsuperscript{402}, mentioned above, which drew the distinction between specialist nursing services and general nursing care, stating that:

\begin{quote}
"...When, after April 1993, a local authority places a person in a nursing home after a joint health authority/local authority assessment, the local authority is responsible for purchasing services to meet the general nursing care needs of that person, including the cost of incontinence services (eg laundry) and those incontinence and nursing supplies which are not available on NHS prescription. Health authorities will be responsible for...the provision of specialist nursing advice...for those people placed in nursing homes by local authorities... Health authorities continue to have the power to enter into a contractual arrangement with a nursing home where a patient’s need is primarily for health care. Such placements must be fully funded by the health authority."\textsuperscript{403}
\end{quote}

\textsuperscript{402} HSG (92) 50 issued by the NHS Management Executive to District Health Authorities, captioned “Local Authority Contracts for Residential and Nursing Home Care; NHS Aspects” as cited at p.856
\textsuperscript{403} As cited at p.856.
In 1995, a further guideline was issued by the Secretary of State for Health\textsuperscript{404} with the purpose of providing greater detail as to the delineation of the division of responsibility between the NHS and local authorities on the issue of continuing health care. Specifically, the guideline provided that specialist medical and nursing services were to be funded and made available by the NHS to those persons who no longer qualified for in-patient care. It also called upon health authorities to develop and publish policies and the criteria to determine eligibility for the purchase of continuing health care as from April, 1996.

Pursuant to this guideline, the North and East Devon Health Authority prepared and published policies and eligibility criteria, in which it defined specialist nursing care in a manner which distinguished it from what it called 'core nursing' services. Significantly, it related specialisation not to qualification but to employment and of all those areas which it identified as specialist nursing care, none were so recognised by the United Kingdom Central Council for Nursing.\textsuperscript{405} In particular, the Health Authority listed such nursing services as continence care, stoma, diabetic, paediatric, palliative and tissue viability as specialist, which was contrary to the recommendation of the National Health Service Executive, which stated that such services were to be regarded as standard, not specialist, in nursing homes.

Miss Coughlan sought judicial review of the decision of the Authority to close Mardon House. Mr Justice Hidden. found for Miss Coughlan on five grounds, the most significant for the

\textsuperscript{404} HSG (95) 8; Local Authority Circular LAC (95) 5 NHS Responsibilities for Meeting Continuing Health Care Needs
\textsuperscript{405} Op cit, para.13.
purposes here, that in law, all nursing care was the sole responsibility of the National Health Service acting through the health authority and that therefore it was not open to a health authority to transfer the long-term nursing care of a patient to the social services department of a local authority.\textsuperscript{406} The Authority appealed the decision, and was joined in its appeal by the Secretary of State for Health, who applied to the court to be heard, and the Royal College of Nursing, which sought to make a written submission on two key points – whether nursing care is required to be provided free of charge in nursing homes and, whether the distinction sought to be made between specialist and general nursing care is contrary to law.

Lord Woolf MR delivered the unanimous judgment of the Court. There were six areas which were addressed by the court, but it is only the first of these - nursing as health care and as social care - that will be discussed here. It is interesting to note that the issue of nursing care was not the primary issue raised by Miss Coughlan in the initial action, rather, it was the closure of Mardon House that was of concern. However, according to Lord Woolf MR, His Honour Mr Justice Hidden made it the most important issue on appeal, when he stated:

"...nothing in either the 1990 Act or in HSG (95) 8 altered the statutory responsibilities of health authorities to provide health services including nursing care. As a result both general and specialist nursing care remain the sole responsibility of the health authorities. Thus the respondent authority was clearly wrong in law in assuming that the law had changed and that it was no longer entitled or empowered to provide or arrange long-term general nursing care in an NHS setting and/or that there had been a transfer to the social services department of such responsibility as a result of 'new legislation'. Those assumptions were wholly misconceived and led to the authority taking account of irrelevant matters. I conclude that nursing is "health care" and

can never be "social care" and that HSG (95) 8 did not make any change to any NHS responsibility for health services including nursing."\(^{407}\)

Lord Woolf noted that whether the decision of Mr Justice Hidden was upheld or overturned, the implications would be significantly adverse – either for the Secretary of State and the health authority, or for those reliant on the provision of nursing services, services which may need to be fully funded by the person requiring their provision.

To make this determination, His Lordship turned to the legislative history of the provision of health and health care services from the Second World War, focusing on the interpretation\(^{408}\) of three sections: ss 1 and 3 of the National Health Service Act 1977 and s.21 of the National Assistance Act 1948.

Lord Woolf noted that s. 1(1) of the 1977 Act entrusted to the Secretary of State the duty to promote a ‘comprehensive health service’...

"...designed to secure improvement – (a) in the physical and mental health of the people...and (b) in the prevention, diagnosis and treatment of illness, and for this purpose to provide or secure the effective provision of services in accordance with this Act."\(^{409}\)

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\(^{407}\) Ibid para.18

\(^{408}\) While the task of creating legislation is parliamentary, the courts have the responsibility of interpreting legislation. Therefore, while parliament is the supreme source for creating law, the courts have the responsibility of deciding the legal meaning of that legislation, together with its application. This process of interpretation is known as ‘statutory interpretation’ and primarily involves identifying and resolving ambiguities in the legislation. To do this, the courts will consider matters as the effect of a particular interpretation of words as well as the legislative purpose underlying the legislation. In Australia, this process is assisted by the provisions of the Acts Interpretation Act 1901 (Cth) and related State and Territory Interpretation Acts. A useful reference for the processes of statutory interpretation is Hall, K. Legislation (Australia: Butterworths, 2002).

\(^{409}\) Ibid,para.20
The extent of this duty, in the opinion of his Lordship, was limited to the ongoing commitment to the promotion of a comprehensive health service, not to the provision of such a service. In addition, it was noted that by virtue of s.1(2), the services to be provided were to be generally provided free of charge, except to the extent that any enactment provided expressly for the making and recovery of charges in relation to those services.

According to His Lordship, in respect to s.3\textsuperscript{410}, this duty of the Secretary of State was qualified in two ways. Firstly, the Secretary of State was only required to provide those services to the extent which was "...necessary to meet all reasonable requirements" and secondly, that in relation to the provision of certain services identified in subsections (d) & (e) he was bound to consider whether or not they were appropriate to be provided "...as part of the health service".

With respect to the first qualification, which His Lordship was the one of significance for the purposes of this case, the Secretary of State has scope

"...to exercise a degree of judgment as to the circumstances in which he will provide the services, including nursing services referred to in the section. He does not automatically have to meet all nursing requirements. In certain circumstances he can exercise his judgment and legitimately decline to provide nursing services. He need not provide nursing services if he does not consider they

\textsuperscript{410} S.3 provides:

"It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements — (a) hospital accommodation; (b) other accommodation for the purpose of any services provided under this Act; (c) medical, dental, nursing and ambulance services; (d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service; (e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service; (f) such other service as are required for the diagnosis and treatment of illness."
are reasonably required or necessary to meet a reasonable requirement.\textsuperscript{411}

Furthermore, in the opinion of His Honour, the fact that the Secretary of State was under a statutory duty to promote a comprehensive health service, this did not mean that a comprehensive service had to be achievable, due to the relevant resource reasons, such as financial and human. His Honour stated, citing Hincks case:

"In exercising his judgment the Secretary of State is entitled to take into account the resources available to him and the demands on these resources... The Secretary of State is entitled to have regard to the resources made available to him under current government policy.\textsuperscript{412}

Having identified the justification for considering the availability of resources when fulfilling a statutory duty, Lord Woolf M.R. then turned his attention to the interpretation of s.21 of the National Assistance Act 1948.

Section 21\textsuperscript{413} provides, \textit{inter alia},

"(1) Subject to and in accordance with the provisions of this Part of this Act, a local authority may with the approval of the Secretary of State, and to such extent as he may direct shall, make arrangements for providing – (a) residential accommodation for persons [aged eighteen or over who by reason of age, illness or disability or any other circumstances are in need of care and attention which is not otherwise available to them; and (aa) residential accommodation for expectant and nursing mothers who are in need of care and attention which is not otherwise available to them.

(2) In making any such arrangement, a local authority shall have regard to the welfare of all persons for whom accommodation is provided, and in particular to the need for providing

\textsuperscript{411} Ibid., para 24
\textsuperscript{412} Ibid., para.26.
\textsuperscript{413} This is a reproduction of the section as amended.
accommodation of different descriptions of such persons as are mentioned in the last foregoing subsection.

(5) References in this Act to accommodation provided under this Part thereof shall be construed as references to accommodation provided in accordance with this and the five next following sections, and as including references to board and other services, amenities and requisites provided in connection with the accommodation except where in the opinion of the authority managing the premises their provision is unnecessary.

(7) Without prejudice to the generality of the foregoing provisions of this section, a local authority may make arrangements for the provision on the premises in which accommodation is being provided of such other services as appear to the local authority to be required.

(8) Nothing in this section shall authorise or require a local authority to make any provision authorised or required to be made (whether by that or by any other authority) by or under any enactment not contained in this Part of this Act or authorised or required to be provided under the National Health Service Act 1977.”

His Lordship indicated that, in relation to the provision of nursing services, whilst s.21 had as its primary focus the provision of accommodation, nursing services may be required to be provided to those seeking accommodation, given the express reference to not only age, but also illness and disability. Accordingly therefore, s.21(5) should be read as requiring nursing services to be provided in connection with accommodation. The only qualification to this requirement could be found in s.21(8) wherein the words ‘...or authorised or required to be provided under the National Health Service Act 1977” are found. It was to these words that His Lordship’s attention turned. He stated:

“Each word is of significance. The powers of a local authority are not excluded by the existence of a power in the 1977 Act to provide the service, but they are excluded where the provision is authorised or required to be made under the 1977 Act. The position is different in the case of ‘any other enactment’, where it is sufficient
In other words, if pursuant to the provisions of the 1977 Act, the Secretary of State legitimately decided that certain services would not be provided by the NHS, then the effect of s.21(8) was that a health authority would not be required to provide those services. Therefore, it was within the authority of the Secretary of State to decide to exclude certain nursing services from the services provided by the NHS. If such services were excluded, a health authority could not then provide them as a health service, but could provide them as a social or care service, provided they could legitimately class the nursing services as being provided in connection with the accommodation provided pursuant to s.21 of the 1948 Act. Once classified as social or care services, the nursing services could be subject to the same payment regime as other social or care services provided by the health authority.

Although some nursing services could be properly classified in this way, this did not, according to the interpretation of the relevant sections by His Lordship, mean that all the nursing services provided by a health authority could be so classified.

"The scale and type of nursing required in an individual case may mean that it would not be appropriate to regard all or part of the nursing as being part of 'the package of care' which can be provided by a local authority. There can be no precise legal line drawn between those services which are and those which are not capable of being treated as included in such a package of care services.

The distinction between those services which can and cannot be so provided is one of degree which in a borderline case will depend on a careful appraisal of the facts of the individual case. However, as a very general indication as to where the line is to be drawn, it can be said that if the nursing services are (i) merely incidental or

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414 Ibid, para.28
ancillary to the provision of the accommodation which a local authority is under a duty to provide to the category of persons to whom s.21 refers and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide, then they can be provided under s.21. It will be appreciated that the first part of the test is focusing on the overall quality of the services and the second part on the quality of the services provided."

His Lordship was clear - The Secretary of State has a duty to promote a comprehensive free health service and can only decline to provide services if he has formed a judgment that those services are not tenable with that long-term duty. The provision of some nursing services may be the responsibility of the NHS where such services form part of the primary health need of a patient, even a patient in a home provided by a local authority. Once health needs are classified as primary health needs for which a health authority is legally responsible, it cannot deny that responsibility merely because social or care services can fill the gap by providing full fee paying services.

Therefore, the lawfulness of a decision of a health authority to transfer nursing services to the local authority would depend on whether the services transferred fell within the parameters of those covered by s.21 of the 1948 Act. In this case, Miss Coughlan required nursing services of a different category and therefore the decision to transfer her required care was based upon a misinterpretation of the health authority’s statutory responsibilities under the provisions of the 1977 Act and was therefore unlawful. The Court also found that given Miss Coughlan was given a promise that she would have a home for life at Mardon House, the decision to close the facility amounted to “...unfairness amounting to an abuse of power by the health authority...”415

415 Ibid, para. 117.
This case clearly demonstrates the nature of statutory responsibilities and how a court, given the task of determining whether those statutory responsibilities have been met, will engage in a detailed process of statutory interpretation to identify the source and nature of legal duties which cannot be abrogated.

A more recent case which discussed the provision of health services under section 1(1) of the National Health Service Act 1977 is _R v North West Lancashire Health Authority, ex parte A and other appeals_ [2000] 2 FCR 525. This case was an appeal from the decision of Hidden J. of the Queen’s Bench Division, quashing of a decision by the North West Lancashire Health Authority which refused to fund gender reassignment surgery for three individuals (identified as A,D & G) all of whom were suffering from an illness called ‘gender identify dysphoria’, otherwise known as transsexualism. Two of the three individuals affected by the decision of the Health Authority were diagnosed as having a clinical need for surgery substituting female for male characteristics – ‘gender re-assignment surgery’ – while the third individual was awaiting assessment of suitability for the surgery. All three claimed that they were ‘ill’ and therefore fell within the provisions of s.1 of the Act. The Health Authority stated as its reason for refusing to fund the treatment its statutory obligation to care for all within its area and the limited financial resources available to it, which required the Health Authority to prioritise medical treatments, resulting in transsexualism having a low priority.

In order to put the case into some context, it is useful to first note that there existed only one specialist clinic in the Britain for the
treatment of transsexuals, the Gender Identity Clinic at Charing Cross Hospital in London. The North Lancashire Health Authority had neither the expertise or facilities to treat transsexualism and any decision to accept responsibility for the funding of treatment for the illness would mean that the Authority would have to enter into an ‘extra-contractual referral’ with the Charing Cross facility, on the basis that the Authority would pay for the gender-reassignment surgery should it become necessary. The court noted that even though transsexualism is a rare condition, only small number of patients ever reached the stage of surgery, following preparatory counselling, hormone treatment and monitoring. 417

The court was told that in 1995, the Health Authority amalgamated with another Authority and in doing so, succeeded the Blackpool Health Authority, which has funded gender reassignment treatment where a recommendation which was made by a local consultant psychiatrist, stated that it was necessary. As a result of this policy, between 1993-94, Blackpool Health Authority referred 13 patients to Charing Cross Clinic. Since 1995, however, a highly restrictive policy was adopted by the North West Lancashire Health Authority, resulting in no such referrals.418

The Court noted that provisions of the National Health Service Act 1977 (U.K.), namely sections 1 and 3, setting out the statutory obligations of the Health Authority. It also noted the qualifications to those provisions as identified in R v North & East Devon Health Authority, ex parte Coughlan419 being that s.1(1) only requires the Secretary of State “to continue to promote” as opposed to provide, a comprehensive health service and, furthermore, that s.3 limits any

418 Ibid at para.5.
duty to provide services to “to such extent as he considers necessary to meet all reasonable requirements” and, in the case of facilities, to those that are considered “...appropriate as part of the health service.”

Mr Justice Hidden, in the first hearing of this matter, determined that:

“...in formulating policy or in applying policy to a particular case before it the Authority has to consider whether there is a demonstrable medical need for the treatment in question. The Court will not seek to allocate scarce resources in a tight budget but will ensure that the Health Authority has asked the right questions and has addressed the right issues before arriving at a policy that is lawful. The Authority has to tackle the vexed problem of transsexualism and it has decided that gender re-assignment ‘will not be purchased’. It is true that it has come to that conclusion subject to the proviso of overriding clinical need, but since it is unable to define or exemplify what is meant by such words, such words either add nothing or alternatively unlawfully fetter the Authority’s discretion in the question it is seeking to answer. To conclude that it will provide counselling but it will not provide hormone treatment or surgery is a conclusion to which it is not entitled to come!”. [Emphasis added].

He continued:

“...I am satisfied that the respondent’s decisions...are Wednesbury unlawful and irrational. They were arrived at without consideration of relevant matters, such as the question of what is a proper treatment or what is recognised as the illness involved in gender identity dysphoria ... or transsexualism. Those decisions were equally arrived at by consideration of irrelevant matters. The policy itself is unlawful because it fetters the respondent’s exercise of its discretion in discharging its duty of providing treatment and providing facilities for the prevention of illness and the cure of persons suffering from that illness.”

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419 Op cit.
420 Ibid at para.8.
421 Ibid at para 31.
422 See Footnote No.241 for an explanation of this notion.
423 The phrases “…without consideration of relevant matters...consideration of irrelevant matters...” and the reference to the policy being unlawful because it “…fetters the respondent’s exercise of its discretion...” are specific references to grounds for judicial
Lord Justice Auld, delivering the judgment of the Court of Appeal, acknowledged that health authorities, in determining allocation of funding, needed to establish priorities, and that furthermore,

"The precise allocation and weighting of priorities is clearly a matter of judgment for each Authority, keeping well in mind its statutory obligations to meet the reasonable requirements of all those within its area for which it is responsible."

His Lordship also identified that in establishing such priorities, it was not only sensible but also rational to have a policy to guide such decision-making. It would also make sense in relation to such a policy, in the opinion of His Lordship, that in its scale of priorities life-threatening conditions such as kidney failure or cancer would be placed higher in the priority ranking than treatment for transsexualism. The appropriateness and lawfulness of a such a policy was explained by the court thus:

"It is proper for an Authority to adopt a general policy for the exercise of such an administrative discretion, to allow for exceptions from it in 'exceptional circumstances' and to leave those circumstances undefined...In my view, a policy to place transsexualism low in an order of priorities of illness for treatment and to deny it treatment save in exceptional circumstances such as overriding clinical need is not in principle irrational, provided that the policy genuinely recognises the possibility of there being an overriding clinical need and requires each request for treatment to be considered on its individual merits."
In the opinion of the court therefore, necessary resource allocation priorities made in compliance with statutory obligations and based upon ‘reasonable’ policy are neither unlawful nor challengeable on the basis of ‘unreasonableness’.

This position is consistent with the view taken by the court in the cases previously discussed and clearly indicates that given the absence of unreasonableness, and the interpretation given to the relevant statutory provisions, specifically s.3 of the National Health Service Act 1977, the courts will not interfere with resource allocation decisions which impact upon the delivery of health care, even where the health care provided is deemed to be provided under a ‘comprehensive health service’. This also reflects a close similarity to the judicial opinion of the Constitutional Court in South Africa, thus showing a consistency in approach.

**MAJOR CASE STUDY 4 - Canada**

Health care in Canada has long been viewed a right and the manner in which the Canadian legislatures and Courts have dealt with the issue of health care provision and access provides a useful study for the purposes of this thesis.

While Canadian governments of all levels are now extensively involved in the delivery and regulation of health care services, this was not always the case. When the Constitution of Canada was being developed between the years of 1864 and 1867, ‘health care’ was not considered to be a separate and discrete area of government administration as were, for example, education and
justice. Accordingly therefore, the *British North America Act 1867*, now known as the *Constitution Act, 1867*, accorded various aspects

of 'health care' legislative competence to both federal and provincial governments. Indeed, Estey J. of the Supreme Court of Canada explained the position in *Schneider v The Queen* when he stated:

"Health is not a subject specifically dealt with in the Constitution Act either in 1867 or by way of subsequent amendment. It is by the Constitution not assigned either to the federal or provincial legislative authority. Legislation dealing with health matters has been found within the provincial power where the approach in the legislation is to an aspect of health, local in nature... On the other hand, federal legislation in relation to 'health' can be supported where the dimension of the problem is national rather than local in nature... In sum 'health' is not a matter which is subject to

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426 Map of Canada, showing all provinces. Retrieved from http://www.chabweb.net/canada.html on 28/04/04


428 139 D.L.R. (3d) 417

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specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question".  

While the status of health care may be regarded as 'amorphous' due to this early lack of constitutional recognition, there have been a number of legislative changes that have occurred over the past 20 years that have seen the emergence of a claim to the existence of a right to universal and comprehensive health care within Canada and it is these legislative changes that will now be examined.

Historical overview of the development of Canadian health care values and principles

According to research\textsuperscript{430}, there are two fundamental notions that had an impact on the development of the Canadian health care system: firstly, the notion that health care is one of the most significant goods that society desires and, secondly, that the provision of health care to all citizens is largely a responsibility of society at large. The development of these notions can be traced by consideration of the historical background of Canadian health\textsuperscript{431}, a background which also serves as the basis upon which the legislative changes to be discussed, can be more appropriately understood.

\textsuperscript{429} Ibid, p.442-3
\textsuperscript{431} It should be noted that this is a very abbreviated overview and its intention is purely to place the following discussion in some historical perspective.
The first link in this historical chain were the early charitable hospitals and other voluntary health agencies established to provide health services to the poor and those who had no family to rely upon to provide care when they became ill. The acceptable use of community funds for this purpose expanded the provisions of services, with the introduction of The Municipal Doctors’ Scheme\textsuperscript{432} being a prime example of this expansion. This type of scheme soon spread to other municipalities, followed closely by the establishment of ‘union hospital districts’ which provided hospital services through tax revenue. While these services were universally available, they were neither comprehensive nor portable from one municipality to another.

![Figure 41\textsuperscript{433}](image)

The fact that limited municipal governments could provide certain services, led to the argument that provincial governments should be able to provide even better services, and according to Kotalik,\textsuperscript{434}

\begin{itemize}
\item \textsuperscript{432} The Western Province of Saskatchewan was one of the first to introduce such schemes, with the appointment of doctors in the rural municipality of Sarnia in 1915. According to Kotalik, this was the first time in Canada that any level of government had provided all its residents with access to clinical services, and paid them from tax income.
\item \textsuperscript{433} Forefathers of Canadian Confederation retrieved from http://www.solon.org/Constitutions/Canada/English on 28/04/04
\item \textsuperscript{434} Ibid.
\end{itemize}
by the end of World War 1, debate on this possibility was occurring on this in several provincial legislatures. Alberta and British Columbia were the first provinces to approve advanced health care statutes, containing comprehensive but non-universal plans for the provision of the full range of health services, but these statutes were never implemented. According to research\textsuperscript{435}, it was not until 1962, following a doctors' dispute, that the first provincial universal health insurance plan was introduced in Saskatchewan.

While such developments were occurring at the provincial level, debate about the possibility of a national health insurance scheme began in the Federal House of Commons in the 1920s. As previously mentioned, health was not specifically dealt with by the Constitution Act, with only two sections containing explicit references: s.91(11) which granted the Parliament of Canada jurisdiction over quarantine and the establishment and maintenance of marine hospitals; and, s.92(7) granting the power to make laws concerning the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province. In fact, it has been argued\textsuperscript{436} that this lack of an express grant of legislative authority in relation to health meant that the Federal Parliament has had to rely primarily on its spending and criminal law powers as the basis of federal action in relation to health.

From a provincial perspective, the Constitution Act set out various responsibilities\textsuperscript{437} which were interpreted to include many aspects

\textsuperscript{435} See Badgley, R.F. & Wolfe, S. Doctor's Strike: Medical Care and Conflict in Saskatchewan (Toronto: Macmillian, 1967) as cited in Kotalik, ibid.

