

# THE RIGHT TO HEALTH IN RESPECT OF TERMINALLY ILL PERSONS IN SOUTH AFRICA

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“My notion of democracy is that under it the weakest should have the same opportunity as the strongest.” -Mahatma Gandhi (1869-1948)<sup>1</sup>

## 1. INTRODUCTION

It is probably true that ‘death is the great equalizer’ amongst human beings and that some of its ‘cousins: illness, dementia, physical debility, and advance age’<sup>2</sup> can ensure a journey marked by severe pain and suffering before we reach our ultimate fate. Yet, despite this reality most people choose not to think or talk about the issues that affect human beings during the period of life called dying, which is possibly the most vulnerable time in human existence. The limited discussions on end-of-life issues arguably exacerbate the vulnerability of those who are affected by terminal illnesses. This is unfortunate and particularly of concern in the South African context where there are indications that thousands of people are not enjoying good health and are in fact facing life-threatening or potentially life-threatening medical diagnoses.

The lack or inadequate engagement on end-of-life issues may be morally comprehensible as death and the issues related to it are not pleasant or popular subjects of discussion for many individuals. Legally, however, cognizance must be taken of the implications of not broaching and dealing with some of these issues. Though the ambit of this paper does not permit an exhaustive or extensive discussion on the myriad of legal issues relevant to persons who are terminally ill, the aim is to highlight the question of health care for such persons.

Health is indeed an important precondition for a dignified life. Much has thus been said and done to raise the profile of the most prevalent contemporary health issues, like maternal and infant health, HIV/AIDS infection, cancer and tuberculosis infection for example. Furthermore, the

<sup>1</sup> <http://www.parliamentarystrengthening.org/humanrightsmodule/2/2a.html> [Accessed 15 June 2012].

<sup>2</sup> Byock, I ‘Dying well in corrections: Why should we care’, 2002 *Journal of Correctional Health* 108.

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courts, Parliament as well as policy-makers have introduced a number of measures to give effect to the constitutional guarantee of health in South Africa. Notwithstanding the diverse nature of the health issues that have been highlighted and addressed in recent years, the question of what the right to health care means in respect of terminally ill South Africans has arguably not enjoyed the attention it deserves. The issue of what terminally ill persons can and cannot legally claim from the state insofar as their health is concerned consequently still looms.

As a result this paper is aimed at considering the meaning and scope of the right to health in respect of terminally ill South Africans. In this regard the right to health as understood in terms of international law as well as the constitutional and statutory framework of South Africa will be discussed. It will also be argued that terminally ill persons have a right to palliative care and may in certain instances be eligible to such care at the state's expense. This assertion is premised on a substantive equality approach to health care services and will also be discussed in greater detail later in this paper.

### **2. THE NEED TO HIGHLIGHT THE PLIGHT OF TERMINALLY ILL PERSONS**

The right to health of terminally ill persons may sound like an oxymoron, because most people who are diagnosed with terminal conditions or illnesses are not capable of regaining or improving their health. It is therefore important to discuss first the meaning of 'terminal illness' and thereafter to briefly sketch the position or plight of terminally ill persons in South Africa, before the right to health and its relevance to persons diagnosed with terminal illnesses can be considered.

#### **2.1 'Terminal illness'?**

There is currently no legal definition of 'terminal illness' in South Africa. McQuoid-Mason and Dada define 'terminal illness' as an illness or injury that will inevitably result in the death of the patient.<sup>3</sup> The South African Law Commission's proposed Draft Euthanasia Act, similarly defined 'terminal illness' as an illness or injury which in the opinion of at least two competent medical practitioners (a) will inevitably result in death and which is causing the patient severe suffering, or (b) is causing the patient to be in a persistent, irreversible, unconscious condition

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<sup>3</sup>D McQuoid-Mason, M Dada, *A-Z of Medical Law* (2011) 414.

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with the result that no meaningful existence is possible for the patient.<sup>4</sup> These definitions imply that a patient should be deemed terminally ill when he or she is diagnosed with a disease or condition or suffers from an injury that is not curable and is likely to cause his or her death. Such a disease or condition must also cause severe physical pain, discomfort and suffering and/or negate a person's prospects of leading a meaningful life.