\textsuperscript{436} Jackman, M. ‘Constitutional Jurisdiction over health in Canada’ (2000) 8 Health Law Journal 95-117

\textsuperscript{437} Including responsibilities for ‘property and civil rights’ – s.92(13) and “generally all matters of a merely local of private nature in the province – s.92(16).
of the provision of health care.\textsuperscript{438} Indeed the extent of the responsibilities for health matters was identified by Mr Justice Dickson in \textit{Schneider v The Queen}\textsuperscript{439} when he made reference to the assigning of jurisdiction over local and private matters to the provinces and stated:

"...it is probable that this power was deemed to cover health matters...[and furthermore that the] view that the general jurisdiction over health matters is provincial ...has prevailed and is now not seriously questioned..."\textsuperscript{440}

The position was further reinforced by the recommendation of a 1928 standing committee of the House of Commons, that federal grants be provided to those provinces whose governments adopted health legislation that met federally established standards.\textsuperscript{441}

By 1943, the first signs of a publicly administered, comprehensive universal scheme to cover all citizens were unveiled with the report of the Advisory Committee on Health Insurance. However, the federal government elected not to implement the scheme in total, preferring to concentrate on the granting of aid for special programs and for the operation of hospitals. As a result, many provincial governments implemented schemes for publicly administered funding of hospital services, choosing to take advantage of this cost-sharing opportunity.

By 1961, there was renewed interest in the establishment of a comprehensive universal national health insurance system and so the Progressive Conservative Prime Minister John Diefenbaker created a \textit{Royal Commission on Health Services}, led by Emmett

\textsuperscript{438} Gibson, op.cit.
\textsuperscript{439} Op cit.
\textsuperscript{441} Kotalik, op.cit.
Hall. The Hall Commission was given the mandate to determine the needs of Canadians for health insurance and health services. Extensive hearings were held across Canada in which many views were expressed by a multitude of groups and individuals. The Hall Commission's Report of 1964 provided the federal government with a set of principles, a "Health Charter for Canadians," and stressed the need for government-sponsored, comprehensive and universal health services across the county.

In order to enact these ideas, the Commission recommended that the federal government enter into cost-sharing agreements with the provinces to provide the fiscal capacity required to cover medical and other services, including, for example, prescription medications and home care services. The Commission also recommended basing medical insurance on freedom of choice of provider, and that the autonomy of physicians be preserved. These proposals were favourably received and resulted in the introduction of the Medical Insurance Care Act 1968. By 1971, all provincial governments had introduced hospital and medical insurance programs designed to fulfill the 4 basic conditions of universality, public administration, comprehensiveness and portability as required by the Federal Government.

By 1977, the Federal Government was concerned that these basic conditions were in fact being eroded and so a new Commission was established, also chaired by Emmett Hall. The result of this further Commission was the introduction of the Canada Health Act of 1985. This new Act, while reasserting the previously stated

443 Canada Health Act, R.S.C. 1985
basic conditions, also required that a further condition be met, that of ‘accessability’.

Given the long-term development historical development of these five principles – universality, public administration, comprehensiveness, portability and accessibility – and that fact that they are regarded as having guided health care practice for several decades, they are regarded by many as:

"...the core values of the Canadian health care system...[comprising] a moral vision of health and health care" 444

Other writers have commented that:

"The ethical significance of the heated controversies over extrabilling and hospital user fees, after passage of the Canada Health Act in 1984, stems from the fact that the Canadian system has been founded upon a principle of public ethics to which the Canadian people fiercely adhere. Equality before the health care system...is as strong a principle in Canada as equality before the law" 445

and,

"Canadian society assumes that access, just and equitable access, to an appropriate level of health care is a matter of right" 446

The Canada Health Act

The Canada Health Act447 (“CHA”) was introduced as a measure which was to solve existing problems within the Canadian health care system and guarantee Canadians access to universal and

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445 Roy, D.J., Williams, J.R. & Dickens, B.M. Bioethics in Canada (Scarborough, Ontario: Prentice-Hall, Canada, 1994) at p.95.
comprehensive health care. It has previously been mentioned that the absence of Federal Constitutional authority in relation to health care resulted in the provision of services by the Provinces, assisted by the provision of grants from the Federal Parliament. Effectively, what the CHA implements is an authorization for the implementation of such federal expenditure to the provinces in respect to insured health services and extended care services, pursuant to authority granted under the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977*.

Whilst this dichotomy in relation to health care may seem to be of little significance on first reading, from the perspective of a population that assumes that access, just and equitable, to an appropriate level of health care is a matter of right, there exist some interpretational issues which may impact upon the realization of such an assumption and are therefore of interest in regards to the focus of this thesis.

The long title of the CHA reads:

> "An act relating to cash contributions by Canada in respect of insured health services provided under provincial health care insurance plans and amounts payable by Canada in respect of extended health care services and to amend and repeal certain Acts in consequence thereof…"

and this is followed by the Act’s second recital, which states:

> "AND WHEREAS the Parliament if Canada wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof…"

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Further, the first substantive provision – section 3 – purports to enunciate a ‘Canadian Health Care Policy’, the wording of which reads:

(5) It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

However, despite the goals of the CHA as identified above and the fact that it has been touted by participants in the health sector as defining the ideal Canadian medical system\(^{449}\), there is increasing concern that the financial pressures being experienced by the health care system are making meeting those goals increasingly difficult. The consequence of this situation is that the CHA is now being viewed as a legal rather than just political instrument, and appropriate legal avenues for redress are being sought by those who regard themselves as the intended beneficiaries of the CHA, and who now seek to protect their interests claimed to be guaranteed by the Act – universality, comprehensiveness, public administration, portability and accessability.

**The Canadian Charter of Rights and Freedoms**

The Canadian Charter of Rights and Freedoms forms part of the Canadian Constitution\(^{450}\). As previously mentioned, the Constitution Act 1867 was the first constitutional document within Canada, but it did not make Canada an independent country from the United Kingdom. It was not until 1982 that agreement was

\(^{449}\) ibid
reached with the British Parliament so that the necessary amending formula could be adopted bringing the power to change the Constitution, so that all constitutional authority could be brought within the sole control of the Parliament of Canada.

The current Canadian Constitution therefore, consists of the two Constitution Acts of 1867 and 1982, setting out the division of powers between the Parliament of Canada and the provincial legislatures, and a set of unwritten conventions, as well as the Canadian Charter of Rights and Freedoms ("the Charter") introduced with the Constitution Act of 1982. While the constitutional documents themselves are of importance, it is the Charter that is concerned with the identification and protection of those individual rights and freedoms regarded as necessary for a free and democratic society. It should be noted that there also exists a Canadian Bill of Rights enacted in 1960 which also sets out certain fundamental rights and freedoms, but the Charter differs from this document by being part of the Constitution of Canada, therefore having associated constitutional authority, and not just an enacted law of the Parliament of Canada.

The first thing to note about the Charter in relation to a right to health care is that there is no specific reference to health care contained within any of sections of the Charter. Therefore, it has been suggested, that the question as to whether health care is a fundamental right which can be said to be afforded protection under the Charter must be answered, if possible, by reference to those legal rights which are afforded protection, specifically the

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rights to life, liberty and security of the person as set out in section 7.\textsuperscript{454} The case of Morgentaler, Smoling and Scott v The Queen (otherwise referred to as \textit{R v Morgentaler}) (1988) 44 D.L.R. (4\textsuperscript{th}) 385 ("Morgentaler") provides significant guidance in relation to this matter, specifically in relation to the defining of the term "health", as well as providing some insight into the opinion of the Supreme Court in being asked to adjudicate on whether legislative initiatives conform to the values as expressed in the \textit{Charter}.

\textit{Morgentaler} concerned a conspiracy to procure a miscarriage contrary to ss 251(1) and 423(1)(d) of the Criminal Code of Canada. The accused were acquitted at trial but a Crown appeal against the decision was allowed and a new trial was ordered. On appeal to the Supreme Court of Canada, the accused argued that s.251(1) of the Criminal Code which prohibited abortions except in the circumstances set out in s.251(4), was unconstitutional. The provisions of s.251(4) concerned the obtaining of a certificate from a therapeutic abortion committee and carrying out of the abortion by a physician other than a member of the therapeutic abortion committee. According to the case report, evidence was led at trial as to the delays encountered by women seeking to comply with the procedure of the therapeutic abortion committee as well as problems with access to abortion services.

Dickson C.J.C. identified the principal issue involved in the appeal as concerning:

"...whether the abortion provisions of the Criminal Code infringe the 'right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of...

\textsuperscript{453} See \url{http://laws.justice.gc.ca/en/C-12.3/26179.html} for a copy of this document – retrieved 19/06/2002
\textsuperscript{454} Windwick, B.F., ‘Health-care and Section 7 of the Canadian Charter of Rights and Freedoms’ (1994) 3 \textit{Health Law Review} No. 1, 20-23
Prior to discussing the merits of the case, His Honour addressed the issue of the role of the Court in reviewing legislative initiatives in light of existing constitutional provisions and ensuring compliance with such provisions. His Honour stated:

"Although no doubt it is still fair to say that courts are not the appropriate forum for articulating complex and controversial programmes of public policy, Canadian courts are now charged with the crucial obligation of ensuring that the legislative initiatives pursued by our Parliament and legislatures conform to the democratic values expressed in the Canadian Charter of Rights and Freedoms."^456

Therefore, while the Court had before it a matter concerning the issue of abortion, clearly a matter which the Court regarded as being capable of categorization as a complex and controversial [programme] of public policy, it was the issue of whether the content of the applicable criminal provisions complied with the democratic values expressed in the Canadian Charter of Rights and Freedoms or whether they constituted an infringement or denial of the rights guaranteed by the Charter, including those within section 7. The relevance and importance of this comment will become obvious later in the discussion of this case and related issues.

The appellants in the case were qualified medical practitioners who had set up an abortion clinic in Toronto to perform abortions for women who had been unable to secure the required certificate from a therapeutic abortion committee as required by s.251(4). In the opinion of the appellants, a woman had an 'unfettered right to

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^456 Ibid at p.393-394
choose whether or not an abortion [was] appropriate in her individual circumstances\textsuperscript{457} and argued three issues:

- that s.251 was \textit{ultra vires} \textsuperscript{458} the Parliament of Canada
- that s.251 infringed ss.2, 7 and 12 of the \textit{Charter}; and
- that s.251 was inconsistent with s.1(b) of the Canadian Bill of Rights.

It was submitted by the lawyers for the appellants that the Court should recognize that s.7 protected a very wide range of rights, arguing that the right to ‘life, liberty and security of the person’ should be seen as a wide-ranging right to control one’s own life, through the protection of individual autonomy, thus allowing an individual to make \textit{unfettered decisions about one’s own life}.

The Court however, regarded that the \textit{Charter} was still in its infancy and that it would therefore be inappropriate to attempt to provide an all-inclusive clarification of the meaning of s.7, preferring to wait until it had had the opportunity to consider a \textit{wide variety of claims and factual situations}\textsuperscript{459}. In fact, the court elected to consider only two aspects of s. 7 – the right to ‘security of the person’ and ‘the principles of fundamental justice’. Whilst this approach may be regarded by some as an abrogation of the responsibility of the court, it is considered that the comments made by their Honours in this case, even taking into consideration the narrowness of the interpretative approach taken, are nevertheless

\textsuperscript{457} Ibid at p.396
\textsuperscript{458} The doctrine of \textit{ultra vires} and is central to the principles of Administrative Law. In essence, the doctrine states that all public authorities must act within the powers given to them by Act of Parliament. If administrative action in excess of power granted under the relevant Act or a statutory power is exercised contrary to some legal principle, then judicial review may find that the relevant action is \textit{ultra vires} and the party affected by the administrative decision may seek an appropriate remedy, such as certiorari – the quashing of the decision. See Wade, H.W.R \textit{Administrative Law} (Oxford University Press: London, 1984) pp.3-20; 22-24; 31-44 for a more detailed discussion of the doctrine of \textit{ultra vires}.
\textsuperscript{459} \textit{Mortantaler} op.cit at p.397
important to the discussion on the justiciability of health care as a human right.

The first issue to be addressed by the Court was that of the interpretation of s.7. Dickson, C.J.C. was of the opinion that rights can only be understood when one considers the interests which they are seeking to protect. In other words, it is inappropriate to seek to define the nature of a right unless the purpose for which the right was introduced – the protection of individual interests – is understood. This recognition of the right of individuals to the protection of certain interests is central to determining whether any alleged action constitutes an infringement of that interest and as such, can be said to accord to the principles of fundamental justice.\textsuperscript{460} In this case, His Honour was quite clear:

\begin{quote}
"I have no doubt that s.7 does impose upon the courts the duty to review the substance of legislation once it has been determined that the legislation infringes an individual's right to "life, liberty and security of the person"...[and] it will be sufficient to investigate whether or not the impugned legislative provisions meet the procedural standards of fundamental justice".\textsuperscript{461}
\end{quote}

In essence therefore, His Honour is stating that an individual, who alleges that his or her rights or freedoms have been impugned by legislative provisions, has an appropriate process of judicial review to pursue. The logical conclusion from this position is that rights, such as the right to 'life, liberty and security of the person', are justiciable where they exist in a constitutional document such as The Canadian Charter of Rights and Freedoms.

Once the court had identified that it had the duty to review, the next task was to determine whether the relevant provision – s.251 – did impair or infringe the right of security of the person. In

\textsuperscript{460} Ibid at p.398.
\textsuperscript{461} Ibid at p.399
coming to the decision that the provision did indeed constitute such
an infringement, the court referred to the risk of damage to the
physical well-being of a woman by delays in complying with the
requirements of the provision.

"In summary, s.251 is a law which forces women to carry a foetus
to term contrary to their own priorities and aspirations and which
imposes serious delay causing increased physical and
psychological trauma to those women who meet its criteria. It must
therefore, be determined whether that infringement is
accomplished in accordance with the principles of fundamental
justice..." 462

The relevance of finding on the basis of ‘increased physical and
psychological trauma’ is in the fact that to determine whether the
infringement was ‘accomplished in accordance with the principles
of fundamental justice’, the court had to discuss the relevant
administrative system established by s.251(4). As the procedure
under this section required a certificate to be granted when the
continuation of a pregnancy would endanger the ‘life or health’ or
the pregnant woman, some determination needed to be made as to
the definition of ‘health’, for without it, a therapeutic abortion
committee would be unable to determine when a therapeutic
abortion should be granted as a matter of law.

His Honour, Dickson C.J.C. was the first of the judges to discuss
this issue. He noted that the term ‘health’ was not defined for the
purposes of the section, and that even though medical witnesses
had testified as to the ambiguity of the ‘health’ standard within the
section, there was unanimous approval of the WHO definition of
health, including as it does a recognition of the importance of
‘physical, mental and social-wellbeing’ to the health of the

462 Ibid at p.408
individual.\textsuperscript{463} This approval however, was seen to be of little benefit, for His Honour referred to the comments of the authors of The Committee on the Operation of the Abortion Law (known as the ‘Badgley Report’)\textsuperscript{464}, who noted that there was no evidence that the WHO definition was being applied by therapeutic abortion committees, and furthermore:

"There has been no sustained or firm effort in Canada to develop an explicit or operational definition of health, or to apply such a concept directly to the operation of induced abortion. In the absence of such a definition, each physician and each hospital reaches an individual decision in this matter. How the concept of health is variably defined leads to considerable inequity in the distribution and the accessibility of the abortion procedure".\textsuperscript{465}

The consequence of this situation, according to His Honour, was that the women could not be expected to know in advance what standard of health would be applied by any given committee. This absence of a clear standard was therefore a serious procedural flaw, given the legal consequences of the decision of the committee.\textsuperscript{466} This procedural flaw, together with other issues raised by the court but not material here, substantiated the claim that there was a failure to comply with the principles of fundamental justice.

Mr Justice Beetz supported the decision of Dickson C.J.C. in finding that s.251(4) did not accord with the principles of fundamental justice, however, His Honour did differ in the interpretation of the meaning of the term 'health'. Mr Justice

\textsuperscript{463} Ibid at p.410
\textsuperscript{464} The Committee on the Operation of the Abortion Law was established by Orders-in-Council P.C. 1975-2305, -2306, and -2307 of September 29, 1975. Its terms of reference instructed it to "conduct a study to determine whether the procedure provided in the Criminal Code for obtaining therapeutic abortions is operating equitably across Canada." The report found that there were serious problems with s.251, by virtue of the administrative and procedural requirements.
\textsuperscript{466} Ibid at p.412
Beetz was of the opinion that the term 'health' clearly referred to the physical or mental health of the pregnant woman\textsuperscript{467} and accordingly therefore, there was no vagueness attaching to the term. His Honour stated:

"I note with interest the decision of the Supreme Court of the United States in U.S. v Vuitch, 402 U.S. 62 (1971) [where] I believe the following extract of the majority opinion delivered by Mr Justice Black to be instructive:

...the general usage and modern understanding of the word 'health'...includes psychological as well as physical well-being. Indeed Webster's Dictionary, in accord with that common usage, properly defines health as the "[s]tate of being...sound in body [or] mind.\textsuperscript{468}"

Before concluding the significance of the above definitional difference, it is important to refer to some of the comments of Mr Justice McIntyre, who presented a dissenting decision in the case. His Honour expressed the view that while the adoption of the Charter increased the scope for the judicial review of legislation, this scope was not unlimited and indeed, should be carefully confined to only those matters ordained in the Charter, noting that:

"I am well aware that there will be disagreement about what was ordained by the Charter and, of course, a measure of interpretation of the Charter will be required in order to give substance and reality to its provisions.\textsuperscript{469}"

However, in making these comments, His Honour warned that courts needed to show restraint in conducting such interpretation, specifically warning against the postulation of rights and freedoms which 'do not have a reasonably identifiable base in the Charter'\textsuperscript{470}. In other words, in ensuring that legislative initiatives conform to

\textsuperscript{467} Ibid at p.441
\textsuperscript{468} Ibid at p.441-442
\textsuperscript{469} Ibid at p.464
\textsuperscript{470} Ibid
the democratic values expressed in the Charter, the courts should confine themselves to those rights and freedoms clearly expressed in the Charter and avoid 'imposing or creating other values not so based'.

Mr Justice McIntyre then provided some useful comments on the difficulties faced by courts involved in interpreting the scope of rights and freedoms as contained in a document such as the Charter, comments that it is argued, have a relevance for any document purporting to list social, economic and cultural rights, including the right to health care. These comments will now be addressed. His Honour stressed that an interpretation of a right or freedom could only be given constitutional status if that interpretation could be expressly or reasonably implied from the document containing the right or freedom – in this case, the Charter. In support of this proposition, he stated:

"It is not for the court to substitute its own views on the merits of a given question for those of Parliament. The court must consider not what is, in its view, the best solution to the problems posed; its role is confined to deciding whether the solution enacted by Parliament offends the Charter. If it does, the provision must be struck down or declared inoperative, and Parliament may then enact such different provisions as it may decide...courts do not substitute their social and economic beliefs for the judgment of legislative bodies, who are elected to pass laws."

Therefore, it is reasonable to suggest that where Parliament has introduced a legislative initiative purporting to restrict access by an citizen or group of citizens to an adequate level of health care, where there exists a constitutional provision guaranteeing such a right, then, in the absence of a qualification such as ‘available

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471 Ibid at p.465
472 Ibid at p.465-66
resources', such a provision should be struck down or declared inoperative. According to the comments of His Honour, it would not be for the courts to decide to impose, for example, a resource allocation solution to the problem posed by the denial of access, as this would constitute a substitution of the court's social and economic beliefs for the judgment of the elected representatives responsible for the legislation.

This is not to say that this process of interpretation is without difficulties, but as was stated by His Honour in the case Reference re Public Service Employee Relations Act (1987)\textsuperscript{473}

"...while a liberal and not overly legalistic approach should be taken to constitutional interpretation, the Charter should not be regarded as an empty vessel to be filled with whatever meaning we might wish from time to time. The interpretation of the Charter, as of all constitutional documents [emphasis added] is constrained by the language, structure and history of the constitutional text, by constitutional tradition, and by the history, traditions, and underlying philosophies of our society..."

echoing the sentiments of Harlan J. in Reynolds v Sims\textsuperscript{474} when he discussed this issue in the Supreme Court, stating:

"This view, in a nutshell, is that every major social ill in this country can find its cure in some constitutional 'principle', and that this Court should 'take the lead' in promoting reform when other branches of government fail to act. The Constitution is not a panacea for every blot upon the general welfare, nor should this Court, ordained as a judicial body, be thought of as a general haven for reform movements. The Constitution is an instrument of government, fundamental to which is the premise that in a diffusion of governmental authority lies the greatest promise that this Nation will realize liberty for all its citizens. This Court limited in its function in accordance with that premise, does not serve its high purpose when it exceeds its authority, even to satisfy justified impatience with the slow workings of the political process. For when, in the name of constitutional interpretation, the Court

\textsuperscript{473} 38 D.L.R. (4th) 161 at 217
\textsuperscript{474} 377 U.S. 533 (1964) at pp.624-5
adds something to the Constitution that was deliberately excluded from it, the Court in reality substitutes its view of what should be so for the amending process.”

While Morgentaler provided useful commentary on both the Constitution and Section 7 of the Charter, the issue as to the extent to which the Charter applies in the health care setting needs to be more closely examined for the purposes of this thesis and it is to those relevant cases that attention will now be directed.

The first case to address this issue was Stoffman v Vancouver General Hospital475 (“Stoffman”), a 1990 case before the Supreme Court. Stoffman concerned the application of the Charter to the Vancouver General Hospital’s mandatory retirement policy for physicians. The appellant claimed the policy violated the prohibition against age discrimination under section 15(1) of the Charter. Justice La Forest, in delivering the majority decision of the court held that that as the hospital did not form part of ‘government’ for the purposes of the Charter, the failure of the hospital to renew the appellant’s admitting privileges when he reached the retirement age as specified by the hospital’s policy, was not subject to review by the Charter.

The next case - Eldridge v British Columbia (Attorney-General)476- is far more significant in that it concerned the failure to provide specific services, in particular, sign language interpretation services under the provincial Medical and Health Care Services Act of 1992 and the Hospital Insurance Act of 1979.

The appellants in this case, Robin Eldridge, John Warren and Linda Warren, residents of British Columbia, had experienced considerable communication problems within the provincial health

475 [1990] 3 S.C.R. 483
476 [1997] 3 S.C.R. 624
care system as they were deaf and there were no sign language interpretation services available. It was alleged that this failure to provide interpretation services increased the risk of misdiagnosis and therefore ineffective treatment.

Medically required services in Columbia are funded by the Medical Services Plan, established and regulated by the Medical and Health Care Services Act 1992, while hospital services are funded under the provisions of the Hospital Insurance Act 1979. Neither provides for sign language interpretation to the deaf.

The Court was required to determine a number of constitutional issues, but importantly, for the purposes of this discussion, it was required to determine whether, and in what manner, did the provisions of the Charter apply to the decision not to provide sign language interpreters for the deaf as part of the publicly funded provision of medical care. Further, if the Charter did apply and a violation had occurred, what the appropriate legal remedy would be.

The Court identified that the Charter applied to provincial legislation in two ways – firstly, provincial legislation could be unconstitutional if it violated a Charter right, and secondly, where a delegated decision-maker acted in a manner which resulted in a Charter infringement in the exercise of their discretion. As Mr Justice La Forest noted:

"Action taken under statutory authority is valid only if it is within the scope of that authority. Since neither Parliament nor a Legislature can itself pass a law in breach of the Charter, neither body can authorize action which would be in breach of the Charter. Thus, the limitations on statutory authority which are imposed by the Charter will flow down the chain of statutory authority (whether legislative, administrative or judicial) which depends for its validity on statutory authority."\(^{477}\)

\(^{477}\) Ibid, para.21
“The evidence clearly demonstrates that, as a class, deaf persons receive medical services that are inferior to those received by the hearing population. Given the central place of good health in the quality of life of all persons in our society, the provision of substandard medical services to the deaf necessarily diminishes the overall quality of their lives. The government has simply not demonstrated that this unpropitious state of affairs must be tolerated in order to achieve the objective of limiting health care expenditures. Stated differently, the government has not made a ‘reasonable accommodation’ of the appellants’ disability. In the language of this Courts’ human rights jurisprudence, it has not accommodated the appellants needs to the point of ‘undue hardship’.”