From the definitions mentioned above it may also be inferred that a person who is terminally ill may require significant assistance on a daily basis. A terminally ill person's needs may range from assistance with basic functions such as maintaining hygiene standards, preparing and consuming appropriate nutrition to the administration of medication, emotional support, counseling and religious guidance. The question that this paper addresses therefore also involves the issue of palliative care which will be discussed in greater detail below. Next, however, a tentative attempt is made to strengthen the case for defining and giving effect to the right to health in respect of persons who suffer from terminal illnesses.

### **2.2 Why the focus on terminally ill persons?**

Most people are not able to foretell the conditions that will precede their demise. Discussions about terminal illnesses are therefore not a popular subject amongst the public. Despite the daunting and sensitive nature of contemplating the issues relevant to terminal illness, it is important to realize that if human beings are to:

“retain the self-consciousness and self-respect that is the greatest achievement of our species, [we] will let neither science nor nature simply take its course, but will struggle to express, in the laws [we] make as citizens and the choices [we] make as people, the best understanding [we] can reach of why human life is sacred, and of the proper place of freedom in its dominion.”<sup>5</sup>

Debatably the rationale for the inclusion of an unqualified right to life and dignity in our supreme Constitution may be substantially attributable to the recognition of the sanctity of human life. It furthermore impels the state to take cognizance of and to address issues affecting the quality of citizens' lives. In doing so, the state ought not to overlook the legal position of terminally ill

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<sup>4</sup> Draft Euthanasia Act section 1, in South African Law Commission *Euthanasia and the Artificial Preservation of Life* Working Paper 53, Project 86 (1994) 54.

<sup>5</sup> Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia* (1993) 241.

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persons who require support to maintain their dignity. This can arguably be achieved by defining the care, services and support that they are entitled to (or not) by virtue of their right to health. The starting point, however, is to gain insight into the extent to which the phenomenon of terminal illness affects the South Africa society.

It is globally estimated that of the 58 million people who die every year, 35 million will experience a prolonged, advance illness.<sup>6</sup> Unfortunately South Africa is not exempt from this reality. The impact of the HIV/AIDS pandemic and predictions by the Cancer Association of South Africa that ‘. . . within half a century, the number of annual cancer diagnoses in South Africa could soar from approximately 100 000 to half a million’<sup>7</sup> cannot be overlooked by the state. Moreover, the World Health Organisation (WHO) estimated that South Africa had 500 000 cases of active tuberculosis in 2011 and has stated that this is worldwide the third highest number of tuberculosis cases after India and China.<sup>8</sup> Additionally, out of the 500 000 tuberculosis cases, WHO estimates that 330 000 (66 per cent) of people are also HIV-positive.<sup>9</sup> Tuberculosis thus ‘continues to be the leading cause of death in South Africa’ with an estimated 25 000 deaths from tuberculosis in 2011.<sup>10</sup> This figure excludes persons who had both tuberculosis and HIV when they died as such persons are internationally considered to have died of HIV.<sup>11</sup>

Some may argue that illnesses like cancer, tuberculosis and HIV infection are not necessarily conditions that render patients terminally ill and that the state should thus focus resources on the curing and prevention of these illnesses. Whilst this sentiment is not objectionable and is thus not criticized here, it cannot be gainsaid that the aforementioned conditions can become incurable even in cases where curative and preventative health services had been provided to patients. The potential for terminal illnesses to develop is therefore real as may be indicative by the number of reported deaths mentioned above. Health care services should thus not be solely

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<sup>6</sup> Stjernsward, J Foley, K, Frank D, Ferris, M ‘The Public Health Strategy for Palliative Care’ (2007) *Journal of Pain and Symptom Management* 487.

<sup>7</sup> Caring the hospice way [http://www.health24.com/medical/Condition\\_centres/777-792-4394-4395,42398.asp](http://www.health24.com/medical/Condition_centres/777-792-4394-4395,42398.asp) [Accessed 7 August 2012]

<sup>8</sup> *TB Statistics for South Africa* [www.tbfacts.org/tb-statistics-south-africa.html](http://www.tbfacts.org/tb-statistics-south-africa.html) [Accessed 1 August 2013].

<sup>9</sup> *Ibid.*

<sup>10</sup> *Ibid.*

<sup>11</sup> *TB Statistics for South Africa* [www.tbfacts.org/tb-statistics-south-africa.html](http://www.tbfacts.org/tb-statistics-south-africa.html) [Accessed 1 August 2013].