Given this attitude of the courts to the Charter, it is useful to turn to what some researchers in this area have argued in relation to both a constitutional basis for a right to health care and the applicability of section 7 of the Charter to health care.

Friesan argues that the right to health care is not constitutionally entrenched in Canada (this, she suggests would come as a shock to most Canadians) and that this is the reason why section 7 of the Charter is the focus of legal scholars, seeking to prove health care is a fundamental socio-economic right. Friesan refers to Jackman, quoting her statement that “…if a right to basic and medically necessary health care and services is recognized as an aspect of the right to ‘Life, liberty and security of the person’, it follows that any government denial of such care must respect the requirements of procedural due process or, in the

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476 Ibid, para. 94
language of section 7, must accord with ‘principles of fundamental justice.”481 Therefore, according to the fundamental principles that we recognize in Australia and the United Kingdom482 as being those underpinning the right to natural justice:

“...any decision to deny access to basic and medically necessary care without advising the person affected that a decision was being made and on what grounds, and without affording him or her an opportunity to participate in the decision-making process or to otherwise respond to the decision, would be open to section 7 scrutiny...In sum, section 7 would require full and meaningful participation by patient in decisions regarding their care.”483

Given the use of the terminology “medically necessary health care” it is appropriate and indeed necessary to ascertain how this term has been defined in Canada and then how it may equate to ‘adequate health care’.

Caulfield484 has suggested that an ‘operational definition’ of the term ‘medically necessary’ has never been more important, given its use as a ‘...concept which can provide boundaries to the public funding of health care.”485 He continues:

“Indeed, ‘core services’, ‘medically required’, basic care’, ‘basic benefits package’ and ‘adequate health care’ are all terms which are intended to provide a context to the almost universally accepted notion that, at a minimum, governments have an obligation to provide ‘adequate care’ to their citizens. Despite wide recognition of this obligation, albeit a somewhat internationally inconsistent recognition, there has yet to be a successful attempt to define the parameters of this duty [Emphasis added]486.

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481 Friesan, op cit at para.14 quoting Jackman at 7.
482 As previously discussed in the case study on the United Kingdom.
483 Friesan, op.cit.
485 Ibid, para.3
486 Ibid.
Caulfield questions whether it is possible to provide a definition which is meaningful and practical, citing Callahan\textsuperscript{487} who writes:

"Is it just an accident that all efforts to find meaningful definitions of ‘adequate’ or ‘minimal’ or ‘necessary’ have failed? Is it from a lack of sufficient effort that they all turn out to be either too general to be of any practical use or too much a shopping list of diverse needs to constitute a coherent or meaningful whole? The failure, I believe, is inevitable, inherent in the project itself."

In Caulfield's opinion, if cost containment is the problem, then given the difficulties which present themselves when determining which services should be included\textsuperscript{488}, a definition of 'medically necessary' may only, at best provide minor financial gains.

Caulfield then examines the use of the term in not only the Canada Health Act 1985, but also in the Alberta health care legislation and cites various international instruments including the CESCR and the Universal Declaration of Human Rights, concluding that these documents:

".. do little to define what any 'package' of health should include outside of the prevention of illness and the rehabilitation and health...[assisting only]...in the formulation of what could be considered a floor and...[placing] health care in a broad context of other social obligations...[therefore leaving] the term...largely...undefined.\textsuperscript{489}

\textsuperscript{488} A clear example of the difficulties alluded to here by Caulfield are those experienced in Oregon during the formulation and implementation of the Oregon Plan. A useful discussion of the Oregon Health Plan is -- Jacobs, L., Marmor, T. & Oberlander, J. \textit{Report from the Field – The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did} (1999) Journal of Health Politics, Policy and Law Vol.24, No.1 available at \url{http://www.mba.yale.edu/faculty/PDF/oregonhpl.pdf} retrieved 13.04.04
\textsuperscript{489} Op cit, para.19.
In relation to relevant case law\(^{490}\), Caulfield comments that there is little if anything to be gleaned from judicial comments to assist in defining the term as

"...Canadian case law has simply utilized the broad and amorphous concepts and terms present in the relevant legislation and literature...[with]...some courts [stating] ...that these matters lie in the hands of the government legislatures – not with the courts.\(^{491}\)"

In saying this however, Caulfield is not necessarily being critical, but merely rephrasing the obvious conclusion – that given the definitional difficulty, it is more prudent, if not necessary for the courts to resort to judicial decision-making based on a refusal to intervene in resource allocation decisions, unless they are totally unreasonable. This emphasizes the distinction between public policy and legal policy - the former the responsibility of the legislature, the latter the courts.

As the court stated in Morgentaler v Prince Edward Island (Minister of Health and Social Services)\(^{492}\)

"The content of publicly funded medical care is the purview of the legislature. Its enacted policies are, in turn, subject to scrutiny by the courts upon challenge by citizens for validity based on administrative law, constitutional, Charter, and human rights considerations; and accountability before those by whom the legislature is elected."

In conclusion, Caulfield suggests that a "...practical, operational and meaningful definition..."\(^{493}\) of the term 'medically necessary' is unattainable and that therefore the term should only be

\(^{490}\) Caulfield cites both Morgentaler and Eldridge as well as Redhill v Ontario Health Insurance Plan (1990) 73 D.L.R. (4th) 457 and Alberta Medical Association v Minister of Hospitals and Medical Care (1987) 50 Alta L.R. (2d) 65
\(^{491}\) Op.cit, para.39
\(^{492}\) (1995) 122 D.L.R. (4th) 728 at 734
\(^{493}\) Op.cit, para.58
recognized as having value as a "...broad concept that symbolizes our society's values, beliefs and goals for the health care system."\(^{494}\)

If one accepts this viewpoint of definitional 'unattainability', it is arguable, if not reasonable, that the given the lack of an 'operational definition' of basic and/or adequate health care that a similar ad hoc approach would be applied to these terms. This then raises the question whether there can ever be any real benefit in legislating a right to such an amorphous notion, if, as has been previously discussed, the issue will be resolved on the 'reasonableness' of the resource allocation decision-making of the health care facility/authority.

In relation to this point, it is worth noting that Jackman\(^{495}\) places emphasis on the notion of 'fundamental justice', commenting that a person's right to 'basic and medically necessary care' (a term she chooses not to define) must be protected by doing more than just providing an individual with a right to object after a decision affecting them has been made. In Jackman's opinion, if "...the entire burden of ensuring Charter compliance...[is placed]...on those most immediately and directly dependent upon the system and the decision-makers operating within it..."\(^{496}\) and if service delivery is determined by resource allocation issues beyond the decision-maker's immediate control, then the only way to guarantee the right to basic and medically necessary care is to guarantee the right to participate in health policy at the broadest possible level. She states:

"...an individual whose health interests are at stake in a particular health delivery setting, including a person threatened by an individual decision to deny basic and medically necessary

\(^{494}\) Ibid, para.59
\(^{496}\) Ibid, para.28
care, has a right to be involved in that decision, according to the requirements of fundamental justice. Where a more generalized policy decision threatens to have the same impact, but on a larger scale, the same principles should apply. In such a case it can be argued that, notwithstanding the broader regulatory character of the decision in question, those who may be adversely affected have a right to be heard, to respond, and to otherwise participate in the decision-making process.\textsuperscript{497}

Jackman is therefore suggesting that that policy-makers must ensure that when making global resource allocation decision, individuals who are at risk of having fundamental interests affected by these decisions, are adequately involved in the policy formulation. In the absence of such involvement, any regulatory decision that \textit{"...impinges upon health-related interests or which may deny basic and medically necessary care..."} will by necessity be fundamentally unjust. This is turn it is suggested by this writer, may mean that the resource allocation decision can be classified as 'unreasonable' and therefore subject to judicial review.

**Native/Aboriginal Health in Canada**

It is appropriate to turn to turn finally to a discussion of the provision of health care to native/aboriginal Canadians pursuant to the Constitution. According to s.91(24) of the Constitution Act, 1867, Parliament is given constitutional authority over \textit{"Indians, and Lands reserved for the Indians"}\textsuperscript{498}, while the Indian Health Regulations\textsuperscript{499} specifically deal with the provision of health services to Indians living on reserves.

\textsuperscript{497} Ibid, para.29
\textsuperscript{498} Note in \textit{Re Eskimos} [1939] S.C.R. 104, the Supreme Court interpreted this section of the Constitution as including the Inuit people.
\textsuperscript{499} Indian Health Regulations, C.R.C., c.955 (1978)
However, according to research\textsuperscript{500} responsibility for the provision of native/aboriginal health is the subject of some dispute, with specific groups claiming the provision of health services as a federal government obligation under treaty. For example, Jackman\textsuperscript{501} refers to a treaty signed in 1876 between the Cree of Central Alberta and Saskatchewan which provided what has been called the ‘Medicine Chest Clause’\textsuperscript{502}. This clause provided for the keeping of a medicine chest in the house of each Indian agent for the use and benefit of the Indians and further that where any Indians were ‘overtaken by any pestilence, or by a general famine, the Queen...will grant...assistance of such character or to such extent as the Chief Superintendant of Indian Affairs shall deem necessary and sufficient to relieve the Indians from calamity...befallen them.’

In 1971, the Saskatchewan Court of Appeal in \textit{R v Swimmer}\textsuperscript{503} was asked to address this clause by determining the extent of the federal government’s obligations to provide health services. The respondent, a status Indian living off-reserve in Saskatchewan was charged with a failure to pay medical and hospital insurance premiums as required by the province. At trial in the first instance, the Court found that the respondent, Swimmer was entitled to receive all medical services, including drugs, hospital care and medical supplies, free of charge under the provisions of Treaty 6, the specific clause known as the ‘medicine chest’ clause. However, Justice Culliton of the Court of Appeal found against this interpretation of the Treaty, rather deciding that there was both no obligation on the federal government or any federal legislation

\textsuperscript{501} Ibid
that required the provision of all medical and hospital services to Indians free of charge. Accordingly therefore, Swimmer was subject to the provisions of the relevant health insurance legislation and required to pay the relevant provincial premiums. Justice Culliton stated:

"The clause itself does not give to the Indian an unrestricted right to the use and benefits of the 'medicine chest' but such rights as are given are subject to the direction of the Indian agent...I can find nothing historically, or in any dictionary definition, or in any legal pronouncement, that would justify the conclusion that the Indians, in seeking and accepting the crown's obligation to provide a 'medicine chest' had in contemplation provision of all medical services, including hospital care."

A similar decision was reached in Manitoba Hospital Commission v Klein & Spence where it was decided that status Indians in Manitoba were subject to the provincial Hospital Services Insurance Act.

Part of the argument in this case concerned an absolute right to hospital services pursuant to the status of the respondent Spence as a 'Treaty Indian'. The respondents in this case had argued that because they had traditionally been supplied with hospital services free of charge by the federal government, they could not be expected to pay for the same services under provincial legislation, in this case, the Hospital Services Insurance Act 1962 (Man).

In determining the respondent's liability to pay for hospital services received, the Court of Appeal referred to both section 87 of the Indian Act 1951 which provides that:

"Subject to the terms of any treaty and any other Act of the Parliament of Canada, all laws of general application from

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503 [1971] 1 W.W.R. 756 (Sask.C.A.)
504 Ibid at 759-690 as cited in Jackman, op.cit. at para. 20
time to time in force in any province are applicable to and in respect of Indians in the province, except to the extent that such laws are inconsistent with this Act..."

and section 72(1)(g) which provided for the Governor in Council to make regulations to provide medical treatment and health services for Indians.

In determining liability, the Court referred to the comments of His Honour Culliton, C.J.S. in *R v Johnston* (1966) 56 D.L.R. (2d) 749, where he cited the same words he used in *R v Swimmer* in relation to the interpretation of the 'medicine chest' clause - that the clause did not:

"...give to the Indian an unrestricted right to the use and benefit of the 'medicine chest' but such rights as are given are subject to the direction of the Indian agent...I can find nothing...that would justify the conclusion that the Indians, in seeking and accepting the Crown's obligation to provide a 'medicine chest' had in contemplation provision of all medical services, including hospital care."\(^{506}\)

It is useful at this point to look at the case of *R v Johnston*, for it does provide assistance in further clarifying this issue. The case concerned the failure by the respondent, an Indian (within the meaning of the *Indian Act*, R.S.C. 1952, c.149) and a resident of Saskatchewan, to pay taxes required by the Saskatchewan Hospitalization Act.

Culliton, C.J.S. in delivering the judgment of the Court, discussed at length the effect of Treaty 6, and in particular the 'medicine chest' clause. His Honour cited the findings of the Magistrate who determined the case at first instance in favour of the respondent Johnston:

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\(^{506}\) Ibid, p528
"Referring to the 'medicine chest' clause of Treaty 6, it is common knowledge that the provisions for caring for the sick and injured in the areas inhabited by the Indians in 1876 were somewhat primitive compared to present day standards. It can be safely assumed that the Indians had limited knowledge of what provisions were available and it is obvious that they were concerned that their people be adequately cared for. With that in view, and possibly carrying on the opinion of Angers, J., a step further, I can only conclude that the 'medicine chest' clause...in Treaty No.6 should be interpreted to mean that the Indians are entitled to receive all medical services, including medicines, drugs, medical supplies and hospital care free of charge. Lacking proper statutory provisions to the contrary, this entitlement would embrace all Indians within the meaning of the Indian Act, without exception..."507

Therefore, at first instance, the Magistrate extended the meaning of the 'medicine chest' clause to cover all medical services, including hospital care.

His Honour, Culliton C.J.S. noted that for the purposes of interpretation a court was entitled to take "...judicial notice of the facts of history whether past or contemporaneous..."508 and that in his perusal of historical documents relating to the negotiation of Treaty No.6, nothing could be found which indicated that the extended meaning as applied by the Magistrate was what was intended. His Honour was only prepared to give to the 'medicine chest' clause, the plain reading which the words conveyed:

"...on the plain reading of the 'medicine chest' clause, it means no more than the words clearly convey: an undertaking by the Crown to keep at the house of the Indian agent a medicine chest for the use and benefit of the Indians at the direction of the agent..."509

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507 Ibid, p.751
508 Ibid, p.752
509 Ibid, p.753
Accordingly, therefore, there was no basis upon which the Court could find that the extended interpretation applied by the Magistrate was valid and legally sustainable.

Both the judgments in *Manitoba* and Johnston referred to the unreported judgment of *Dreaver v The King* (cited in *R v Johnston*), where Mr Justice Angers commented extensively on the ‘medicine chest’ clause:

"...the treaty [Treaty 6] stipulates that a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of the Agent. This, in my opinion, means that the Indians were to be provided with all the medicines, drugs or medical supplies which they might need entirely free of charge...I do not think that the Department [of Indian Affairs] had, under the treaty, the privilege of deciding which medicines, drugs and medical supplies were to be furnished to the Indians gratuitously and which were to be charged to the funds of the band. The treaty makes no distinction; it merely states that a medicine chest shall be kept at the house of the Indian Agent for the use and benefit of the Indians. The clause might unquestionably be more explicit but, as I have said, I take it to mean that all medicines, drugs or medical supplies which might be required by the Indians ... were to be supplied to them free of charge."\(^{510}\)

In *Johnston* this statement was treated as supporting the extended interpretation position as adopted by the Magistrate,

The decision of the case of *The Wuskwi Sipiikh Cree Nation, The Mathias Colomb Cree Nation, The Opaskwayak Cree Nation, The Sapotewayek Cree Nation, The Mosakahiken Cree Nation, The Grand Rapids First Nation, and the Chemawawin Cree Nation v The Queen* (as represented by the Minister of National Health and Welfare\(^{511}\) is also useful in this discussion. The plaintiffs in this case brought an action for perceived deficiencies in the provision of health, arguing that there existed a general understanding that

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\(^{510}\) Op.cit, para.11

\(^{511}\) 1999 Fed. Ct. Trial LEXIS 57
the federal government will continue to provide, as it had done, health care where treaties, such as Treaty 6, are silent.

The Federal Court, referred to both Dreaver and Johnston, commenting again that the interpretation of Mr Justice Angers in Deavers was a broad one. It was also noted that in Johnston, the Court commented that treaty provisions were to be given their literal meaning and that this literal meaning did not contemplate the provision of medical services, including hospital care. The Federal Court however, decided that the view adopted in Johnston was probably wrong, given that subsequent decisions, specifically that of The Queen v Sparrow [1990] 1 S.C.R. 1075, had:

"...concluded that aboriginal rights ought to be interpreted in a flexible manner in order to permit their evolution rather than leaving such rights frozen at a past time..."\(^{512}\)

The Court was of the opinion that treaties and statutes relating to Indians should be construed liberally and doubts resolved in favour of Indians. Accordingly therefore,

"...Mr Justice Angers took a proper approach in his...decision in Dreaver, reading the Treaty No.6 medicine chest clause in a contemporary manner to mean a supply of all medicines, drugs and medical supplies. Certainly, it is clear that the Saskatchewan Court of Appeal took what is now a wrong decision in Johnston. In a current context the clause may well require a full range of contemporary medical services."\(^{513}\)

This approach to interpretation of the 'medicine chest clause' based upon a liberal construction and historical considerations is reflective of the South African Constitutional Court in Soobramoney, where the Court a 'purposive' approach to constitutional interpretation.

\(^{512}\) Ibid, para.12
\(^{513}\) Ibid, para.14
It could also be argued that the approach taken in The Queen v Sparrow is reflective of the awareness, albeit not specified in the judgment, of the provisions of the Maastrict Guidelines, specifically those acts of commission identified as being:

"...the adoption of legislation or policies which are manifestly incompatible with pre-existing legal obligations relating to those rights....[and]...the active denial of such rights to particular individuals or groups, whether through legislated or enforced discrimination."

**MAJOR CASE STUDY 5 - New Zealand**

The New Zealand Government and judiciary has been confronted with the issue of the right to health care on a number of occasions and the manner in which this issue has been addressed on these occasions provides a useful commentary for the purposes of this thesis.

In 1994, the New Zealand Medical Association wrote to the Minister of Health, the Rt Honourable W. Birch suggesting that the Health and Disability Services Bill, which was before Parliament, should be amended to include a right to health care. However, the Minister was of the opinion that "the inclusion of such rights would be inappropriate and unmanageable" and would "risk stating as fundamental rights matters which it was not always within the power of the Government to deliver" and that therefore he could not countenance "a statement of people's rights to health care, unencumbered by financial considerations, being incorporated into the legislation."
However, despite the statement of the Minister that the inclusion of rights to health care in legislation were "inappropriate and unmanageable" there have been several pieces of legislation introduced in New Zealand that have both recognized certain aspects of patient’s health care rights and provided for the effective enforcement and adjudication of those rights. One such piece of legislation is the Health and Disability Services Act 1993 (NZ).

In the case of Shortland v Northland Health Ltd the New Zealand Court of Appeal was asked to decide whether the failure to provide dialysis treatment was a deprivation of the right to life contrary to s.8 of the New Zealand Bill of Rights Act 1990. The New Zealand legislation does not include any specific right to health care, but section 11 does provide the right to everyone to refuse medical treatment and section 8 provides:

*Right not to be deprived of life*

No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice.

The essence of the Shortland case concerned the provision of dialysis treatment to a patient (a Mr Williams) suffering from Type II diabetes, the complications of which were chronic renal failure and brain damage. Mr Williams had previously suffered an acute episode of a temporary malfunctioning kidney, for which he had received beneficial dialysis, but his subsequent chronic renal failure meant that a kidney transplant was the only effective treatment. For some patients in this condition, dialysis is offered until a transplant becomes possible.
Mr Williams was assessed as to his suitability for acceptance onto the dialysis treatment programme and as he was deemed to be an unsuitable candidate, his dialysis ceased in September of 1997. Following this decision, Mr Williams instituted judicial review proceedings, averring that Northland Health Ltd, as a Crown Health Enterprise under section 37 of the Health and Disability Services Act 1993, had failed in its duty or alternatively, had been wrong in its exercise of statutory power. In his statement of claim, Mr Williams referred to the Authority’s obligation to provide the best health, care and support for those needing health and disability services, the need to exhibit a sense of social responsibility having regard to the interests of the community within which the Authority operated and the need to uphold certain ethical standards which are generally expected of the providers of health and disability services.\textsuperscript{515}

It was argued on behalf of Mr Williams that as the Northland Regional Health Authority had the means to provide the treatment he alleged he required, it had a corresponding duty to provide it. However, Salmon J refused Mr Williams application citing as the reason the right of medical staff "to act in accordance with their clinical judgment."\textsuperscript{516} His Honour also was clear to state that this was not a case of refusal to treatment, rather it was a case of exercising "professional judgment ...as to the appropriate treatment to adopt."\textsuperscript{517} His Honour’s decision was based upon the interpretation of the general obligations in the Act as not being absolute but subject to clinical judgment. In his opinion, providing

\textsuperscript{514} 1 NZLR 433
\textsuperscript{516} Ibid, p.436
\textsuperscript{517} Ibid.
the process that the Authority used to select applicants for treatment was consistent with the guidelines drafted for this purpose, then the clinical decision made was not reviewable for deficiency. In coming to its decision, the Court referred to and endorsed the comments of Lord Donaldson in *Re J* as previously discussed.

It is interesting to note that, similarly to the *Sooobramoney case*, the issue of resource allocation was mentioned, albeit in passing, by the Court. Here however, the court indicated that because the decision-making processes were not under challenge, the issue as to whether the decision to withdraw dialysis was based upon a resource allocation assessment was not for the court to decide.

Mr Williams took his case to the High Court but again failed on the basis of the veracity of the clinical decision taken by the medical staff. The matter then went to the Court of Appeal, where it was alleged that the decision to deny dialysis treatment was unlawful for two reasons – firstly, that it was a breach of the requirement of good medical practice and secondly, that the decision was in breach of s.8. While the discussion concerning the first reason provides interesting reading, it is to the second reason that the focus now turns.

The court identified that the basis of s. 8 is to be found in the sanctity of life principle, but that the section was clear in specifying that the right was not absolute. The question to be determined by the court therefore was whether the actions of Northland Health Ltd were such as to “deprive” Mr Williams of his right to life within the meaning of s.8. To make this determination, the court referred to the requirements of s.151 of the *Crime Act*
1961, which required Northland Health Ltd to provide Mr Williams with all the “necessaries of life”, a legal duty to which criminal responsibility is attached.

The court decided that the “careful process adopted in this case and the clinical judgments to which it lead ... could not be said [to have resulted in Northland Health Ltd being] in breach of its duty under s.151 of the Crimes Act to provide the necessaries of life.”518 Equally therefore, the decision to refuse to provide dialysis could not be said to ‘deprive’ Mr Williams of his right to life in terms of s.8.

The similarities of the facts and arguments in this case to those of Soobramoney are significant even if for only the fact that while the court in Soobramoney’s case had s.27 of the Constitution to base its decision upon and so did not have to revert to a detailed discussion of the right to life arguments, the court in Soobramoney’s case did reject those arguments, stating:

“However the right to life may come to be defined in South Africa, there is in reality no meaningful way in which it can constitutionally be extended to encompass the right indefinitely to evade death.”519

a comment which could have had equal application in the case of Mr Williams.

Hunt520 refers to the “core services debate” which took place following the 1991 announcement by the then Minister for Health of major reforms of the New Zealand health system. A key element of the reform concerned the identification of those ‘core health services’ which would be publicly funded. The Committee... known

518 Ibid. p.445
519 Op.cit per Sachs, J at 308.
as the *National Advisory Committee on Core Health and Disability Services* – was initially commissioned to draw up a list either of services which people would be entitled to, or services which they would be excluded from. However, by 1995-96, the Committee had rejected this list as being ‘too simplistic’ an approach, preferring instead to identify four “fundamental principles” upon which decisions for the public funding of services or treatment could be based, cited by Hunt as being – “...value for money, a fair use of public funding, a consistency with communities’ values, and the provision of benefit”\textsuperscript{521}

In its 1994-95 Report\textsuperscript{522} the Committee stated:

> "When the idea of defining core services was first raised, a list approach was proposed. The Committee has moved well beyond the idea of a list approach. We believe that an approach, which identifies services as “in” or “out” of the core, is overly simplistic and potentially unfair because it may ignore the benefit of a particular service to a particular person at a particular time. Such an approach means that the question of core services is not so much which services should be publicly funded, but whether and when a service should be publicly funded.”

By 1992, the work of the Committee in relation to the health policy based upon these four fundamental principles, had seen, amongst other achievements, the introduction of booking systems for elective procedures as well as the introduction and continued use of evidence-based guidelines for the “…rational and explicit basis for funding services and – critically – a basis where available evidence underpins decisions about resource allocation.”\textsuperscript{523}

\textsuperscript{520} Op.cit.
\textsuperscript{521} Ibid, p.144
\textsuperscript{522} National Advisory Committee on Core Health and Disability Support Services, 1993, *Core Services for 1994/95* (Wellington, New Zealand: National Advisory Committee on Core Health and Disability Support Services) p.17
Clearly there are on-going resource allocation issues which are being addressed within New Zealand and, similarly to other jurisdictions, the reasonableness of such resource allocation will no doubt form the basis of any future challenge to the availability and access of health care.\textsuperscript{524}

MAJOR CASE STUDY 6 - The Australian Position

The general responsibility and powers of the Commonwealth in relation to health are derived from the Australian Constitution\textsuperscript{525}, specifically s.51(xxiiiA), s.51(ix), and s.96. Section 51(xxiiiA) provides:

\textit{\textbf{“51. The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:}}}

\textit{(xxiiiA.) The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances:”}

thus giving the Commonwealth Parliament the power to provide direct health services and benefits through programs such as the Pharmaceutical Benefits Scheme and Medicare. Section 51(ix) provides powers in relation to the subject matter of ‘quarantine’, while s.96 provides that:

\textsuperscript{523} See Media release – 18 April, 2002 at http://www.nbc.govt.nz/MediaReleases/18042002.html retrieved 30/04/04
\textsuperscript{524} The Mental Health Act 1992 (NZ) is said to have a ‘potent range of patient rights’ under Part VI, with complaints being able to be made to independent ‘ombudsmen’, a right to refer a complaint to a review tribunal which is subject to judicial review, thus making patient’s rights enforceable in the courts. See Hunt, op.cit pp.139-140 for a further discussion of this.
\textsuperscript{525} http://www.aph.gov.au/senate/general/constitution/
Thus granting to the Commonwealth Parliament the authority to made grants to the States for specific purposes, such as the provision of health care and health services.

Therefore, while there is specific provision within section 51 of the Australian Constitution for the provision of health and medical services, there is no identifiable guaranteed right to such services. It should also be noted that the concept of Australian federalism, which provides for a constitutional division of powers between the Commonwealth and the state and territory governments, whilst ensuring that neither the Commonwealth nor the states hold significant exclusive powers, has however seen the Commonwealth dominate in the area of personal income tax collection.526 This position has therefore meant that the Commonwealth is capable of raising revenue far in excess of its own expenditure requirements, and although providing grants to the states and territories, under s.96, has seen the Commonwealth in the on-going position to exert considerable political and policy influence over the provision of health care services in Australia.

The absence of a right to health and medical services in the Constitution has, it can be argued, been supplemented by the introduction of Medicare- the current universal health insurance system, publicly funded, and providing basic527 medical and hospital cover for all Australians.

527 This term is used by Stephen R.Leeder in Healthy Medicine – Challenges facing Australia's health services (Allen & Unwin: St Leonards, 1999) at p.24, but is not defined.
Whilst it is not appropriate to give a detailed history of Medicare, it is important to provide some discussion of its historical development, as it has been argued\(^{528}\) that the underlying factors which influenced the establishment of a universal health insurance system have had an ongoing impact on health policy and therefore may indicate, that despite an absence of a constitutionally guaranteed right to health care, the intent of the legislature and policy makers, is that such a right does indeed exist, albeit in an unlegislated form.

The first government-sponsored health insurance scheme in Australia – the Earl Page\(^{529}\) scheme – was introduced in 1953 by the Menzies Liberal-Country Party coalition government, which had foreshadowed the introduction of a voluntary health insurance scheme whilst in Opposition, as an alternative to a national health program. The focus of the scheme was the subsidization of privately held insurance by the part payment of the cost of medical expense rebates. The scheme was established under the provisions of ........ However, the scheme failed to cover the whole Australian population, primarily, it is argued\(^{530}\), for two key reasons: its costliness and administrative complexity and the often large gap between fees charged and refunds obtained from the health funds.\(^{531}\)

The period before the 1969 federal election saw the Australian Labor Party develop an alternative health insurance program based principally on the work of Richard Scotton and John Deeble, 


\(^{529}\) Sir Earle Page was the Minister for Health in the post-war Menzies coalition government – see http://www.mna.gov.au/publications/fact_sheets/fs77.html for further information.

\(^{530}\) Palmer & Short, op.cit.

\(^{531}\) See the recommendations of the Committee of Inquiry into Health Insurance 1969 (Chairperson, J.A.Nimmo) Report, Australian Government Publishing Service, Canberra
two health economists. This program proposed to cover the entire Australian population, being funded entirely from taxation revenue and centrally administered by a Commonwealth government authority.

The subject of the right to health or health care under the Australian Constitution has not been the focus of litigation. However, the issue of individual rights and the Constitution has been the focus of judicial determination and accordingly, to ascertain the likely status of a claim to an implied right to health care, it is to the decision of the High Court in *Alec Kruger & Ors v The Commonwealth of Australia* (1997) 190 CLR 1, that attention must now be directed.

*Alec Kruger & Ors v The Commonwealth of Australia* (1997) 190 CLR 1

This case concerned, *inter alia*, the existence of an implied constitutional immunity from removal and subsequent detention without due process of law in the exercise of the judicial power of the Commonwealth, the existence of a constitutional implication of freedom of movement and association, and the availability of damages from the Commonwealth for breach of the Constitution by an officer of the Commonwealth.

In examining these and other issues, the Court had to first provide a statement on the statutory nature and purpose of the Constitution. Chief Justice Brennan noted that the primary object of the Constitution was the “creation of the Federation...[prescribing] the charter of the respective powers of the Commonwealth and States”. Given this division of power, it is

532 *Kruger v The Commonwealth* (1997) 190 CLR 1 at 23
necessary, according to the Court, to be watchful of the nature of the powers which are sought to be exercised by the Commonwealth. Therefore, as the primary object of the Constitution was to define the boundaries of State and Commonwealth powers, the Court was clear in its stand on the existence of private enforceable rights within the Constitution – there are none for which an action in damages against the Commonwealth could be sustained.

"The Constitution creates no private rights enforceable directly by an action for damages. It is concerned with the powers and functions of government and the restraints upon their exercise...The Constitution reveals no intention to create a private right of action for damages for an attempt to exceed the powers it confers or to ignore the restraints it imposes. The causes of action enforceable by awards of damages are created by the common law (including for this purpose the doctrines of equity) supplemented by statutes which reveal an intention to create such a cause of action for breach of its provisions. If a government does or omits to do anything which, under the general law, would expose it or its servants or agents to a liability in damages, an attempt to deny or to escape that liability fails when justification for the act done or omission made depends on a statute or an action that is invalid for want of constitutional support. In such a case, liability is not incurred for breach of a constitutional right but by operation of the general law. But if a government does or omits to do something the doing or omission of which attracts no liability under the general law, no liability in damages for doing or omitting to do that thing is imposed on the government by the Constitution."

Therefore, according to Brennan CJ, if there is no private right under the Constitution which is enforceable by an action for damages, then the only way in which liability for damages would attach for an act or omission by a government in relation to private rights would be where it could be established that there was an action for damages in relation to that act or omission under the general law. On this basis therefore, a private right to the

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533 See Spratt v Hermes (1965) 114 CLR 226 at 242 per Barwick CJ
534 Ibid at p. .. per Brennan CJ.
provision of health care cannot be said to exist, either expressly or
impliedly within the Constitution. Therefore, because it is the
common law, supplemented by clear statutory intent that creates
those causes of action for which the remedy is an award in
damages, an action for damages against the Commonwealth is
unavailable for an act or omission that otherwise would not attract
liability under the general law.

Dawson J in his judgment provides some significant guidance with
respect to the Constitution and individual rights, and therefore
some assistance in relation to the status of the right to health care
under the Constitution. His Honour was clear that case law
showed that the Constitution did not seek to establish the
existence of personal liberty or individual rights, by the placement
of restrictions on the exercise of governmental power. Dawson J
stated:

"Those who framed the Australian Constitution accepted the view
that individual rights were on the whole best left to the protection
of the common law and the supremacy of parliament. Thus the
Constitution deals, almost without exception, with the structure
and relationship of government rather than with individual
rights...The Constitution does not contain a Bill of Rights. Indeed
the 1898 Constitutional Convention rejected a proposal to include
an express guarantee of individual rights largely based upon the
14th Amendment to the United States Constitution and
including a right to due process of law and the equal protection of
laws. The framers preferred to place their faith in the democratic
process for the protection of individual rights and saw
constitutional guarantees as restricting that process. Thus the
Constitution contains no general guarantee of the due process of
law. The few provisions contained in the Constitution which afford
protection against governmental action in disregard of individual
rights do not amount to such a general guarantee..."536

535 See [http://www.law.cornell.edu/constitution/constitution_amendmentsiv.html](http://www.law.cornell.edu/constitution/constitution_amendmentsiv.html) for a full
text of the 14th Amendment.
536 Ibid at p...
Finally, it is appropriate to turn to the comments of Gaudron J regarding the possibility of an action for damages for infringement of constitutional rights. Her Honour identified that s.116 of the Constitution, an issue of contention in this case, did not provide, "...in form, a constitutional guarantee of the rights of individuals" by binding the States. Rather, s.116 denied to the Commonwealth the authority to intrude into the area of religion, but left the States free to "enact laws imposing religious observances, prohibiting the free exercise of religion or otherwise..." Therefore, according to Gaudron J, one cannot speak of a constitutional right to religious freedom where it is obvious that "...the Constitution clearly postulates that the States may enact laws in derogation of that right...[and] ...it cannot be construed as impliedly conferring an independent or free-standing right which, if breached, sounds in damages at the suit of the individual whose interests are thereby affected."  

If there is no constitutional right to religious freedom, given the provisions of s.116, and it has been established that the Constitution has as its primary purpose the structure and relationship of government rather than a recognition of individual rights, then there is little to be achieved by arguing that an implied constitutional right to health care exists under the general power given to the Commonwealth under s.51(xxiiiA).

Given the absence of a constitutional guarantee, it is necessary to consider whether there are any provisions within the National

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537 Section 16 of the Australian Constitution provides: "The Commonwealth shall not make any law for establishing any religion, or for imposing any religious observance, or for prohibiting the free exercise of any religion, and no religion text shall be required as a qualification for any office or public trust under the Commonwealth."
538 Kruger, op cit, at p....
539 Ibid
540 Ibid
Health Act 1953 (Cth) or the Health Insurance Act 1973 which assist in establishing a statutory right to health care.

Section 9 of the National Health Act 1953 provides:

“(1) The Governor-General may provide, or arrange for the provision of:
(a) aerial medical and dental services;
(b) diagnostic and therapeutic services for medical practitioners and hospitals, and for patients of medical practitioners or hospitals;
(c) teaching, research and advisory services in relation to maternal and child health;
(d) teaching, research and advisory services for or in relation to the improvement of health or the prevention of disease; and
(e) anything incidental to a service referred to in paragraph (a), (b), (c) or (d).
(2) The Minister may disseminate information relating to health or the prevention of disease.”

This provision therefore provides no assistance in that it is permissive and not mandatory on the Commonwealth to provide such services. Similarly, s. 9A which deals with the provision of medical and surgical aids and appliances by the Commonwealth, and s.9B which deals with the provision of vaccines, are likewise both permissive in terminology and intent.

In relation to the Health Insurance Act 1973 (Cth), s.6 provides for the Minister to declare what specified persons or class or persons shall or shall not be entitled to be classified as an ‘eligible person’ for the purposes of the Act, and therefore eligible, under s.10(1) of a ‘medicare benefit’ for medical expenses incurred in respect of a professional service provided in Australia. Section 10(2) identifies that there may be professional services excluded, by regulation, from those for which a benefit may be payable, and that in any event, the amount payable shall be equal to no more than 85% of the fee which can be charged for that service.
What these provisions therefore mean therefore is that although a person may be classified as an ‘eligible person’ and therefore able to claim a medicare benefit for medical professional services provided pursuant to the *Health Insurance Act* 1973, the Minister retains the right to ‘declassify’ a eligible person and regulations can be made removing professional services from those for which a benefit can be paid.

Whilst it is highly unlikely that such a ‘declassification’ would occur for Australian citizens, the existence of the power in the Minister could be said to substantiate an argument that the right to claim a medicare benefit (and therefore a right to health care) is not a fundamental right, but only exists as long as the legislation allows for the right to claim such a benefit.

If therefore there is no statutory or constitutional right to health or health care within Australia, the final question to be asked is whether Australia could be said to be in violation of its international obligations in relation to this right.

As previously discussed, the *Maastricht Guidelines* refer to violations based upon acts of ‘commission’ and acts of ‘omission’. Given the types of examples provided by the *Guidelines* and the notion of ‘progressive realisation’ which is ascribed to the rights contained in the *ICESCR*, and given the availability of medicare benefits to such a wide range of medical services in Australia, in the opinion of this writer, it would be very difficult if not impossible, to sustain an argument of violation.
Chapter Six

CONCLUSION

"We can cure physical diseases with medicine but the only cure for loneliness, despair and hopelessness is love. There are many in the world who are dying for a piece of bread but there are many more dying for a little love."

- Mother Teresa (1910-1997)

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This thesis began with a statement from the television drama series *Law and Order* — “People only have those rights which they can defend — only those rights” — and has, through the use of the example of the right to health care, striven to show the importance of justiciability in securing those rights for the purposes of the law of international human rights and public health.

The methodology undertaken to achieve this objective has been multi-facted and has gone through several metamorphases. Firstly, an examination of the relevant human rights international instruments, including the UDHR and the ICESCR, was undertaken as was a review of all other relevant United Nations documentation, including such documentation as committee reports related to Article 12, ICESCR. Reference was also made to more obscure, but no less important, international documentation such as the the *Cairo Declaration on Human Rights in Islam* and the *African Charter on Human and Peoples Rights*.

Secondly, relevant sections of a number of Constitutional documents were sourced and listed as an indication of the current international state of the constitutional importance of health and health care within these different jurisdictions. These Constitutional documents contain significantly different provisions, in both scope and application and have assisted to highlight the range of political issues which underpin the right to health and health care.

Thirdly, a brief discussion of the concept of cultural relativism and the universality of human rights was included, noting that these

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Drake, Sir Philip Fysh & R.E. O'Connor. Retrieved from
issues have been and will continue to be the subject of much dissertation, the content of which is well beyond the scope, and relevance, of this thesis. It was acknowledged that this discussion was limited but was deemed to be of contextual value. This was accompanied by a review of specific recommendations as to what constitutes adequate or basic health care, with particular reference to the comments of the President’s Commission and Chapman. It was noted that despite the value of these recommendations and the significance of them from a human rights perspective, they do little to assist in determining, from a justiciability perspective, what constitutes adequate health care.

Fourthly, and most importantly, a selective case study methodology was employed to illustrate the approach taken in jurisdictions that have attempted either by constitutional inclusion or legislative measures to recognize a right to health care – either to the population as a whole or a segment thereof – and also, a jurisdiction for which only a claim to rights pursuant to international convention can be employed.

It should also be noted at this point that the availability of secondary source material, specifically journal articles, is extensive and there has been no deliberate attempt to pursue the views of some authors over others, by exclusion rather than inclusion. I am indebted to those authors whose material I have read and who have contributed to my knowledge in this area. The challenges presented by this wealth of material cannot be under-estimated and it is hoped that further scholarly writing will embrace the opportunities that it presents.

Economic, social and cultural rights, howsoever described, are integral to the fulfillment of the World Health Organization definition of health, as contained in its preamble and restated here:

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Figure 43\textsuperscript{342} “Peace of Mind” linocut by Philip Bandenhorst representing Clause 19 of the South African Bill of Rights retrieved from \url{http://www.durbanet.co.za/exhib/dag/hr/cl.19.htm} 22.06.05
"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and the control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provisions of adequate health and social provisions."

The political and humanitarian obligations of signatories to the ICESCR as well as, the other related United Nations conventions and declarations, in the light of this definition, are not only significant but fundamental – the provision of a justiciable right to basic and adequate health care.

If one returns to the seven key reasons identified by the President's Commission for a human rights approach to health
care, then it can clearly be seen that the Commission had political responsibility for health care firmly in its agenda. This is especially clear in the emphasis given to the significance of health care reform and the centrality of rights within a political reform agenda. Health care, as a human right, therefore, in the language of the Commission, provides governments with the political armoury, if not the wherewithal, to pursue health care reform to ensure that those who are in most need, will have their needs met.

It is however, not sufficient to merely constitutionally recognize the right to health or health care, for in the absence of an appropriate and equitable avenue of redress, a constitutional recognition is no more effective than the mere existence of the right as stated in the ICESCR. The statement in the Maastricht Guidelines\textsuperscript{544} that:

\begin{quote}
"In order to achieve effective judicial and other remedies for victims of violations of economic, social and cultural rights, lawyers, judges, adjudicators, bar associations and the legal community generally should pay far greater attention to these violations in the exercise of their profession."
\end{quote}

places the responsibility squarely at the feet of members of the legal profession to ensure that those who are working in the field of public health are adequately supported in their fight for the provision of such rights to the people with whom they are working.

There is no doubt, given the comments of the South African Constitutional Court that economic, social and cultural rights are justiciable and that effective remedies must be available in the event that such rights are violated. I recall the comments of Mr

\textsuperscript{543} See pp.101-104
\textsuperscript{544} Op.cit, #205
Justice Ackermann in *Fose v Minister of Safety and Security* when he stated:

"I have no doubt that this Court has a particular duty to ensure that, within the bounds of the Constitution, effective relief be granted for the infringement of any of the rights entrenched in it. In our context an appropriate remedy must mean an effective remedy, for without effective remedies for breach, the values underlying and the rights entrenched in the Constitution cannot properly be upheld or enhanced.

Particularly in a country where so few have the means to enforce their rights through the courts, it is essential that on those occasions when the legal process does establish that an infringement of an entrenched right has occurred, it be effectively vindicated. The courts have a particular responsibility in this regard and are obliged to 'forge new tools' and shape innovative remedies, if needs be, to achieve this goal."

However, as has been revealed, the courts often, given the resource implications of enforcing economic, social and cultural rights, because of their 'negative' obligation qualities, will resort to determination based upon the 'reasonableness' of the decision-making process. In the absence of 'unreasonableness', courts seem reluctant to intervene.

There are also those who argue against a right to health care, alleging that health is primarily an individual responsibility and not something that one should be able to claim as a right. For example, Leon Kass has stated:

"Health is a state of being, not something that can be given, and only in direct ways something that can be taken away or undermined by other human beings. It no more makes sense to claim a right to health care than a right to wisdom or courage. These excellences of soul and body require natural gift, attention,

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545 1997 (7) BCLR 851
effort, and discipline on the part of each person who desires them. To make my health someone else’s duty is not only unfair; it is to impose a duty impossible to fulfil."\textsuperscript{46}

The fact is however, that there is clearly a recognition by the countries listed in this Thesis that health and health care are the responsibility, albeit arguably a progressive one, of the State, and this undermines such an argument as presented by Kass. ‘Reasonableness’ may well be a tool used to disguise some decisions based upon a rationing of services which may indeed arise from personal health choices. This does not detract however from the obligations which arise pursuant to ratification of international conventions and incorporation into domestic law.

What is clear however, is that if the right to health care is to be of value to those to whom it is granted, constitutionally or otherwise, then those who embrace the task of interpreting and applying such law, the legal profession and the judiciary in particular, must be prepared to, in the face of criticism of judicial activism and allegations of the breaching of the notion of separation of powers in order to “...forge new tools and shape innovative remedies...” to ensure that the less fortunate, the vulnerable and the discriminated against, have a forum within which effective remedies will be available.

\textsuperscript{46} Kass, L. “Regarding the End of Medicine and the Pursuit of Health”, The Public Interest, 40 (1975), p.39
APPENDIX 1


B. Part of the Report Relating to Specific Rights

Article 12 of the Covenant

1. Please supply information on the physical and mental health of your population, in respect of both aggregate and the different groups within your society. How has the health situation changed over time with regard to these groups? In case your Government has recently submitted reports on the health situation in your country to the World Health Organisation (WHO) you may wish to refer to the relevant parts of these reports rather than repeat the information here.

2. Please indicate whether your country has a national health policy. Please indicate whether a commitment to the WHP primary health care approach has been adopted as part of the health policy of your country. If so, what measures have been taken to implement primary health care?

3. Please indicate what percentage of GNP as well as your national and/or regional budget(s) is spent on health. What percentage of those resources is allocated to primary health care? How does this compare with 5 years ago and 10 years ago?

4. Please provide, where available, indicators as defined by the WHO, relating to the following issues:
   (a) Infant mortality rate (in addition to the national value, please provide the rate by sex, urban/rural division, and also, if possible, by socio-economic or ethnic group and geographical area. Please include national definitions of urban/rural and other subdivisions);
   (b) Population access to safe water (please disaggregate urban/rural);
   (c) Population access to adequate excreta disposal facilities (please disaggregate urban/rural);
(d) Infants immunized against diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis (please disaggregate urban/rural and by sex);
(e) Life expectancy (please disaggregate urban/rural, by socio-economic group and by sex);
(f) Proportion of the population having access to trained personnel for the treatment of common diseases and injuries, with regular supply of 20 essential drugs, within one hour’s walk or travel;
(g) Proportion of pregnant women having access to trained personnel during pregnancy and proportion attended by such personnel for delivery. Please provide figures on the maternity mortality rate, both before and after childbirth;
(h) Proportion of infants having access to trained personnel for care;
(Please provide breakdowns by urban/rural and socio-economic groups for indicators (f) to (h).

5. Can it be discerned from the breakdowns of the indictors employed in paragraph 4, or by other means, that there are any groups in your country whose health situation is significantly worse than that of the majority of the population? Please define these groups as precisely as possible and give details. Which geographical areas in your country, if any, are worse off with regard to the health of their population?
(a) During the reporting period, have there been any changes in national policies, laws and practices negatively affecting the health situation of these groups or areas? If so, please describe these changes and their impact.
(b) Please indicate what measures are considered necessary by your Government to improve the physical and mental health situation of such vulnerable and disadvantaged groups or in such worse-off areas.
(c) Please explain the policy measures your Government has taken, to the maximum of available resources, to realise such improvement. Indicate time-related goals and bench-marks for measuring your achievements in this regards.
(d) Please describe the effect of these measures on the health situation of the vulnerable and disadvantaged groups or worse-off areas under consideration, and report on the successes, problems and shortcomings of these measures.
(e) Please describe and measures taken by your Government in order to reduce the still-birth rate and infant mortality and to provide for the healthy development of the child.