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targeted at recovery and prevention, but must also afford care and treatment that are palliative in nature. As will be explained in greater detail later in this paper, a substantive equality approach must therefore be taken when it comes to fulfilling the right to health of a vulnerable group such as terminally ill persons.

In summation, it appears that there are sound reasons why the plight of terminally ill persons and specifically their right to health must be considered and prioritized by the state. The sanctity of human life finds expression in and commands concretization of the absolute rights to life and dignity in the South African Constitution. This entails that laws must take cognizance of and give effect to the enhancement of the quality of citizens' lives. Those who are terminally ill cannot be excluded in this regard. Their exclusion ought not to be permitted particularly in the light of the prevalence of life-threatening illnesses that human beings are afflicted by in contemporary times. These illnesses render a substantial proportion of the population vulnerable to the pain and suffering. Without any state intervention many of the affected individuals will die having experienced degradation despite the constitutional guarantee of dignity.

### **3. THE RIGHT TO HEALTH OF PERSONS WHO ARE TERMINALLY ILL**

Terminally ill persons' need for palliative care may be more evident than an obligation on the state to fulfill it. It is therefore important to understand what the right to health generally means and whether there is any legal basis for a claim to specific support by terminally ill persons. Below the international and domestic legal framework underpinning the right to health is briefly discussed. Arguments that an international human right to palliative care exists and that South Africa should adopt a substantive equality approach to health by endorsing the right to palliative care as part of the right to health care are also made.

#### **3.1 The meaning of the right to health**

The legal meaning of the right to health is not self-evident. Mubangizi and Twinomugisha state that there is no conflict between the terms 'right to health' and the 'right to health care' provided it is understood that the 'right to health' is not possibly intended to guarantee a person's good health, but rather [that it is used] as a more convenient shorthand to cover detailed language and

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references that are found in international treaties.’<sup>12</sup> They further state that the right to health care can be defined as ‘the prevention, treatment and management of illness and the preservation of mental and physical well-being through services by the . . . health professions.’<sup>13</sup>

Based on this understanding of the right to health it emerges that there is an acceptance that human beings require an array of services and care insofar as their health is concerned. Inevitably the degree and type of care required differ from one individual to another and may also change over time for an individual as our health is not infallible or unchangeable. Importantly, it seems that a person’s actual health status is not an obstacle to his position as a bearer of the right to health. It may therefore be inferred that the right to health literally applies to everyone including terminally ill persons. Logically thus it may be argued tentatively that the right to health must include ‘palliative care’ as WHO describes it as ‘an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness.’<sup>14</sup> Before this assertion can be bolstered it is necessary to consider a comprehensive definition of palliative care.

Palliative care includes total care: physical; psychosocial; and spiritual.<sup>15</sup> ‘[T]he essence of palliative care is the relief of pain.’<sup>16</sup> Palliative care aims to: (a) recognise the importance of life, but regards dying as a normal process; (b) provide relief from pain and other distressing symptoms; (c) integrate the psychological and spiritual aspects of patient care; (d) help patients live as actively as possible until death; and (e) to assist the family to cope during the patient’s illness and their subsequent bereavement when the patient dies;<sup>17</sup> (f) neither hasten or postpone death; (g) use a team approach to address the needs of patients and their families.<sup>18</sup> The WHO adds to this that palliative care is applicable early in the course of the illness, ‘in conjunction

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<sup>12</sup> Mubangizi, J., Twinomugisha, B., ‘The right to health care in the specific context of access to HIV/AIDS medicines: What can South Africa and Uganda learn from each other?’ (20120) *African Human Rights law Journal* 109.

<sup>13</sup> *Ibid.*

<sup>14</sup> WHO Definition of palliative care <http://www.who.int/cancer/palliative/definition/en/> [Accessed 1 September 2013].

<sup>15</sup> *Legal Aspects of Palliative Care* at 2 <http://www.osf.org.za/Publications/default.asp?PubCatID=34> [Accessed on 8 August 2011].

<sup>16</sup> *Ibid.*

<sup>17</sup> McQuoid-Mason, D., Dada, M., *A –Z of Medical Law* (2011) 312.

<sup>18</sup> World Health Organization (WHO) Definition of Palliative Care <http://www.who.int/cancer/palliative/defintion/en/> [Accessed on 8 August 2011].