(f) Please list the measures taken by your Government to improve all aspects of environmental and industrial hygiene.

(g) Please describe the measures taken by your Government to prevent, treat and control epidemic, endemic, occupational and other diseases.

(h) Please describe the measures taken by your Government to assure to all medical service and medical attention in the event of sickness.

(i) Please describe the effect of the measures listed in subparagraphs (e) to (h) on the situation of the vulnerable and disadvantaged groups in your society and in any worse-off areas. Report on difficulties and failures as well as positive results.

6. Please indicate the measures taken by your Government to ensure that the rising costs of health care for the elderly do not lead to infringements of these persons right to health.

7. Please indicate what measures have been taken in your country to maximize community participation in the planning, organization, operation and control of primary health care.

8. Please indicate what measures have been taken in your country to provide education concerning prevailing health problems and the measures of preventing and controlling them.

9. Please indicate the role of international assistance in the full realization of the right enshrined in Article 12.
APPENDIX 2

Form for the Reports submitted in pursuance of Article 21 of the European Social charter as adopted by the Committee of Ministers in December 1981. (SOC (81), 3, Strasbourg, 22 December 1981)

Article 11 – the Right to Protection of Health

Article 11, para 1

A. Please indicate the main forms of ill-health which at present raise the greatest public health problems in your country by reason of their frequency, gravity and any sequels. Please indicate what illnesses were the main causes of death.

B. Please indicate how public health services are organised in your country and state, if possible:
   a. the number of private or public preventive and diagnostic clinics (general or specialised, particularly in the fields of tuberculosis, venereal disease, mental health, mother and child welfare etc) and the annual attendance at them making special mention of services for schoolchildren;
   b. what regular health examinations are arranged for the population in general or for a part thereof, and at what intervals?
   c. the number of general hospitals and public or private establishments for specialised treatment (especially for tuberculosis, psychiatry (including day hospital), cancer, after-care, functional and occupational rehabilitation. Give the respective proportions of public and private establishments; number of beds available (or of places in case of day hospitals or rehabilitation clinics accepting out-patients);
   d. the number per (1) persons of doctors, dentists, midwives, nurses. Distinguish between urban and rural areas; if possible:
   e. the number of pharmacies.

C. Please describe any special measures taken to protect the health of;
   a. mothers and babies;
b. children and young persons;\textsuperscript{547}
c. the aged.

D. Please indicate what general protective measures are taken in the public health field, such as:

a. i. prevention of air pollution;
   ii. prevention of water pollution;
   iii. preservation of the elements against radioactive substances;

d. noise abatement;

e. food control;

f. minimum housing standards;

g. restrictive measures in the campaign against alcoholism and drugs, and in particular restrictions on their use and where applicable, on the use of tobacco by minors.

E. Please describe any measures taken to further health education.

F. Please indicate on what conditions the various health services are made available to the whole population of the country.

\textit{Article 11, para.2}

A. Please describe any measures taken to further health education.\textsuperscript{548}

B. Please indicate what advisory and diagnostic services exist:

a. for schools;

b. for other groups.

\textit{Article 11, para.3}

A.\textsuperscript{549} Please indicate the main forms of ill-health which at present raise the greatest public health problems in your country by reasons of their frequency, gravity and any sequels. What illnesses were the main causes of death.

\textsuperscript{547} If your country has accepted paragraphs 9 and 10 of Article 7, there is no need to repeat the information given thereon.

\textsuperscript{548} If you have answered Question E under paragraph 1 of this Article, it is not necessary to answer this question.

\textsuperscript{549} If you answered Question A under paragraph 1 of this Article it is not necessary to answer this question.
B. Please indicate how public health services are organised in your country and state, if possible:
   a. the number of public or private preventative and diagnostic clinics (general or specialised particularly in the fields of tuberculosis, venereal diseases, mental health, mother and child welfare etc), and the annual attendance at these making special mention of services for schoolchildren;
   b. what regular health examinations are arranged for the population in general or for a part thereof and at what intervals;
   c. the number of general hospitals and public or private establishments for specialised treatment (especially for tuberculosis, psychiatry (including day hospitals), cancer, after-care, functional and occupational rehabilitation). Give the proportion of public and private establishments. Number of beds available (or of places in the cases of day hospitals) or rehabilitation clinics accepting out-patients;
   d. the number per persons of doctors, dentists, midwives, nurses. Distinguish between urban and rural areas if possible;
   e. the number of pharmacies.

C. Please describe what measures have been taken to further health education.

D. Please indicate what measures other than those mentioned above are taken to prevent epidemic, endemic and other diseases (compulsory or optional vaccination, disinfection, epidemics policy).

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550 If you answered Question B under paragraph 1 of this Article, it is not necessary to answer this question.
551 As a percentage if possible
552 If you have answered Question E under paragraph 1 of this Article, it is not necessary to answer this question.
APPENDIX 3

Extract from


Chapter 4 – Strategic Objectives and Action

C. Women and health

91. Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology. However, health and well-being elude the majority of women. A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups. In national and international forums, women have emphasized that to attain optimal health throughout the life cycle, equality, including the sharing of family responsibilities, development and peace are necessary conditions.

92. Women have different and unequal access to and use of basic health resources, including primary health services for the prevention and treatment of childhood diseases, malnutrition, anaemia, diarrhoeal diseases, communicable diseases, malaria and other tropical diseases and tuberculosis, among others. Women also have different and unequal opportunities for the protection, promotion and maintenance of their health. In many developing countries, the lack of emergency obstetric services is also of particular concern. Health policies and programmes often perpetuate gender stereotypes and fail to consider socio-economic disparities and other differences among women and may not fully
take account of the lack of autonomy of women regarding their health. Women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women.

93. In many countries, especially in developing countries, in particular the least developed countries, a decrease in public health spending and, in some cases, structural adjustment, contribute to the deterioration of public health systems. In addition, privatization of health-care systems without appropriate guarantees of universal access to affordable health care, further reduces health-care availability. This situation not only directly affects the health of girls and women, but also places disproportionate responsibilities on women, whose multiple roles, including their roles within the family and the community, are often not acknowledged; hence they do not receive the necessary social, psychological and economic support.

94. Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men, but women experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, discrimination due to race and other forms of discrimination, the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health. Lack of food and inequitable distribution of food for girls and women in the household, inadequate access to safe water, sanitation facilities and fuel supplies, particularly in rural and poor urban areas, and deficient housing conditions, all overburden women and their families and have a negative effect on their health. Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.

95. Discrimination against girls, often resulting from son preference, in access to nutrition and health-care services endangers their current and future health and well-being. Conditions that force girls into early marriage, pregnancy and child-bearing and subject them to harmful practices, such as female genital mutilation, pose grave health risks. Adolescent girls need, but too often do not have, access to necessary health and nutrition services as they mature. Counselling and access to sexual and reproductive health information and services for adolescents are still inadequate or lacking completely, and a young woman's right to privacy, confidentiality, respect and informed consent is
often not considered. Adolescent girls are both biologically and psychosocially more vulnerable than boys to sexual abuse, violence and prostitution, and to the consequences of unprotected and premature sexual relations. The trend towards early sexual experience, combined with a lack of information and services, increases the risk of unwanted and too early pregnancy, HIV infection and other sexually transmitted diseases, as well as unsafe abortions. Early child-bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world. Overall, for young women early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on the quality of their lives and the lives of their children. Young men are often not educated to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction.

96. Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

96 bis. Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free
of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

97. The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

98. Further, women are subject to particular health risks due to inadequate responsiveness and lack of services to meet health needs related to sexuality and reproduction. Complications related to pregnancy and childbirth are among the leading causes of mortality and morbidity of women of reproductive age in many parts of the developing world. Similar problems exist to a certain degree in some countries with economies in transition. Unsafe abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk. Most of these deaths, health problems and injuries are preventable through improved access to adequate health-care services, including safe and effective family planning methods and emergency obstetric care, recognizing the right of women and men to be informed and to have access to safe, effective, affordable and acceptable methods
of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. These problems and means should be addressed on the basis of the report of the International Conference on Population and Development, with particular reference to relevant paragraphs of the Programme of Action of the Conference. In most countries, the neglect of women's reproductive rights severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment. The ability of women to control their own fertility forms an important basis for the enjoyment of other rights. Shared responsibility between women and men in matters related to sexual and reproductive behaviour is also essential to improving women's health.

99. HIV/AIDS and other sexually transmitted diseases, the transmission of which is sometimes a consequence of sexual violence, are having a devastating effect on women's health, particularly the health of adolescent girls and young women. They often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment. Women, who represent half of all adults newly infected with HIV/AIDS and other sexually transmitted diseases, have emphasized that social vulnerability and the unequal power relationships between women and men are obstacles to safe sex, in their efforts to control the spread of sexually transmitted diseases. The consequences of HIV/AIDS reach beyond women's health to their role as mothers and caregivers and their contribution to the economic support of their families. The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases need to be seen from a gender perspective.

100. Sexual and gender-based violence, including physical and psychological abuse, trafficking in women and girls, and other forms of abuse and sexual exploitation place girls and women at high risk of physical and mental trauma, disease and unwanted pregnancy. Such situations often deter women from using health and other services.

101. Mental disorders related to marginalization, powerlessness and poverty, along with overwork and stress and the growing incidence of domestic violence as well as substance abuse, are among other health issues of growing concern to women. Women throughout the world, especially young women, are increasing their use of tobacco with serious effects on their health and that of
their children. Occupational health issues are also growing in importance, as a large number of women work in low-paid jobs in either the formal or the informal labour market under tedious and unhealthy conditions, and the number is rising. Cancers of the breast and cervix and other cancers of the reproductive system, as well as infertility affect growing numbers of women and may be preventable, or curable, if detected early.

102. With the increase in life expectancy and the growing number of older women, their health concerns require particular attention. The long-term health prospects of women are influenced by changes at menopause, which, in combination with life-long conditions and other factors, such as poor nutrition and lack of physical activity, may increase the risk of cardiovascular disease and osteoporosis. Other diseases of ageing and the interrelationships of ageing and disability among women also need particular attention.

103. Women, like men, particularly in rural areas and poor urban areas, are increasingly exposed to environmental health hazards owing to environmental catastrophes and degradation. Women have a different susceptibility to various environmental hazards, contaminants and substances and they suffer different consequences from exposure to them.

104. The quality of women's health care is often deficient in various ways, depending on local circumstances. Women are frequently not treated with respect, nor are they guaranteed privacy and confidentiality, nor do they always receive full information about the options and services available. Furthermore, in some countries, over-medicating of women's life events is common, leading to unnecessary surgical intervention and inappropriate medication.

105. Statistical data on health are often not systematically collected, disaggregated and analysed by age, sex and socio-economic status and by established demographic criteria used to serve the interests and solve the problems of subgroups, with particular emphasis on the vulnerable and marginalized and other relevant variables. Recent and reliable data on the mortality and morbidity of women and conditions and diseases particularly affecting women are not available in many countries. Relatively little is known about how social and economic factors affect the health of girls and women of all ages, about the provision of health services to girls and women and the patterns of their use of such services, and about the value of disease prevention and health promotion programmes for women. Subjects of importance to women's health have not been adequately researched and women's
health research often lacks funding. Medical research, on heart disease, for example, and epidemiological studies in many countries are often based solely on men; they are not gender specific. Clinical trials involving women to establish basic information about dosage, side-effects and effectiveness of drugs, including contraceptives, are noticeably absent and do not always conform to ethical standards for research and testing. Many drug therapy protocols and other medical treatments and interventions administered to women are based on research on men without any investigation and adjustment for gender differences.

106. In addressing inequalities in health status and unequal access to and inadequate health-care services between women and men, Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes, so that, before decisions are taken, an analysis is made of the effects for women and men, respectively.

**Strategic objective C.1. Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services.**

**Actions to be taken:**

107. By Governments, in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions:

(a) Support and implement the commitments made in the Programme of Action of the International Conference on Population and Development, as established in the report of that Conference and the Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development and the obligations of States parties under the Convention on the Elimination of All Forms of Discrimination against Women and other relevant international agreements, to meet the health needs of girls and women of all ages;

(b) Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation, for example; review existing legislation, including health legislation, as well as policies, where necessary, to reflect a commitment to women's health and to ensure that they meet the changing roles and responsibilities of women wherever they reside;

(c) Design and implement, in cooperation with women and community-based organizations, gender-sensitive health
programmes, including decentralized health services, that address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands on their time, the special needs of rural women and women with disabilities and the diversity of women's needs arising from age and socio-economic and cultural differences, among others; include women, especially local and indigenous women, in the identification and planning of health-care priorities and programmes; and remove all barriers to women's health services and provide a broad range of health-care services;

(d) Allow women access to social security systems in equality with men throughout the whole life cycle;

(e) Provide more accessible, available and affordable primary health-care services of high quality, including sexual and reproductive health care, which includes family planning information and services, and giving particular attention to maternal and emergency obstetric care, as agreed in the Programme of Action of the International Conference on Population and Development;

(f) Redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communications skills and the user's right to privacy and confidentiality. These services, information and training should adopt a holistic approach;

(g) Ensure that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards in the delivery of women's health services aimed at ensuring responsible, voluntary and informed consent. Encourage the development, implementation and dissemination of codes of ethics guided by existing international codes of medical ethics as well as ethical principles that govern other health professionals;

(h) Take all appropriate measures to eliminate harmful, medically unnecessary or coercive medical interventions, as well as inappropriate medication and over-medication of women. All women should be fully informed of their options, including likely benefits and potential side-effects, by properly trained personnel;

(i) Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to quality health services for women and girls, reduce ill health and maternal morbidity and achieve worldwide the agreed-upon goal of reducing maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015; ensure that the
necessary services are available at each level of the health system; and make reproductive health care accessible, through the primary health-care system, to all individuals of appropriate ages as soon as possible and no later than the year 2015;

(j) Recognize and deal with the health impact of unsafe abortion as a major public health concern, as agreed in paragraph 8.25 of the Programme of Action of the International Conference on Population and Development;

(k) Paragraph 8.25 of the Programme of Action of the International Conference on Population and Development states: "In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion 15/ as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions." Consider reviewing laws containing punitive measures against women who have undergone illegal abortions;

(l) Give particular attention to the needs of girls, especially the promotion of healthy behaviour, including physical activities; take specific measures for closing the gender gaps in morbidity and mortality where girls are disadvantaged, while achieving internationally approved goals for the reduction of infant and child mortality - specifically, by the year 2000, the reduction of mortality rates of infants and children under five years of age by one third of the 1990 level, or 50 to 70 per 1,000 live births, whichever is less; by the year 2015 an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000;

(m) Ensure that girls have continuing access to necessary health and nutrition information and services as they mature, to facilitate a healthful transition from childhood to adulthood;
(n) Develop information, programmes and services to assist women to understand and adapt to changes associated with ageing and to address and treat the health needs of older women, paying particular attention to those who are physically or psychologically dependent;

(o) Ensure that girls and women of all ages with any form of disability receive supportive services;

(p) Formulate special policies, design programmes and enact the legislation necessary to alleviate and eliminate environmental and occupational health hazards associated with work in the home, in the workplace and elsewhere with attention to pregnant and lactating women;

(q) Integrate mental health services into primary health care systems or other appropriate levels, develop supportive programmes and train primary health workers to recognize and care for girls and women of all ages who have experienced any form of violence especially domestic violence, sexual abuse or other abuse resulting from armed and non-armed conflict;

(r) Promote public information on the benefits of breast-feeding; examine ways and means of implementing fully the WHO/UNICEF International Code of Marketing of Breast-milk Substitutes, and enable mothers to breast-feed their infants by providing legal, economic, practical and emotional support;

(s) Establish mechanisms to support and involve non-governmental organizations, particularly women's organizations, professional groups and other bodies working to improve the health of girls and women, in government policy-making, programme design, as appropriate, and implementation within the health sector and related sectors at all levels;

(t) Support non-governmental organizations working on women's health and help develop networks aimed at improving coordination and collaboration between all sectors that affect health;

(u) Rationalize drug procurement and ensure a reliable, continuous supply of high-quality pharmaceutical, contraceptive and other supplies and equipment, using the WHO Model List of Essential Drugs as a guide, and ensure the safety of drugs and devices through national regulatory drug approval processes;

(v) Provide improved access to appropriate treatment and rehabilitation services for women substance abusers and their families;
(w) Promote and ensure household and national food security, as appropriate, and implement programmes aimed at improving the nutritional status of all girls and women by implementing the commitments made in the Plan of Action on Nutrition of the International Conference on Nutrition, 16/ including a reduction world wide of severe and moderate malnutrition among children under the age of five by one half of 1990 levels by the year 2000, giving special attention to the gender gap in nutrition, and a reduction in iron deficiency anaemia in girls and women by one third of the 1990 levels by the year 2000;

(x) Ensure the availability of and universal access to safe drinking water and sanitation and put in place effective public distribution systems as soon as possible;

(y) Ensure full and equal access to health care infrastructure and services for indigenous women.

**Strategic objective C.2. Strengthen preventive programmes that promote women's health.**

**Actions to be taken**

108. By Governments, in cooperation with non-governmental organizations, the mass media, the private sector and relevant international organizations, including United Nations bodies, as appropriate:

(a) Give priority to both formal and informal educational programmes that support and enable women to develop self-esteem, acquire knowledge, make decisions on and take responsibility for their own health, achieve mutual respect in matters concerning sexuality and fertility and educate men regarding the importance of women's health and well-being, placing special focus on programmes for both men and women that emphasize the elimination of harmful attitudes and practices, including female genital mutilation, son preference (which results in female infanticide and prenatal sex selection), early marriage, including child marriage, violence against women, sexual exploitation, sexual abuse, which at times is conducive to infection with HIV/AIDS and other sexually transmitted diseases, drug abuse, discrimination against girls and women in food allocation and other harmful attitudes and practices related to the life, health and well-being of women, and recognizing that some of these practices can be violations of human rights and ethical medical principles;
(b) Pursue social, human development, education and employment policies to eliminate poverty among women in order to reduce their susceptibility to ill health and to improve their health;

(c) Encourage men to share equally in child care and household work and to provide their share of financial support for their families, even if they do not live with them;

(d) Reinforce laws, reform institutions and promote norms and practices that eliminate discrimination against women and encourage both women and men to take responsibility for their sexual and reproductive behaviour, ensure full respect for the integrity of the person, take action to ensure the conditions necessary for women to exercise their reproductive rights and eliminate coercive laws and practices;

(e) Prepare and disseminate accessible information, through public health campaigns, the media, reliable counselling and the education system, designed to ensure that women and men, particularly young people, can acquire knowledge about their health, especially information on sexuality and reproduction, taking into account the rights of the child to access to information, privacy, confidentiality, respect and informed consent, as well as the responsibilities, rights and duties of parents and legal guardians to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention on the Rights of the Child, and in conformity with the Convention on the Elimination of All Forms of Discrimination against Women. In all actions concerning children, the best interests of the child shall be a primary consideration;

(f) Create and support programmes in the educational system, in the workplace and in the community to make opportunities to participate in sport, physical activity and recreation available to girls and women of all ages on the same basis as they are made available to men and boys;

(g) Recognize the specific needs of adolescents and implement specific appropriate programmes, such as education and information on sexual and reproductive health issues and on sexually transmitted diseases, including HIV/AIDS, taking into account the rights of the child and the responsibilities, rights and duties of parents as stated in paragraph 108 (e);

(h) Develop policies that reduce the disproportionate and increasing burden on women who have multiple roles within the family and the community by providing them with adequate support and programmes from health and social services;
(i) Adopt regulations to ensure that the working conditions, including remuneration and promotion of women at all levels of the health system, are non-discriminatory and meet fair and professional standards to enable them to work effectively;

(j) Ensure that health and nutritional information and training form an integral part of all adult literacy programmes and school curricula from the primary level;

(k) Develop and undertake media campaigns and information and educational programmes that inform women and girls of the health and related risks of substance abuse and addiction and pursue strategies and programmes that discourage substance abuse and addiction and promote rehabilitation and recovery;

(l) Devise and implement comprehensive and coherent programmes for the prevention, diagnosis and treatment of osteoporosis, a condition that predominantly affects women;

(m) Establish and/or strengthen programmes and services, including media campaigns, that address the prevention, early detection and treatment of breast, cervical and other cancers of the reproductive system;

(n) Reduce environmental hazards that pose a growing threat to health, especially in poor regions and communities; apply a precautionary approach, as agreed to in the Rio Declaration on Environment and Development, adopted by the United Nations Conference on Environment and Development, 17/ and include reporting on women's health risks related to the environment in monitoring the implementation of Agenda 21;

(o) Create awareness among women, health professionals, policy makers and the general public about the serious but preventable health hazards stemming from tobacco consumption and the need for regulatory and education measures to reduce smoking as important health promotion and disease prevention activities;

(p) Ensure that medical school curricula and other health care training include gender-sensitive, comprehensive and mandatory courses on women's health;

(q) Adopt specific preventive measures to protect women, youth and children from any abuse - sexual abuse, exploitation, trafficking and violence, for example - including the formulation and enforcement of laws, and provide legal protection and medical and other assistance.
Strategic objective C.3. Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.

Actions to be taken

109. By Governments, international bodies including relevant United Nations organizations, bilateral and multilateral donors and non-governmental organizations:

(a) Ensure the involvement of women, especially those infected with HIV/AIDS or other sexually transmitted diseases or affected by the HIV/AIDS pandemic, in all decision-making relating to the development, implementation, monitoring and evaluation of policies and programmes on HIV/AIDS and other sexually transmitted diseases;

(b) Review and amend laws and combat practices, as appropriate, that may contribute to women's susceptibility to HIV infection and other sexually transmitted diseases, including enacting legislation against those socio-cultural practices that contribute to it, and implement legislation, policies and practices to protect women, adolescents and young girls from discrimination related to HIV/AIDS;

(c) Encourage all sectors of society, including the public sector, as well as international organizations, to develop compassionate and supportive, non-discriminatory HIV/AIDS-related policies and practices that protect the rights of infected individuals;

(d) Recognize the extent of the HIV/AIDS pandemic in their countries, taking particularly into account its impact on women, with a view to ensuring that infected women not suffer stigmatization and discrimination including during travel;

(e) Develop gender-sensitive multisectoral programmes and strategies to end social subordination of women and girls and to ensure their social and economic empowerment and equality; and facilitate promotion of programmes to educate and enable men to assume their responsibilities to prevent HIV/AIDS and other sexually transmitted diseases;

(f) Facilitate the development of community strategies that will protect women of all ages from HIV and other sexually transmitted diseases, provide care and support to infected girls, women and their families and mobilize all parts of the community in response to the HIV/AIDS pandemic to exert pressure on all responsible authorities to respond in a timely, effective, sustainable and gender-sensitive manner;
(g) Support and strengthen national capacity to create and improve gender-sensitive policies and programmes on HIV/AIDS and other sexually transmitted diseases, including the provision of resources and facilities to women who find themselves the principal caregivers or economic support for those infected with HIV/AIDS or affected by the pandemic, and the survivors, particularly children and older persons;

(h) Provide workshops and specialized education and training to parents, decision makers and opinion leaders at all levels of the community, including religious and traditional authorities, on prevention of HIV/AIDS and other sexually transmitted diseases, and their repercussions on both women and men of all ages;

(i) Give all women and health workers all relevant information and education about sexually transmitted diseases including HIV/AIDS and pregnancy and the implications for the baby, including breastfeeding;

(j) Assist women and their formal and informal organizations to establish and expand effective peer education and outreach programmes and to participate in the design, implementation and monitoring of these programmes;

(k) Give full attention to the promotion of mutually respectful and equitable gender relations and, in particular, to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality;

(l) Design specific programmes for men of all ages and male adolescents, recognizing the parental roles referred to in paragraph 108 (e), aimed at providing complete and accurate information on safe and responsible sexual and reproductive behaviour, including voluntary, appropriate and effective male methods for the prevention of HIV/AIDS and other sexually transmitted diseases through, inter alia, abstinence and condom use;

(m) Ensure the provision, through the primary health care system, of universal access of couples and individuals to appropriate and affordable preventive services with respect to sexually transmitted diseases, including HIV/AIDS, and expand the provision of counseling and voluntary and confidential diagnostic and treatment services for women; ensure that high-quality condoms as well as drugs for the treatment of sexually transmitted diseases are, where possible, supplied and distributed to health services;

(n) Support programmes which acknowledge that the higher risk among women of contracting HIV is linked to high-risk behaviour,
including intravenous substance use and substance-influenced unprotected and irresponsible sexual behaviour, and take appropriate preventive measures;

(o) Support and expedite action-oriented research on affordable methods, controlled by women, to prevent HIV and other sexually transmitted diseases, on strategies empowering women to protect themselves from sexually transmitted diseases, including HIV/AIDS, and on methods of care, support and treatment of women, ensuring their involvement in all aspects of such research;

(p) Support and initiate research which addresses women's needs and situations, including research on HIV infection and other sexually transmitted diseases in women, on women-controlled methods of protection, such as non-spermicidal microbicides, and on male and female risk-taking attitudes and practices.

Strategic objective C.4. Promote research and disseminate information on women's health.

Actions to be taken

110. By Governments, the United Nations system, health professions, research institutions, non-governmental organizations, donors, pharmaceutical industries and the mass media, as appropriate:

(a) Train researchers and introduce systems that allow for the use of data collected, analysed and disaggregated by, among other factors, sex and age, other established demographic criteria and socio-economic variables, in policy-making, as appropriate, planning, monitoring and evaluation;

(b) Promote gender-sensitive and women-centred health research, treatment and technology and link traditional and indigenous knowledge with modern medicine, making information available to women to enable them to make informed and responsible decisions;

(c) Increase the number of women in leadership positions in the health professions, including researchers and scientists, to achieve equality at the earliest possible date;

(d) Increase financial and other support from all sources for preventive, appropriate biomedical, behavioural, epidemiological and health service research on women's health issues and for research on the social, economic and political causes of women's health problems, and their consequences, including the impact of gender and age inequalities, especially with respect to chronic and non-communicable diseases, particularly cardiovascular diseases and conditions, cancers, reproductive tract infections and injuries,
HIV/AIDS and other sexually transmitted diseases, domestic violence, occupational health, disabilities, environmentally related health problems, tropical diseases and health aspects of ageing;

(e) Inform women about the factors which increase the risks of developing cancers and infections of the reproductive tract, so that they can make informed decisions about their health;

(f) Support and fund social, economic, political and cultural research on how gender-based inequalities affect women's health, including etiology, epidemiology, provision and utilization of services and eventual outcome of treatment;

(g) Support health service systems and operations research to strengthen access and improve the quality of service delivery, to ensure appropriate support for women as health-care providers and to examine patterns with respect to the provision of health services to women and use of such services by women;

(h) Provide financial and institutional support for research on safe, effective, affordable and acceptable methods and technologies for the reproductive and sexual health of women and men, including more safe, effective, affordable and acceptable methods for the regulation of fertility, including natural family planning for both sexes, methods to protect against HIV/AIDS and other sexually transmitted diseases and simple and inexpensive methods of diagnosing such diseases, among others. This research needs to be guided at all stages by users and from the perspective of gender, particularly the perspective of women, and should be carried out in strict conformity with internationally accepted legal, ethical, medical and scientific standards for biomedical research;

(i) Since unsafe abortion is a major threat to the health and life of women, research to understand and better address the determinants and consequences of induced abortion, including its effects on subsequent fertility, reproductive and mental health and contraceptive practice, should be promoted, as well as research on treatment of complications of abortions and post-abortion care;

(j) Acknowledge and encourage beneficial traditional health care, especially that practised by indigenous women, with a view to preserving and incorporating the value of traditional health care in the provision of health services, and support research directed towards achieving this aim;

(k) Develop mechanisms to evaluate and disseminate available data and research findings to researchers, policy makers, health professionals and women's groups, among others;
Monitor human genome and related genetic research from the perspective of women's health and disseminate information and results of studies conducted in accordance with accepted ethical standards.

**Strategic objective C.5. Increase resources and monitor follow-up for women's health.**

*Actions to be taken*

111. By Governments at all levels, and where appropriate, in cooperation with non-governmental organizations, especially women's and youth organizations:

(a) Increase budgetary allocations for primary health care and social services, with adequate support for secondary and tertiary levels, and give special attention to the reproductive and sexual health of girls and women; priority should be given to health programmes in rural and poor urban areas;

(b) Develop innovative approaches to funding health services through promoting community participation and local financing; increase, where necessary, budgetary allocations for community health centres and community-based programmes and services that address women's specific health needs;

(c) Develop local health services, promoting the incorporation of gender-sensitive community-based participation and self-care and specially designed preventive health programmes;

(d) Develop goals and time-frames, where appropriate, for improving women's health and for planning, implementing, monitoring and evaluating programmes, based on gender-impact assessments using qualitative and quantitative data disaggregated by sex, age, other established demographic criteria and socio-economic variables;

(e) Establish, as appropriate, ministerial and interministerial mechanisms for monitoring the implementation of women's health policy and programme reforms and establish, as appropriate, high-level focal points in national planning authorities responsible for monitoring to ensure that women's health concerns are mainstreamed in all relevant government agencies and programmes.

112. By Governments, the United Nations and its specialized agencies, international financial institutions, bilateral donors and the private sector, as appropriate:
(a) Formulate policies favourable to investment in women's health and, where appropriate, increase allocations for such investment;

(b) Provide appropriate material, financial and logistical assistance to youth non-governmental organizations in order to strengthen them to address youth concerns in the area of health including sexual and reproductive health;

(c) Give higher priority to women's health and develop mechanisms for coordinating and implementing the health objectives of the Platform for Action and relevant international agreements to ensure progress.

D. Violence against women

113. Violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms. The longstanding failure to protect and promote those rights and freedoms in the case of violence against women is a matter of concern to all States and should be addressed. Knowledge about its causes and consequences, as well as its incidence and measures to combat it, have been greatly expanded since the Nairobi Conference. In all societies, to a greater or lesser degree, women and girls are subjected to physical, sexual and psychological abuse that cuts across lines of income, class and culture. The low social and economic status of women can be both a cause and a consequence of violence against women.

114. The term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

115. Other acts of violence against women include violation of the human rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery and forced pregnancy.

115 bis. Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, prenatal sex selection and female infanticide.

116. Some groups of women, such as women belonging to minority groups, indigenous women, refugee women, women migrants, including women migrant workers, women in poverty living in rural or remote communities, destitute women, women in institutions or in detention, female children, women with disabilities, elderly women, displaced women, repatriated women, women living in poverty and women in situations of armed conflict, foreign occupation, wars of aggression, civil wars, terrorism, including hostage-taking, are also particularly vulnerable to violence.

118. Acts or threats of violence, whether occurring within the home or in the community, or perpetrated or condoned by the State, instil fear and insecurity in women's lives and are obstacles to the achievement of equality and for development and peace. The fear of violence, including harassment, is a permanent constraint on the mobility of women and limits their access to resources and basic activities. High social, health and economic costs to the individual and society are associated with violence against women. Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men. In many cases, violence against women and girls occurs in the family or within the home, where violence is often tolerated. The neglect, physical and sexual abuse, and rape of girl children and women by family members and other members of the household, as well as incidences of spousal and non-spousal abuse, often go unreported and are thus difficult to detect. Even when such violence is reported, there is often a failure to protect victims or punish perpetrators.

119. Violence against women is a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of women's full advancement. Violence against women throughout the life cycle derives essentially from cultural patterns, in particular the harmful effects of certain traditional or customary practices and all acts of extremism linked to race, sex,
language or religion that perpetuate the lower status accorded to women in the family, the workplace, the community and society. Violence against women is exacerbated by social pressures, notably the shame of denouncing certain acts that have been perpetrated against women; women's lack of access to legal information, aid or protection; the lack of laws that effectively prohibit violence against women; failure to reform existing laws; inadequate efforts on the part of public authorities to promote awareness of and to enforce existing laws; and the absence of educational and other means to address the causes and consequences of violence. Images in the media of violence against women, in particular those that depict rape or sexual slavery as well as the use of women and girls as sex objects, including pornography, factors contributing to the continued prevalence of such violence, adversely influencing the community at large, in particular children and young people.

120. Developing a holistic and multidisciplinary approach to the challenging task of promoting families, communities and States that are free of violence against women is necessary and achievable. Equality, partnership between women and men and respect for human dignity must permeate all stages of the socialization process. Educational systems should promote self-respect, mutual respect, and cooperation between women and men.

121. The absence of adequate gender-disaggregated data and statistics on the incidence of violence makes the elaboration of programmes and monitoring of changes difficult. Lack of or inadequate documentation and research on domestic violence, sexual harassment and violence against women and girls in private and in public, including the workplace, impede efforts to design specific intervention strategies. Experience in a number of countries shows that women and men can be mobilized to overcome violence in all its forms and that effective public measures can be taken to address both the causes and the consequences of violence. Men's groups mobilizing against gender violence are necessary allies for change.

122. Women may be vulnerable to violence perpetrated by persons in positions of authority in both conflict and non-conflict situations. Training of all officials in humanitarian and human rights law and the punishment of perpetrators of violent acts against women would help to ensure that such violence does not take place at the hands of public officials in whom women should be able to place trust, including police and prison officials and security forces.

123. The effective suppression of trafficking in women and girls for the sex trade is a matter of pressing international concern.
Implementation of the 1949 Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others, 18/ as well as other relevant instruments, needs to be reviewed and strengthened. The use of women in international prostitution and trafficking networks has become a major focus of international organized crime. The Special Rapporteur of the Commission on Human Rights on violence against women, who has explored these acts as an additional cause of the violation of the human rights and fundamental freedoms of women and girls, is invited to address, within her mandate and as a matter of urgency, the issue of international trafficking for the purposes of the sex trade, as well as the issues of forced prostitution, rape, sexual abuse and sex tourism. Women and girls who are victims of this international trade are at an increased risk of further violence, as well as unwanted pregnancy and sexually transmitted infection, including infection with HIV/AIDS.

124. In addressing violence against women, Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that before decisions are taken an analysis may be made of their effects on women and men, respectively.

**Strategic objective D.1. Take integrated measures to prevent and eliminate violence against women.**

*Actions to be taken*

125. By Governments:

(a) Condemn violence against women and refrain from invoking any custom, tradition or religious consideration to avoid their obligations with respect to its elimination as set out in the Declaration on the Elimination of Violence against Women;

(b) Refrain from engaging in violence against women and exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons;

(c) Enact and/or reinforce penal, civil, labour and administrative sanctions in domestic legislation to punish and redress the wrongs done to women and girls who are subjected to any form of violence, whether in the home, the workplace, the community or society;

(d) Adopt and/or implement and periodically review and analyse legislation to ensure its effectiveness in eliminating violence
against women, emphasizing the prevention of violence and the prosecution of offenders; take measures to ensure the protection of women subjected to violence, access to just and effective remedies, including compensation and indemnification and healing of victims, and rehabilitation of perpetrators;

(e) Work actively to ratify and/or implement international human rights norms and instruments as they relate to violence against women, including those contained in the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;

(f) Implement the Convention on the Elimination of All Forms of Discrimination against Women, taking into account general recommendation 19 adopted by the Committee on the Elimination of Discrimination against Women, at its eleventh session;

(g) Promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes related to violence against women and actively encourage, support and implement measures and programmes aimed at increasing the knowledge and understanding of the causes, consequences and mechanisms of violence against women among those responsible for implementing these policies, such as law enforcement officers, police personnel and judicial, medical and social workers, as well as those who deal with minority, migration and refugee issues, and develop strategies to ensure that the revictimization of women victims of violence does not occur because of gender-insensitive laws or judicial or enforcement practices;

(h) Provide women who are subjected to violence with access to the mechanisms of justice and, as provided for by national legislation, to just and effective remedies for the harm they have suffered and inform women of their rights in seeking redress through such mechanisms;

(i) Enact and enforce legislation against the perpetrators of practices and acts of violence against women, such as female genital mutilation, prenatal sex selection, infanticide and dowry-related violence and give vigorous support to the efforts of non-governmental and community organizations to eliminate such practices;

(j) Formulate and implement, at all appropriate levels, plans of action to eliminate violence against women;
(k) Adopt all appropriate measures, especially in the field of education, to modify the social and cultural patterns of conduct of men and women, and to eliminate prejudices, customary practices and all other practices based on the idea of the inferiority or superiority of either of the sexes and on stereotyped roles for men and women;

(l) Create or strengthen institutional mechanisms so that women and girls can report acts of violence against them in a safe and confidential environment, free from the fear of penalties or retaliation, and file charges;

(m) Ensure that women with disabilities have access to information and services in the field of violence against women;

(n) Create, improve or develop as appropriate, and fund the training programmes for judicial, legal, medical, social, educational and police and immigrant personnel, in order to avoid the abuse of power leading to violence against women and sensitize such personnel to the nature of gender-based acts and threats of violence so that fair treatment of female victims can be assured;

(o) Adopt laws, where necessary, and reinforce existing laws that punish police, security forces or any other agents of the State who engage in acts of violence against women in the course of the performance of their duties, review existing legislation and take effective measures against the perpetrators of such violence;

(p) Allocate adequate resources within the government budget and mobilize community resources for activities related to the elimination of violence against women, including resources for the implementation of plans of action at all appropriate levels;

(q) Include in reports submitted in accordance with the provisions of relevant United Nations human rights instruments, information pertaining to violence against women and measures taken to implement the Declaration on the Elimination of Violence against Women;

(r) Cooperate with and assist the Special Rapporteur of the Commission on Human Rights on violence against women in the performance of her mandate and furnish all information requested; cooperate also with other competent mechanisms, such as the Special Rapporteur of the Commission on Human Rights on torture and the Special Rapporteur of the Commission on Human Rights on summary, extrajudiciary and arbitrary executions, in relation to violence against women;
(a) Recommend that the Commission on Human Rights renew the mandate of the Special Rapporteur on violence against women when her term ends in 1997 and, if warranted, to update and strengthen it.

126. By Governments, including local governments, and community organizations, non-governmental organizations, educational institutions, the public and private sectors, particularly enterprises, and the mass media, as appropriate:

(a) Provide well-funded shelters and relief support for girls and women subjected to violence, as well as medical, psychological and other counselling services and free or low-cost legal aid, where it is needed, as well as appropriate assistance to enable them to find a means of subsistence;

(b) Establish linguistically and culturally accessible services for migrant women and girls, including women migrant workers, who are victims of gender-based violence;

(c) Recognize the vulnerability to violence and other forms of abuse of women migrants, including women migrant workers, whose legal status in the host country depends on employers who may exploit their situation;

(d) Support initiatives of women's organizations and non-governmental organizations all over the world to raise awareness on the issue of violence against women and to contribute to its elimination;

(e) Organize, support and fund community-based education and training campaigns to raise awareness about violence against women as a violation of women's enjoyment of their human rights and mobilize local communities to use appropriate gender-sensitive traditional and innovative methods of conflict resolution;

(f) Recognize, support and promote the fundamental role of intermediate institutions, such as primary-health-care centres, family-planning centres, existing school health services, mother and baby protection services, centres for migrant families and so forth in the field of information and education related to abuse;

(g) Organize and fund information campaigns, educational and training programmes in order to sensitize girls and boys and women and men to the personal and social detrimental effects of violence in the family, community and society; teach them how to communicate without violence; promote training for victims and potential victims so that they can protect themselves and others against such violence;
(h) Disseminate information on the assistance available to women and families who are victims of violence;

(i) Provide, fund and encourage counselling and rehabilitation programmes for the perpetrators of violence, and promote research to further efforts concerning such counselling and rehabilitation so as to prevent the recurrence of such violence;

(j) Raise awareness of the responsibility of the media in promoting non-stereotyped images of women and men, as well as in eliminating patterns of media presentation that generate violence, and encourage those responsible for media content to establish professional guidelines and codes of conduct, consistent with freedom of expression; and also raise awareness of the important role of the media in informing and educate people about the causes and effects of violence against women and in stimulating public debate on the topic.

127. By Governments, employers, trade unions, community and youth organizations and non-governmental organizations, as appropriate:

(a) Develop programmes and procedures to eliminate sexual harassment and other forms of violence against women in all educational institutions, workplaces and elsewhere;

(b) Develop programmes and procedures to educate and raise awareness of acts of violence against women that constitute a crime and a violation of the human rights of women;

(c) Develop counselling, healing and support programmes for girls, adolescents and young women who have been or are involved in abusive relationships, particularly those who live in homes or institutions where abuse occurs;

(d) Take special measures to eliminate violence against women, particularly those in vulnerable situations, such as young women, refugee, displaced and internally displaced women, women with disabilities and women migrant workers, including enforcing any existing legislation and developing, as appropriate, new legislation for women migrant workers in both sending and receiving countries.

128. By the Secretary-General of the United Nations: Provide the Special Rapporteur of the Commission on Human Rights on violence against women with all necessary assistance, in particular staff and resources required to perform all mandated functions, especially in carrying out and following up on missions undertaken either separately or jointly with other special rapporteurs and
working groups, and adequate assistance for periodic consultations with the Committee on the Elimination of Discrimination against Women and all treaty bodies.


**Strategic objective D.2. Study the causes and consequences of violence against women and the effectiveness of preventive measures.**

**Actions to be taken**

130. By Governments, regional organizations, the United Nations, other international organizations, research institutions, women's and youth organizations and non-governmental organizations, as appropriate:

(a) Promote research, collect data and compile statistics, especially concerning domestic violence relating to the prevalence of different forms of violence against women and encourage research into the causes, nature, seriousness and consequences of violence against women and the effectiveness of measures implemented to prevent and redress violence against women;

(b) Disseminate findings of research and studies widely;

(c) Support and initiate research on the impact of violence, such as rape, on women and girl children, and make the resulting information and statistics available to the public;

(d) Encourage the media to examine the impact of gender role stereotypes, including those perpetuated by commercial advertisements which foster gender-based violence and inequalities, and how they are transmitted during the life cycle and take measures to eliminate these negative images with a view to promoting a violence-free society.

**Strategic objective D.3. Eliminate trafficking in women and assist victims of violence due to prostitution and trafficking.**

**Actions to be taken**
131. By Governments of countries of origin, transit and destination, regional and international organizations, as appropriate:

(a) Consider the ratification and enforcement of international conventions on trafficking in persons and on slavery;

(b) Take appropriate measures to address the root factors, including external factors, that encourage trafficking in women and girls for prostitution and other forms of commercialized sex, forced marriages and forced labour in order to eliminate trafficking in women, including by strengthening existing legislation with a view to providing better protection of the rights of women and girls and to punishing the perpetrators, through both criminal and civil measures;

(c) Step up cooperation and concerted action by all relevant law enforcement authorities and institutions with a view to dismantling national, regional and international networks in trafficking;

(d) Allocate resources to provide comprehensive programmes designed to heal and rehabilitate into society victims of trafficking including through job training, legal assistance and confidential health care and take measures to cooperate with non-governmental organizations to provide for the social, medical and psychological care of the victims of trafficking;

(e) Develop educational and training programmes and policies and consider enacting legislation aimed at preventing sex tourism and trafficking, giving special emphasis to the protection of young women and children.
# TABLE OF CASES

*Applicant v Administrator, Transvaal* 1993 (4) S.A. 733

*Associated Provincial Picture Houses v Wednesbury Corporation*  
[1948] 1 KB 233  

*Biljon v Minister of Correctional Services* 11778/96, C.P.D. (South African High Court)

*Brandy v Human Rights and Equal Opportunity Commission*  
(1995) 183 CLR 245

*Builders’ Construction Employees and Builders’ Labourers Federation of New South Wales v Minister for Industrial Relations*  
(1986) 7 NSWLR 372


*Executive Council, Western Cape Legislature and Others v President of the Republic of South Africa and Others* 1995 (4) SA 877 (CC); 1995 (10) BCLR 1289 (CC)

*Irene Grootboom v Oostenberg Municipality, Cape Metropolitan Council, The Premier of the Province of the Western Cape, National Housing Board, Government of the Republic of South Africa – Case No. 6826/99 – High Court of South Africa*
Jaftha v Schoeman and Others; Van Rooyen v Stoltz and Others
2003 (10) BCLR 1149 (C)


Maradean Barcume, Chari Bortner, Barbara Burnett at al v The City of Flint, a municipal Corporation, and the Flint Police Officers Association, a labor union (1986) U.S. Dist. LEXIS 26923, No.84-CV-8066-FL

MEC for KwaZulu-Natal Province, Housing v Msunduzi Municipality and Another 2003 (4) BCLR 405 (N)


Minister of Health and others v Treatment Action Campaign, Dr Harold Saloojee & Children’s Rights Centre CCT 8/02 July, 2002


Ontario Nursing Home Association et al v The Queen in right of Ontario et al; Ontario Association of Non-Profit Homes & Services for Seniors et al., Intervenors (1990) 72 D.L.R. (4th) 166

Operation Dismantle v The Queen [1985] 1 S.C.R. 441

P.C. v North and East Devon Health Authority [1999] E.W.J. No.3698
R v Central Birmingham Health Authority ex parte Collier (6 January, 1988, unreported)

R v Central Birmingham Health Authority ex parte Walker (1987) 3 BMLR 32

R v Davison (1954) 90 CLR 368

R v Johnston (1966) 56 D.L.R. (2d) 749

R v North and East Devon Health Authority; ex parte Coughlan (Secretary of State for Health and another intervening) [2000] 3 All ER 850

R v Morgenthaler (1988) 44 DLR (4th) 385

R v Secretary of State for Social Services ex parte Hincks (1980) 1 BLMR 93


Re J [1992] 3 WLR 507


Schneider v The Queen 139 D.L.R. (3rd) 417 (1982)

Shortland v Northland Health Ltd (2000) 1 NZLR 433

Soobramoney v Minister of Health (KwaZulu Natal) 1997 (12) B.C.L.R. 1696 (CC)

Stoffman v Vancouver General Hospital [1990] 3 S.C.R. 483

The Government of the Republic of South Africa, The Premier of the Province of the Western Cape, Cape Metropolitan Council, Oostenberg Municipality v Irene Grootboom and Others - Case CCT11/00, Constitutional Court of South Africa, 4 October, 2000


Treatment Action Campaign v South Africa (Minister of Health) [2002] S.A.J. No.48

Union Steamship Co of Australia Pty Ltd v King (1988) CLR 1
TABLE OF STATUTES

Bill of Rights 1996 (S.A.)
British North America Act 1867
Canada Health Act 1985
Canadian Bill of Rights 1960
Canadian Charter of Rights and Freedoms, Part 1 of the
Constitution Act, 1982 being Schedule B to the Canada Act, 1982 (U.K.)
Chronically Sick and Disabled Persons Act 1970 (U.K.)
Constitution Act 1867 (Canada)
Constitution Act 1982 (Canada)
Constitution of the Republic of South Africa 1996
Crimes Act 1961 (N.Z.)
Federal Provincial Fiscal Arrangements and Established Programs
Financing Act 1977 (Canada)
Health and Disability Services Act 1993 (N.Z.)
Health Insurance Act 1973 (Cth) (Aust.)
Human Rights Act 1998 (U.K.)
Maternal and Infant Child Health Law 1995 (China)
Medical Insurance Care Act 1968 (Canada)
Medicines and Related Substances Control Act 101 of 1965 (S.A)
Medicines and Related Substances Control Amendment Act 1997 (S.A.)
National Health Act 1953 (Cth) (Aust.)
National Health Service Act 1948 (U.K.)
National Health Service Act 1977 (U.K.)
National Health Service Act 1997 (U.K.)
National Health Service and Community Care Act 1990 (U.K.)
Table of International Conventions and Related Documents

(otherwise known as 'the Protocol of San Salvador')


American Convention on Human Rights (1969)

American Declaration of Independence (1776)

American Declaration on the Rights and Duties of Man (1948)

Cairo Declaration on Human Rights in Islam (1990)

Charter of the Organisations of American States (1948)

Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries (International Labor Organisation)

Convention against Torture and other Cruel Inhumane and Degrading Treatment or Punishment (1987)


Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)

Convention on the Rights of the Child (1990)

Declaration of the Alma-Ata (1978) (World Health Organisation)

Declaration on the Promotion of Patients' Rights in Europe (1994) (World Health Organisation)

European Convention for the Protection of Human Rights and Fundamental Freedoms (1953)

European Social Charter (1961)
European Social Charter (Revised) (1996)

International Covenant on Civil and Political Rights (1976)


Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health (1991)


Protocol of Buenos Aires (1967) (amending the Charter of the Organisations of American States)

Standard Minimum Rules for the Treatment of Prisoners (1957)

Universal Declaration of Human Rights (1948)
BIBLIOGRAPHY


Allars, M. Administrative Law – Cases and Commentary (Butterworths: Sydney, 1977)


Amnesty International Female Genital Mutilation – A Human Rights Information Pack as found at http://www.amnesty.org/ailib/ntcam/femgen/fgm5.htm


Asian-Pacific Resource & Research Centre for Women (ARROW) Advancing the Women's Health Agenda in the Asia-Pacific Region at http://www.awroc.org/org/arrow/arrow.html


Bayliss, F. Health Care Ethics in Canada (Toronto: Harcourt Brace, 1995)


Berglund, C.A. Ethics for Health Care (South Melbourne: Oxford University Press, 1998)


*Butterworths Australian Legal Dictionary* (Australia: Butterworths Australia, 1997)

Butterworths Concise Australian Legal Dictionary (2nd Ed.) (Australia: Butterworths, 1998)


Center for Economic and Social Rights, Committee on Economic, Social and Cultural Rights General Comment 14 – The right to the
highest attainable standard of health (Article 12) at http://www.cesr.org/ESCR/gencomment14.htm


Devlin, R.F. *Some Recent Developments in Canadian Constitutional Theory with Particular Reference to Beatty and Hutchinson* (1996) 22 Queen’s L.J. 81

Donnelly, J. “Establishing a Right to Health Care in the United States: An International Human Rights Perspective” (American
Association for the Advancement of Science Consultation on the Right to Health Care, Washington, D.C. December, 4, 1992


Elhauge, E. Allocating Health Care Morally (1994) 82 Calif.L.Rev 1449-1544


Evans, J.R., Lashman Hall, K. & Warford, J. *Shattuck Lecture – Health care in the developing world: Problems of scarcity and choice* – Delivered at the Bicentennial meeting of the Massachusetts Medical Society, Boston, October 21, 1981 (http://media.payson.tulane.edu:8086/cgi...


Forrester, K. & Griffiths, D. *Essentials of Law for Health Professionals* (Sydney: Harcourt Australia, 2001)

Freckelton, I. & Petersen, K. *Controversies in Health Law* (Sydney: The Federation Press, 1999)


Fried, C. *Equality and Rights in Medical Care*. Hastings Center Report, 1976, Vo. 6, no.1, pp. 29-34.

Fried, C. *Right and Wrong* (Massachusetts: Harvard University Press, 1978)


Gibbs, Sir H. Law and Government, Quadrant, October 1990, 25-27

Gibson, D. The Canada Health Act and the Constitution (1996) 4 Health Law Journal 1-33


Grbich, C. Health in Australia – Sociological concepts and issues (2nd Ed.) (New South Wales: Prentice Hall Australia, 1999)


Hall, K. Legislation (Australia: Butterworths, 2002)

Harris, D. *The European Social Charter* (Charlottesville; University Press of Virginia, 1984)


Hendricks, A. *The right to health: promotion and protection of women’s right to sexual and reproductive health under international law: the economic covenant and the women’s convention.* (1994-1995) 44 American University Law Review 1123-1144


Human Rights Act 1998 (U.K.)


Hutchinson, T., Researching and Writing in Law (Australia: Lawbook Co., 2002)


International Conference on Health Promotion, *Ottawa Charter for Health Promotion* (Ottawa, November 21, 1986)


Jackman, M. *The Regulation of Private Health Care under the Canada Health Act and the Canadian Charter* (1995) 6 Constitutional Forum 54


Kelley, D. *Is there a right to health care*? at http://ascc.artsci.wustl.edu/~diana/ac/essays/health


Kingsbury, B. *Competing Conceptual Approaches to Indigenous Group Issues in New Zealand Law* (2002) 52 Univ. of Toronto L.J. 101-134


Kluge, E.H. *Biomedical Ethics in a Canadian Context* (Scarborough, Ontario: Prentice-Hall Canada, 1992)


Leeder, S. *Healthy Medicine – Challenges facing Australia's health services* (St Leonards, N.S.W.: Allen & Unwin, 1999)

*Lemuel Shattuck* (1793-1859) at [http://www.hsc.usf.edu/~kmbrown/shattuck.htm](http://www.hsc.usf.edu/~kmbrown/shattuck.htm) retrieved 7/11/01


Mann, J.M., Gruskin, S., Grodin, M.A. & Annas, G.J. Health and Human Rights – A Reader (New York; Routledge, 1999)


Minyuku, R. Developing a Complaint Mechanism: The South African Human Rights Commission (SAHRC) and the Commission on Gender Equality (CGE). Research Report No.11, Nadel Human
Rights Research and Advocacy Project at
http://sunsite.wits.ac.za/nadelproject/publications/publications.htm


National Health and Medical Research Council, A guide to the development, implementation and evaluation of clinical practice guidelines (Commonwealth of Australia, 1999)


Nemes, I. & Coss, G. Effective Legal Research (2nd Ed.) (Australia: Butterworths, 2001)


Pinet. G. The WHO European program of health legislation and the Health for All policy. (1986) 12 American Journal of Law and Medicine 441-460


Roy, D.J., Williams, J.R. & Dickens, B.M. *Bioethics in Canada* (Scarborough, Ontario: Prentice-Hall, Canada, 1994)

Schick, T. Jr. *Is morality a matter of taste? Why professional ethicists think that morality is not purely ‘subjective’.* Free Inquiry, Fall 1998, Vol.18, n.4 p.32

Schneiderman, D. Dualing Charters: The harmonics of rights in Canada and Quebec (1992) 24 Ottawa L. Rev. 235-263


Shannon, T.A. An Introduction to Bioethics (3rd Ed.) (New Jersey: Paulist Press, 1997)

Shorts, E. & de Than, C. Human Rights Law in the UK (London: Sweet & Maxwell, 2001)


Sutherland, R.W. & Fulton, M.J. *Health Care in Canada* (Ottawa: The Health Group, 1988)


Taylor, M.G. *Health Insurance and Canadian Health Policy: the Seven Decisions that Created the Canadian Health Insurance System* (Montreal: McGill-Queen’s University Press, 1978)


Wallace, M. Health care and the law (3rd ed) (Sydney: Lawbook Co. 2001)


World Health Organisation, Health for All – Development of Indicators for Monitoring Progress Toward Health for All by the Year 2000 (Series No.4) (Geneva: WHO, 1981)


Zulficar, M *From Human Rights to Program Reality: Vienna, Cairo, and Beijing in Perspective* (1994-995) 44 Am U.L. Rev. 1017-1036

The Ottawa Charter was a declaration of the 1986 first world conference on health promotion health in Canada under the auspices of the World Health Organisation.

Ibid.


Ibid p.72

WHO resolution WHA 34, 36, May 1981

Development of Indicators for Monitoring Progress Toward health for All by the Year 2000, Geneva: WHO "Health for All" Set No 4 (1981)


Ibid., para 5.

Ibid., op.cit., pp.128-129

Note the similarities in content to the documents identified in Appendix 1 and 2 of this thesis.

Ibid., p.129. Work of both these authors can be found in the Bibliography of this Thesis.

Evans, J.R., Lashman Hall, K. & Warford, J. Shattuck Lecture – Health care in the developing world: Problems of scarcity and choice – Delivered at the Bicentennial meeting of the Massachusetts Medical Society, Boston, October 21, 1981 (http://media.payson.tulane.edu:8086/cgi-bin/search.pl?search=right%20to%20health&l=te&d=B.207.6.2.2) retrieved 18/7/00.

Lemuel Shattuck (1793-1859) at http://www.hsc.usf.edu/~kmbrown/shattuck.htm (retrieved 7/11/01) for a more detailed analysis of his recommendations.


WHO, Constitution op.cit.

A biography of John Locke can be found at http://www.utm.edu/research/jsep/locke.htm or at http://plato.stanford.edu/entries/locke/.

It should be noted that Thomas Hobbes and Hugo Grotius were also exponents of the natural law theory.

Piotrowicz & Kaye, op.cit.

The theory of ‘absolutism’ fundamentally proposes that the best form of government is autocracy – the person in power is not to be questioned or disobeyed. See http://www.ausu.edu/~dee/GLOSSARY/ABSOLUTE.HTM for a more detailed analysis of the theory.

Charles I (1625-49) retrieved from http://www.britannica.com/history/monarchs/mon47.html

This notion derived from the theory of ‘absolutism’ and argued that certain kings ruled because they were chosen by God to do so. In other words, power was bestowed by God and this bestowal legitimated autocracy. The king ruled by virtue of God’s authority and therefore should be obeyed in all things. See http://www.ausu.edu/~dee/GLOSSARY/DIVRIGHT.HTM for more discussion.

Ibid., p.13.

Known as the Virginia Declaration of Rights. A full copy of this document can be found at http://www.archives.gov/national_archives_experience/virginiadclaration_of_rights.html
A full copy of which can be found at http://www.archives.gov/national_archives_experience/declaration.html

A full copy of which can be found at http://www.hcrc.org/docs/frenchdec.html

Article 2.

It should be noted that a further declaration followed as a prefix to the Constitution of 5 Fruitidor of the Year III (22 August 1795) that further defined these rights. See Kamenka, E. Ideas and Ideologies of Human Rights (New York; St Martin’s Press, 1978) p.4.

Full title – Reflections on the Revolution in France & On the Proceedings In Certain Societies in London Relative to that Event In a Letter Intended to Have Been Sent To A Gentleman in Paris.” A full copy of this can be found at http://www.ourcivilisation.com/burke/

See http://www.utilitarianism.com/bentham.htm for a more detailed discussion on this point,

Kamenka, E. Ideas and Ideologies of Human Rights (New York; St Martin’s Press, 1978)

Ibid, p.5

Piotrowicz & Kaye, op.cit.p.16.

See Union Steamship Co of Australia Pty Ltd v King (1988) 166 CLR 1 and Builders’ Construction Employees and Builders’ Labourers Federation of New South Wales v Minister for Industrial Relations (1986) 7NSWLJR 372 re breadth of power in parliaments of Australia.

The Columbia Encyclopedia, 6th Ed. at http://www.bartleby.com/65/m/a/mandates.html

See Piotrowicz & Kaye, op.cit for a further discussion of this issue.

See the website of the ILO at http://www.ilo.org/public/english/about/index.htm for further information about the structure and function of the Organisation.

A full copy of the Covenant can be located at http://www.ku.edu/carr/dcoets/texts/leagmat.html

Franklin D Roosevelt, 32nd President of the United States of America, 1933-1945 retrieved from http://www.whitehouse.gov/history/presidents/fr32.html on 21.04.04


United Nations Charter, signed at San Francisco, June 26, 1945

Universal Declaration of Human Rights, adopted and proclaimed by UN General Assembly Resolution 217A (III) (December 10, 1948)

A full copy of this document is available at http://www.un.org/Overview/rights.html

Kirby, J in Galligan & Sampford, op.cit at p.3

Ibid.

Piotrowicz & Kaye, op.cit, at p.6

Ibid p.7

Kirby, op.cit p.4. See also Mann et al, op.cit at p.25, where third generation rights are described in the following manner:

“In addition to these two basic recognised rights, a third category of rights, known as solidarity rights, should be mentioned. These rights which have not yet been generally recognised at the international level as legally enforceable, urge solidarity with the less privileged in order to rectify the unequal distribution of resources and to prevent and respond to human suffering. This category of rights includes the rights to development, to peace, to the equal enjoyment of the common heritage of humankind, and to an unpolluted natural environment.”

Allan Rosas cited by Kirby, ibid, provides a useful evaluation of the third generation ‘right of development’ when he states:

The right to development should, perhaps, be seen as an umbrella concept and programme rather than a specific human right. It may be of particular relevance as a summary and pointer of the human rights dimension for development cooperation and development aid purposes, including the notion of ‘human rights impact statements’. It could then play a role in planning and implementing policies and programmes, rather than function as a legal mechanism per se. For the right to development to play a constructive role in such contexts, however, there must be less political controversy and more analytical and critical discussion surrounding the concept. [From Rosas, A (1995) ‘The Right to Development’ in Eide, A. & Rosas, A. (eds) (1995) Economic, Social and Cultural Rights (Nijhoff).
Ibid.

Piotrowicz & Kaye, op.cit. p.7

In 1979, Karel Vasak, a French Jurist at the International Institute of Human Rights in Strasbourg, proposed that this three generation division was based upon the three watchwords of the French Revolution – Liberté, Égalité and Fraternité. First generation rights dealing with liberty being mostly negative rights, second generation rights dealing with equality being mostly positive rights, and third generation rights focusing on fraternity. See http://en.wikipedia.org/wiki/Three_generations_of_human_rights for more discussion.


These Guidelines were formulated by some 30 experts who met at Maastricht from 22-26 January, 1997 for the purpose of elaborating on the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, which had been formulated 10 years previously. The elaboration was specifically in relation to the nature and scope of violations of economic, social and cultural rights and appropriate responses and remedies. A full copy of these guidelines is available from the Netherlands Institute of Human Rights, Faculty of Law – SIM Special 20 @ http://www.uu.nl/uu/publish/home/rechtsgeneer/den/den6/english/publications/simspecial/no/23076main.html retrieved 20/02/04

The Committee on Economic, Social and Cultural Rights, Fact Sheet No.16 (Rev.1) – a copy of which can be found at http://www.unhchr.ch/html/menu6/2/fs16.html retrieved 23/11/00.

Resolution 32/130, 16 December, 1977

A full copy of this document is available at http://www.unhchr.ch/html/menu3/b/a cesr.htm

General Assembly resolution 2200 A (XXI) of 16 December 1966.

The signing of the Civil Rights Act (US), July 2, 1964 extracted from http://www.humanrights.state.mn.us/resources_hp11.html on 21.04.04

A full copy of the Charter is available at http://www1.umn.edu/humanrts/euro/231escch.html

This phrase was inserted in the text of the Revised Charter – Strasbourg, 3.V.1996 a full copy of which is available at http://www.itcilo.it/english/actrav/telearn/global/ilo/law/coesoci.htm

See Harris, D. The European Social Charter (Charlottesville: University Press of Virginia, 1984) at 105. Harris also remarks that there are earlier ILO conventions protecting health in employment, but not health in general.


Ibid, p.65


A full copy of this Convention is available at http://www.unhchr.ch/html/menu3/b/c1cedaw.htm

A full copy of this Convention is available at http://www.unhchr.ch/html/menu3/b/k2crc.htm


General Assembly resolution 46/119 of 17 December 1991. A full copy of this document is available at http://www1.umn.edu/humanrts/instree/2pppmil.htm
situation in certain areas of the world, some of these constitutions may be suspended or
amended without the knowledge of the author at the time of the completion of this thesis.
Robertson, G. *The Justice Game* (Vintage, London, 1999) at p.85
http://www.washlaw.edu/foritin/alpha/c/constitutionallaw.htm:
http://www.confinder.richmond.edu; http://www.uni-wuerzburg.de/law/home.html:
http://www.constitution.org/cons.natlcons.htm

789 Map of the Caribbean region retrieved from
http://www.geographic.org/maps/caribbean_maps.html - 17.06.2005
790 UK Red Cross worker assists drought victims, Bati Camp, Ethiopia 5/11/84 – 164669 e
UN/DP/I/J.Isaac retrieved from http://www.un.org/UN50/Photos/80s.html
791 Mrs Roosevelt holds a Declaration of Human Rights poster, Lake Success, New York,
Nov. 1949 – retrieved from http://www.un.org/UN50/Photos/40s.html on 27/04/04
792 Map of Libya retrieved from http://www.geographic.org/maps/libya_maps.html -
17.06.2005
793 Mozambique villagers, the focus of UNICEF HIV/AIDS education from
http://www.unicef.org/mozambique/late_news.htm/#7859685706985 retrieved 17.06.2005
794 Representation of Mestizos during Latin American colonial period. Mestizos make up
95% of the population in Paraguay, being of mixed European and Amerindian ancestry.
Picture found at http://en.wikipedia.org/wiki/Mestizo retrieved 17.06.05
795 Boy playing in a Kabul graveyard retrieved from
796 Children play in a burnt out farm outside the city of Nazran in famine stricken Sierra
797 Segregated stands in sports arena, Bloemfontein, South Africa, 6/69. UN# 177913,
UN/DP/I/H.Vassel retrieved from http://www.un.org/UN50/Photos/90s.html on 22/04/04
798 The effects of drought in the village of Lusitu, Zambia retrieved from
http://www.time.com/europe/photosessays/africadrought1.html on 28/04/04
800 Women at a UNICEF-assisted family planning clinic, Settat, Morocco, 7/87 –
UN#156359e UN/DP/I/J.Isaac retrieved from http://www.un.org/UN50/Photos/90s.html
rights* (New York: St Martin’s Press, 1978)
803 Ibid, p.2
804 Ibid.p.3
806 Ibid.p.16
807 Ibid.
808 Ibid. p.17
809 Ibid.
810 As cited in Hunter, K.W. & Mack, T.C. (ed.) *International Rights and Responsibilities for
the Future* (Praeger, Westport, Connecticut, USA, 1996)
Human Rights Perspective” (paper prepared for the American Association for the
Advancement of Science Consultation on the Right to Health Care, Washington, D.C.,
December 4, 1992).
812 Brock, D.W. “The President’s Commission on the Right to Health Care” in Chapman,
University Press, 1994)
813 Ibid, p.69
814 See Gribich, C. *Health in Australia – Sociological concepts and issues* (2nd Ed.) (NSW:
Prentice Hall Australia, 1999) for a discussion of the influence of the AMA in the health
system.
815 Chapman, A. ‘Reintegrating Rights and Responsibilities – Towards a new Human Rights
Paradigm’ in Hunter & Mack, op.cit. p.20
816 Ibid.
817 Ibid p.21
Ibid
Ibid.
Ibid
Ibid
Ibid, p.22
Ibid, p.23
Ibid
Ibid, p.24
Chapman is referring to the health care system in the United States, but there are distinct similarities with the situation within both the Australian system, and as the Case Study on South Africa reveals, historical factors have had a significant impact on the state of health care within that country as well as the development of new health care policy.
Ibid
Ibid, p.25
Ibid
Ibid
Congolese being vaccinated against smallpox, Leopoldville 1/62 – 73798
Op.cit, p.35
Ibid.
Ibid
Ibid
Ibid, p.36
Ibid
Ibid, p.110
Ibid
Photo retrieved from http://www.fotosearch.com/photos-images/pharmaceuticals-still-life.html on 17.06.05
Ibid, para.9
Ibid, para.11
Ibid, para.12. See also #165.
Slum area, Nairobi, Kenya retrieved from http://www.un.org/ecosocdev/geninfo/afric/vol18no2/182environ.htm on 20.06.05
Ibid, para.17
Ibid, para.43
Ibid, para.44
Article 2, Universal Declaration of Human Rights, op.cit.
Ibid.
Mann et al. op.cit.
Ibid
Op.cit.p.4


See Bailey, P.H. Human Rights: Australia in an International Context (Sydney: Butterworths, 1990 pp2-3 for a further discussion of this position)

Ibid, at p.191
Ibid
Described as the ‘benchmark man...possess[ing] all the characteristics of the dominant side of a string of dualisms against which ‘otherness’ is measured in our society’ by Margaret Thornton ‘Embodying the Citizen’ in Thornton, M. (ed) Public and Private: Feminist Legal Debates (Oxford: Oxford University Press, 1995)
See above.
Ibid.
Ibid, p.192

UN Charter with USSR, UK and US signatures, San Francisco, 26/6/45 (UNC1O 2715 UN/DP/1/M.Boloney) retrieved from http://www.un.org/UN50/Photos/40s.html on 29/04/04
Op.cit at p.10
Ibid
Ibid, p.80

For a comprehensive human rights discussion on female genital mutilation see Amnesty International at http://www.amnesty.org/ailib/intcom/femgen/fgm1.htm retrieved 21.06.05
Note also reference to the unacceptability of female genital mutilation in Article 114(a) and 125(i) of the Beijing Declaration located in Appendix 3.

Worshipper at a mosque in Djenne, Mail. Djenne, 4/86. (154730c UN/DP/1/I.Isac retrieved from http://www.un.org/UN50/Photos/80s.html on 29/04/04
See above note 112
Cited in Perry, op.cit at p.66
As cited in Perry, ibid, p.69
Ibid at p.41

Paragraph 10 of the Guidelines provides: “In many cases, compliance with such obligations may be undertaken by most States with relative ease, and without significant resource implications. In other cases, however, full realisation of the rights may depend upon the availability of adequate financial and material resources. Nonetheless, as established by Limburg Principles 25-28, and confirmed by the developing jurisprudence of the Committee on Economic, Social and Cultural Rights, resource scarcity does not relieve States of certain minimum obligations in respect of the implementation of economic, social and cultural rights.”
Ibid, para.11
Ibid, para.14
Ibid, para.15
Ibid, para.22
Ibid, para.28
Poster of Preamble of the Charter 7/83 – 161694 e UN/DP1/M.Grant retrieved from http://www.un.org/UN50/Photos/40s.html 27/04/04
894 See http://www.concourt.gov.za/about.html retrieved 29/12/01
895 All cases referred to in this section were retrieved from
http://www.concourt.gov.za/about.html
896 Case No. CCT 23/96. The Court consisted of Chaskalson, P, Mahmood DP, Ackermann J
(who fell ill during proceedings and withdrew), Dicott J, Goldstone J, Kriegler J, Langa J,
Madala J, Mokgoro, J, O’Regan J and Sachs J. The decision of their Honours was unanimous.
897 A succinct portrayal of the political history of South Africa is found in the judgment of
the Constitutional Court in Executive Council, Western Cape Legislature and Others v
President of the Republic of South Africa and Others 1995 (4) SA 877 (CC); 1995 (10)
BCLR 1289 (CC) at para 7 where it was stated:
“... The Constitution itself makes provision for the complex issues involved in bringing together
again in one country, areas which had been separated under apartheid, and at the same time
establishing a constitutional State based on respect for fundamental human rights, with a
decentralised form of government in place of what had previously been authoritarian rule
enforced by a strong central government. On the day the Constitution came into force 14
structures of government cased to exist. They were the four provincial governments, which
were non-elected bodies appointed by the central government, the six governments of what
were known as self-governing territories, which had extensive legislative and executive
competences but were part of the Republic of South Africa, and the legislative and executive
structures of Transkei, Bophuthatswana, Venda and Ciskei, which, according to South
African law, had been independent States. Two of these States were controlled by military
regimes, and at the time of the coming into force of the new Constitution two were being
administered by administrators appointed by the South African authorities. The legislative
competences in these 14 areas were not the same. Laws differed from area to area, though
there were similarities because at one time or another all had been part of South Africa. In
addition the Constitution was required to make provision for certain functions which had
previously been carried out by the national government to be transferred as part of the
process of decentralisation to the nine new provinces which were established on the day the
Constitution came into force, and simultaneously for functions that had previously been
performed by the 14 executive structures which had ceased to exist to be transferred partly
to national government and partly to the new provincial governments which were to be
established. All this was done to ensure constitutional, legislative, executive, administrative
and judicial continuity.”
898 Re Certification, op cit, para.10
899 It should be noted that court decisions are not generally divided into Chapters, however,
given the multiplicity of issues and the complexity of the task before the Court, the decision
was taken to divide the judgment into separate Chapters, each dealing with a separate topic.
900 Ibid, para.76
901 This approach is referred to in Australian Constitutional Law as the concept of
computation and denotation — that is, that a constitutional provision may be read in light of
the circumstances prevailing at the time of its formulation (computation) but may be amended
in interpretation to “denote” something additional in the future. For a discussion of this see
(Butterworths: Sydney, 1999) at Chap.11
902 See Hanks & Cass at p.350-351 for a definition of the doctrine under the Australian
Constitution. See also Re Constitution paras.105-113 for a discussion of the doctrine.
903 Re Certification, op.cit para.77.
904 Ibid, para.78
905 Ibid.
906 43 yr old Loveness Mudaala of Zambia with some of her 18 children, which are not all
hers by birth. She has taken n nephews and nieces as her own brothers and sisters have died
of AIDS. Retrieved from
http://www.time.com/time/europe/photoessays/africadrought/2.html on 28/04/04
907 Para.4.
908 Para.8.
This statement was taken from the decision of His Honour in *S v Makwanyane and Another* 1995 (3) SA 391 (CC) citing the decision of the Constitutional Court in *S v Zuma and Two Others* (5 April 1995) CCT/5/94. In that decision, Kekana AJ, in addressing the issue of what approach should be adopted in the interpretation of the fundamental rights enshrined in Chapter Three of the Constitution stated: 

"The meaning of a right or freedom guaranteed by the Charter was to be ascertained by an analysis of the purpose of such a guarantee; it was to be understood, in other words, in the light of the interests it was meant to protect. In my view this analysis is to be undertaken, and the purpose of the right or freedom in question is to be sought by reference to the character and larger objects of the Charter itself, to the language chosen to articulate the specific right or freedom, to the historical origins of the concept enshrined, and where applicable, to the meaning and purpose of the other specific rights and freedoms with which it is associated within the text of the Charter. The interpretation should be...a generous rather than legalistic one, aimed at fulfilling the purpose of a guarantee and securing for individuals the full benefit of the Charter’s protection."

Para. 15

Para. 19

Para. 42 & 43

Para. 54.

Para. 58

Para. 57

Para. 58

President Nelson Mandela delivers inauguration speech, Pretoria, 10 May, 1994 – UN# 186835c UN/DP1/C.Sattlebergter retrieved from [http://www.un.org/UN50/Photos/90shtml](http://www.un.org/UN50/Photos/90shtml) on 27/04/04


Para. 13

(1996) AIR SC 2426

Ibid at p.2429


Ibid.

Ibid

There has been much written about the quality of life debate but this thesis does not present the opportunity to act as a forum for discussion. However, the following are references for those interested in reading more about this topic. Berglund, C.A. *Ethics for Health Care* (South Melbourne: Oxford University Press, 1998); Morton, J. (Ed) *An Easeful Death? Perspectives on Death, Dying and Euthanasia* (NSW: The Federation Press, 1996); Singleton, J. & McLaren, S. *Ethical Foundations of Health Care – Responsibilities in Decision Making* (London: Mosby, 1995)

Various pills used in treatment of HIV & AIDS retrieved from [http://www.avert.org/photos.htm](http://www.avert.org/photos.htm) on 28/04/04

Irene Groothoom & Others v Oostenberg Municipality, Cape Metropolitan Council, The Premier of the Province of the Western Cape, National Housing Board, & The Government of the Republic of South Africa 2000 (3) BCLR 777/ Case No. 6826/99

Ibid per Davis J at 293A

Ibid at 285-A-B

Ibid

"a structure affording protection from rain, wind or sun; any screen or place of refuge from the weather. A place of temporary lodging for the homeless poor..."

The term ‘obiter dicta’ is a term used to describe those observations made by judges that do not form part of the reasoning of a case. Such observations are not binding on lower courts nor subsequently on the court that makes them. They are however useful in illustrating key points and can be used as persuasive argument before a court.
These comments were made in the context of the claim to an unqualified right to shelter and may be of limited use, but it is significant that the court at least addressed this issue. A baby, one of 2.5 million people facing famine in Sudan, given oral rehydration solution by nurse. UN/187754C UN/DP1/E. Debebe retrieved from http://www.un.org/UN50/Photos/90s.html on 27.04.04

Office of the High Commissioner for Human Rights, The nature of States parties obligations (Art.2,par.1): 14/12/90. CESC General Comment 3. (General Comments) at http://www.unhchr.ch/tbs/doc.nsf/((symbol)CESCR+General+Comment+3.En)?Open

Document


Op.cit

Ibid at

The Government of the Republic of South Africa, The Premier of the Province of the Western Cape, Cape Metropolitan Council and Oostenberg Municipality

"amicici curiae" is the Latin term for ‘friend of the court’. That is, a person, usually a barrister who, with the court’s permission, may advise the court on a point of law or on a matter of practice. Amici curiae have no personal interest in the case as a party and do not advocate a point of view in support of one party of another. The court may hear an amici curiae if it considers it is in the interests of justice to do so. See Butterworths Australian Legal Dictionary, 1997 for this definition. Note also the comments in para 17 of the judgment where the court thanked the representative of the amici curiae for “...a detailed, helpful and creative approach to the difficult and sensitive issues involved in this case.”

Section 38 of the Constitution of South Africa empowers the Court to grant appropriate relief for the infringement of any right entrenched in the Bill of Rights.

Para.20


Para.23

Young African boy cares for his younger sibling while his mother is in hospital being treated for AIDS retrieved from http://www.time.com/time/europe/photoessays/aids on 28/04/04

Para.25

See #175

See #177

Section 39 of the Constitution provides:

(1) When interpreting the Bill of Rights, a court, tribunal or forum –
   (a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
   (b) must consider international law; and
   (c) may consider foreign law.

(2) When interpreting any legislation, and when developing the common law or customary law, every court or tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.

(3) The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.”

Ibid, para.31

Ibid, para.33


Hink, R. Intellectual Property and AIDS Medication in South Africa at http://www.american.edu/TED/aidstrips.htm retrieved 10/01/02


Republic of South Africa Department of Health Annual Report 1997 as cited in Bond, op.cit.

Bond op.cit at p. 2


Constitutional Case CCT8/02, heard 2,3 & 6 May, 2002; [2002] S.A.J. No.48

Ibid, para.8


Ibid, para.16

Ibid, para 19, Section 195(1) of the Constitution states:

195. (1) Public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:

   a. A high standard of professional ethics must be promoted and maintained.

   b. Efficient, economic and effective use of resources must be promoted.

   c. Public administration must be development-oriented.

   d. Services must be provided impartially, fairly, equitably and without bias.

   e. People’s needs must be responded to, and the public must be encouraged to participate in policy-making.

   f. Public administration must be accountable.

   g. Transparency must be fostered by providing the public with timely, accessible and accurate information.

   h. Good human-resource management and career-development practices, to maximise human potential, must be cultivated.

   i. Public administration must be broadly representative of the South African people, with employment and personnel management practices based on ability, objectivity, fairness, and the need to redress the imbalances of the past to achieve broad representation.
Limitation of rights

36. (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including

a. the nature of the right;

b. the importance of the purpose of the limitation;

c. the nature and extent of the limitation;

d. the relation between the limitation and its purpose; and

e. less restrictive means to achieve the purpose.

These sections provide:

Housing

26. (1) Everyone has the right to have access to adequate housing.

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

(3) No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.

Health care, food, water and social security

27. (1) Everyone has the right to have 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.

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

(3) No one may be refused emergency medical treatment.

OP.cit., para.34
Ibid, para.35
Ibid, para.38
Ibid, para.98.
982 1997 (3) SA 786 (CC); 1997 (7) BCLR 851 (CC) at para.69.
984 Ibid p.134
987 Ibid p.135
988 Ibid
990 Tucker in Galligan & Sampford, op.cit. p.137
991 Op.cit
992 Ibid, para.19
993 Retrieved from http://www.dec.org/partners/afr/photogallery/search_results.cfm on 27/04/04
995 International Commission of Jurist, Tibet and the Chinese People’s Republic: A Report to the International Commission of Jurists by its Legal Inquiry Committee on Tibet - 1960
996 Tibet: Human Rights and the Rule of Law, op.cit. p.13
997 Tibet Justice Centre (http://www.tibetjct.org), Tibetan Centre for Human Rights and Democracy (http://www.tibet.com) and Lawyer for Tibet are three such organisations.
998 Map of Tibet retrieved from http://www.travelchinaguide.com/picture/tibet on 27/04/04
999 Article 5(e)(iv)
1000 Article 24
1001 Article 12(1)
1002 Article 14(2)(b)
1003 Article 12 (2), ICESCR
1005 Ibid, p.225
1006 Tibet. op.cit., p.227 and see also Information Office of the State Council of the People’s Republic of China, New Progress in Human Rights in the Tibet Autonomous Region (Beijing, February 1998) as found at http://www.chinaguide.org/e-white/last/index.htm retrieved 15/11/01
1007 A full copy of this report is available at http://www.worldbank.org.cn/Englishb/Content/fiscal.org - retrieved 16/06/2003
1009 Old woman with child retrieved from http://www.historylink101.net/china/tibet-1.htm on 27/04/04
1011 See http://www.tibet.com/Humanrights/HumanRights97/hr97.html for this report.
1013 The Tibetan Women’s Association is a non-governmental organisation founded in Tibet in 1959 by a group of Tibetan women to protest the forcible occupation of their homeland. In 1984, the Association was re-established by Tibetan women living in exile in India, and currently has over 10,000 members and 40 world-wide branches. The main objective of the
Association is to alert communities to the human rights abuses faced by Tibetan women in Chinese-occupied Tibet.  
1008 Ibid. The report cites that in Nyangren town, 342 of 379 married women were sterilised. The report also states that between September and October 1996, 308 women in the district of Takar were sterilised over a period of 22 days.  
1012 See also Cook, R.J. International Protection of Women’s Reproductive Rights 24 N.Y.U.J. INT’L & POL. 645 (1992)  
1013 Chapman, op.cit, p.1168.  
1023 The Beijing Women’s Conference, held in September 1995, was attended by representatives of 180 governments and had as its them “Action for Equality, Development and Peace”. The Platform for Action reaffirmed the fundamental principle set forth in the Vienna Declaration and Programme for Action, and adopted by the World Conference on Human Rights, that the human rights of woman and the girl child are an inalienable, integral and indivisible part of universal human rights.  
1024 See Appendix 3 for the relevant Extract from the Report of the Beijing Conference. A full copy of the Beijing Declaration and Platform for Action can be found at http://www1.umn.edu/humanrts/instree/e5dpwl.htm#four  
1025 Beijing Declaration for Action, Strategic Objective C/92  
1026 Ibid  
1027 Ibid. For further information on the status of female political prisoners, especially nuns see Marshall, S. Rukhag 3 : The Nuns of Drapchi Prison, Tibet Information Network (TIN), September 2000  
1028 United Nations Treaty Series 277, entered into force 12 January 1951  
1029 Symbol of Kunphen, the first and only bilingual Tibetan Non-Government Organisation catering to the needs of substance abuse, HIV/AIDS & HRD based in Dharamshala retrieved from http://www.dharamsalaneti.com/links/health.htm on 27/04/04  
1031 Ibid,  
1032 This information quoted by the ICJ is extracted from Yangsun, J. Li, Su, Pei, C. & Husheng, W. “A Study on Patterns in the Average Life Expectancies and Mortality Rates of 56 Nationalities in China in 1990,” Chinese Journal of Population Science, vo.6, no.3, 1994, 263 at 268  
1033 see http://www.chinaguide.org/e-white/ast/1-3.htm op.cit.  
1036 Article 7 states: (1) The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his parents. (2) States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations.
under the relevant international instruments in their field, in particular where the child would otherwise be stateless.

Article 8 states: (1) States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognised by law without unlawful interference. (2) Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to speedily re-establishing his or her identity.

See http://www.tibetictl.org/reports/un/unint3.html
See http://www.tibet.com/op.cit

Ibid, p.293.
Ibid at p.11
TCHRD reports a decline from a high of 1,324 in 1997 to 1,237 in 2000.
Tibetan Centre Annual Report 2002, op.cit at p.5
Staff at Sershul County Hospital in Gyurga Town retrieved from http://www.tibetfoundation.org/aic/timetype/g141310.html on 27/04/04
2.lse.ac.uk/collections/pamphlets/document_service/HB7/000000145/doc.pdf (retrieved 09/05/02) for the complete report of this Committee.
See http://www.bbc.co.uk/education/medicine/nonint/modern/ph/mopbbi2.shtml retrieved 9/05/02
These statutes include the National Health Service and Community Care Act 1990 and the Chronically Sick and Disabled Persons Act 1970.
See comments by Hendrick, J. Law and Ethics in Nursing and Health Care (Cheltenham, U.K.: Stanley Thomes (Publishers) Ltd at p.133.
See Wallace, M. Health care and the law (3rd Ed) (Sydney: Lawbook Co., 2001) for a discussion of the principles of negligence in relation to the health care professions.
It was Lord Greene MR who firmly introduced the concept of unreasonableness as a ground of review in Associated Provincial Picture Houses v Wednesbury. It was in this case that a regulation preventing the admission of any child under the age of 15 into the local picture house was castigated as unreasonable. In arriving at his conclusion Lord Greene presented unreasonableness as having two meanings. The first was merely as a general rubric containing the other grounds of review, such as relevancy and impropriety of purpose.
However, it is evident from his proposition that “if a decision on a competent matter is so unreasonable that no reasonable authority could ever come to it then the court can interfere,” that he envisaged a second meaning of unreasonableness, that is, as an independent substantive ground of review. He emphasised that to prove unreasonableness in this sense would require something overwhelming. It was intended only as a safety net to catch those decisions that were manifestly absurd but may escape review on any of the more specific grounds of attack. Hence as a substantive ground of review unreasonableness would have only very limited applicatio. From here unreasonableness has continued to develop as a
legitimate basis upon which to challenge an exercise of administrative discretion. In the fifty
years that have passed since its emergence there has been much debate, both academic and
judicial, over the definition and appropriate scope of unreasonableness as a ground of review.

1059 R v Central Birmingham Health Authority, ex parte Walker 3 BMLR 32 at 33. A copy of
this judgment is available at
http://www.lexis.com/research/retrieve/frames?_m=dc2b3a4af23b4b779afe1a7a4570017&
csrc=bl&cf=boo1&_fmtstr=XCITE&docnum=1&_startdoc=1&wchp=dGLbVtb-
zSkAB&_md5=d70a25cf8e837c2a70a12334f380d9ed

1060 Ibid

1061 A copy of the unreported judgment is available at
http://www.lexis.com/research/retrieve/frames?_m=dc2b3a4af23b4b779afe1a7a4570017&
csrc=bl&cf=boo1&_fmtstr=XCITE&docnum=1&_startdoc=1&wchp=dGLbVtb-
zSkAB&_md5=d70a25cf8e837c2a70a12334f380d9ed

1062 Also at [1993] Fam 15, a copy of the judgment is available at
http://www.lexis.com/research/retrieve/frames?_m=244086ce5f8f32e67d5cfb2348ed27b1&
csrc=bl&cf=boo1&_fmtstr=XCITE&docnum=1&_startdoc=1&wchp=dGLVzz-
zSkAk&_md5=e72aed940e8071ba4731c043af41a582

1063 Ibid at 519

1064 [1992] 3 WLR 507 at 517

1065 Mr Justice Wuite has ordered that the health authority “...were to cause such measures,
including artificial ventilation to be applied to J, for so long as they were capable of
prolonging his life”.

1066 In fact, the only human rights covered by the Human Rights Act 1998 are those that are
categorised as civil and political rights, thus one could argue, an indication in itself of the
perceived difficulty of enforcing those rights categorised as social, economic and cultural.

1067 A copy of this judgment is available at
http://www.butterworthsonline.com/lpBin20/lpext.dll?f=templates&fn=bwalmain-hit-
j.htm&2.0

1068 British ambulances with UNPROFOR, Vukovar, Croatia 7/92 (UN# 159206C
UN/DPI/S. Whitehouse) retrieved from http://www.un.org/UN50/Photos/90s.html on
29/04/04

1069 HSG (92) 50 issued by the NHS Management Executive to District Health Authorities,
captioned “Local Authority Contracts for Residential and Nursing Home Care: NHS
Aspects” as cited at p.856

1070 As cited at p.856.

1071 HSG (95) 8; Local Authority Circular LAC (95) 5 NHS Responsibilities for Meeting
Continuing Health Care Needs

1072 Op cit, para.13.


1074 Ibid para.18

1075 While the task of creating legislation is parliamentary, the courts have the responsibility
of interpreting legislation. Therefore, while parliament is the supreme source for creating
law, the courts have the responsibility of deciding the legal meaning of that legislation,
together with its application. This process of interpretation is known as 'statutory
interpretation' and primarily involves identifying and resolving ambiguities in the legislation.
To do this, the courts will consider such matters as the effect of a particular interpretation of
words as well as the legislative purpose underlying the legislation. In Australia, this process
is assisted by the provisions of the Acts Interpretation Act 1901 (Cth) and related State and
Territory Interpretation Acts. A useful reference for the processes of statutory interpretation
is Hall, K. Legislation (Australia: Butterworths, 2002).

1076 Ibid para.20

1077 S.3 provides :

"It is the Secretary of State’s duty to provide throughout England and Wales, to such extent
as he considers necessary to meet all reasonable requirements – (a) hospital accommodation;
(b) other accommodation for the purpose of any services provided under this Act; (c)
medical, dental, nursing and ambulance services; (d) such other facilities for the care of
expectant and nursing mothers and young children as he considers are appropriate as part of
the health service; (e) such facilities for the prevention of illness, the care of persons
suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service; (f) such other service as are required for the diagnosis and treatment of illness.”

Ibid., para 24


This is a reproduction of the section as amended.

Ibid, para.28

Ibid, para.117.


Ibid at para.5.

Op cit.

Ibid at para.8.

Ibid at para 31.

See Footnote No.241 for an explanation of this notion.

The phrases “...without consideration of relevant matters...consideration of irrelevant matters...” and the reference to the policy being unlawful because it “...futters the respondent's exercise of its discretion...” are specific references to grounds for judicial review of administrative action, as provided under Administrative Law. Under the principles of Administrative law, an administrator, in the exercise of a broad discretionary power, is required to exercise that power according to the principles of natural justice and procedural fairness. Specifically, an administrator is required, when making a determination, to take into account all those factors that are ‘relevant’, to avoid taking into account factors that are ‘irrelevant’ and, to avoid ‘self-fettering’ – that is, applying policy inflexibly or acting under the dictation of another person, Where it can be shown that a decision-making process has been affected by such matters, then the person affected by the decision of the administrator has the standing to bring an action to seek review of the decision and have it quashed, and the matter sent back to the administrator to reconsider. For a substantive discussion of these issues, the reader is referred to Aronson, M. & Dyer, B. Judicial Review of Administrative Action (2nd Ed.) (Sydney: LBC Information Services, 2000) Chap. 6.


Ibid, para.43

Map of Canada, showing all provinces. Retrieved from http://www.erahweb.net/canada.html on 28/04/04


139 D.L.R. (3d) 417

Ibid, p.442-3


It should be noted that this is a very abbreviated overview and its intention is purely to place the following discussion in some historical perspective.

The Western Province of Saskatchewan was one of the first to introduce such schemes, with the appointment of doctors in the rural municipality of Sarnia in 1915. According to Kotalik, this was the first time in Canada that any level of government had provided all its residents with access to clinical services, and paid them from tax income.

Forefathers of Canadian Confederation retrieved from http://www.solon.org/Constitutions/Canada/English on 28/04/04

Ibid.


Including responsibilities for ‘property and civil rights’ – s.92(13) and “generally all matters of a merely local of private nature in the province – s.92(16).
Gibson, op.cit.
Kotalik, op.cit.
http://www.arts.mcgill.ca/programs/misc/pages/feem_section4a.html retrieved 8/6/02
Canada Health Act, R.S.C. 1985
Roy, D.J., Williams, J.R. & Dickens, B.M. Bioethics in Canada (Scarborough, Ontario: Prentice-Hall, Canada, 1994) at p.95.
Ibid
Ibid at p.393-394
Ibid at p.396
Ibid the doctrine of ultra vires and is central to the principles of Administrative Law. In essence, the doctrine states that all public authorities must act within the powers given to them by Act of Parliament. If administrative action in excess of power granted under the relevant Act or a statutory power is exercised contrary to some legal principle, then judicial review may find that the relevant action is ultra vires and the party affected by the administrative decision may seek an appropriate remedy, such as certiorari – the quashing of the decision. See Wade, H.W.R Administrative Law (Oxford University Press: London, 1984) pp.3-20; 22-24; 31-44 for a more detailed discussion of the doctrine of ultra vires.
Mortantaler op.cit at p.397
Ibid at p.398.
Ibid at p.399
Ibid at p.408
Ibid at p.410
The Committee on the Operation of the Abortion Law was established by Orders-in-Council P.C. 1975-2305, -2306, and –2307 of September 29, 1975. Its terms of reference instructed it to “conduct a study to determine whether the procedure provided in the Criminal Code for obtaining therapeutic abortions is operating equitably across Canada.” The report found that there were serious problems with s.251, by virtue of the administrative and procedural requirements.
Ibid at p.412
Ibid at p.441
Ibid at p.441-442
Ibid at p.464
Ibid
Ibid
Ibid
Ibid at p.465
Ibid at p.465-66

Friesan, op cit at para.14 quoting Jackman at 7.

As previously discussed in the case study on the United Kingdom.


Ibid. para.3

Ibid.


Caulfield cites both Mortgentaler and Eldridge as well as Redhill v Ontario Health Insurance Plan (1990) 73 D.L.R. (4th) 457 and Alberta Medical Association v Minister of Hospitals and Medical Care (1987) 50 Alta L.R. (2d) 65


Op cit, para.58

Ibid, para.59


Ibid, para.28

Ibid, para.29

Note in Re Esquimous [1939] S.C.R. 104, the Supreme Court interpreted this section of the Constitution as including the Inuit people.

Indian Health Regulations, C.R.C., c.955 (1978)


Ibid


1971] 1 W.W.R. 756 (Sask.C.A.)

Ibid at 759-690 as cited in Jackman, op.cit.at para. 20


Ibid, p528

Ibid, p.751

Ibid, p.752

Ibid, p.753

1214 If your country has accepted paragraphs 9 and 10 of Article 7, there is no need to repeat the information given thereon.

1215 If you have answered Question E under paragraph 1 of this Article, it is not necessary to answer this question.

1216 If you answered Question A under paragraph 1 of this Article it is not necessary to answer this question.

1217 If you answered Question B under paragraph 1 of this Article, it is not necessary to answer this question.

1218 As a percentage if possible

1219 "If you have answered Question E under paragraph 1 of this Article, it is not necessary to answer this question."