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with other therapies that are intended to prolong life, such as chemotherapy or radiotherapy, and includes those investigations needed to better understand and manage distressing clinical complications.<sup>19</sup> This form of care takes cognisance of the fact that ‘dying is more than a set of medical problems to be solved. Dying is personal; it is experiential. Caring for people who are dying involves helping them to say and do the things that matter most *to them*.’<sup>20</sup>

### 3.1.1 International law

The description of the right to health and the WHO’s definition of palliative care is perhaps not inconsistent with a contention that terminally ill persons may have a legitimate claim for such care from the state; Given that palliative care entails more than medical care it must also be emphasized that other rights like the right to social security, food, accommodation and importantly, the right to dignity, indirectly supports the claim for palliative care.<sup>21</sup> To further assist in cementing such a contention, the right to health in international law will be discussed next. Though there is no express right to palliative care in terms of international law, there appears to be a growing recognition of such an international human right.<sup>22</sup> Brennan for example contends that the ‘right to palliative care’ can be implied from the overall human right to health.<sup>23</sup> Indications of the possible existence of such a right are thus highlighted below.

#### *The World Health Organization (WHO)*

Historically states did not automatically accept the obligation to ensure the well-being of people.<sup>24</sup> The right to the highest attainable standard of health was therefore only articulated in the Constitution of the World Health Organization (WHO) in 1946 for the first time.<sup>25</sup> As pointed out earlier, the right to health does not obligate states to guarantee every citizen’s good

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<sup>19</sup> *Ibid.*

<sup>20</sup> Byock 2002 *Journal of Correctional Health* 110.

<sup>21</sup> Albertus, C ‘Palliative care for terminally ill inmates: Does the state have a legal obligation’ *SACJ* 2012 (1), 78.

<sup>22</sup> See the Cape Town Declaration (2002), The Korean Declaration (2005) and the Budapest Commitment (2007).

<sup>23</sup> F Brennan ‘Palliative care as an international human right’ (2007) *Journal of Pain and Symptom Management* 495.

<sup>24</sup> See Loughlin, K, and Berridge, V, *Global Health Governance: Historical Dimensions of Global Governance* Discussion Paper 2, March 2002, Department of Health and Development, World Health Organization, Centre on Global Change and Health London School of Hygiene and Tropical Medicine at 26 where it is stated that ‘. . . historically speaking the state, as such, was a relative latecomer in terms of providing for the health needs of its domestic population.’

<sup>25</sup> See Riedel, E, ‘The Human Right to Health: Conceptual Foundations in Realizing the Right to Health’ ed Clapham, A., Robinson, M, Publisher Rüffer & Rub 2009 Switzerland 21.

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health as such an obligation may prove to be impossible to meet, particularly in respect of individuals who suffer from life-threatening diseases. Despite this a suggestion that this right does not apply to terminally ill persons cannot be accepted. A more reasonable understanding of the right may be that every person is entitled to support that would ensure his or her optimum health taking into consideration his actual physical and/or biological conditions. Put plainly, in respect of a terminally ill person the state should consider, taking into consideration the actual medical prognosis of the individual, how the person can be assisted to ensure that suffering is minimized and optimal comfort is enjoyed. Advocates for palliative care would argue that palliative measures are often the best way of ensuring such comfort to the patient.

More pertinent to the existence of a right to palliative care is the fact that at least fourteen palliative care medications are on the WHO Essential Drug List.<sup>26</sup> Significantly, as will be explained later, access to these drugs has been described as part of the core minimum content of the right to health. This strengthens the assertion of an emerging right to palliative care. If access to the very drugs which often forms a primary part of palliative care is to be deemed part of the right to health itself then it is reasonable to assume that at least the basis for the emergence of a right to palliative care has begun to unfold.

### *Universal Declaration of Human Rights (UDHR)*

In December 1948 the United Nations General Assembly adopted the Universal Declaration of Human Rights (UDHR). The UDHR provided in article 25(1) that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services.' Arguably this formulation promotes the holistic approach which palliative care affords patients.<sup>27</sup> There appears to be an appreciation of the fact that for many 'health and well-being' is closely linked to the living and health conditions of the individual and his or her family.

Furthermore, though this section of the paper addresses the right to health it is relevant to consider article 5 of the UDHR which prohibits cruel, inhuman and degrading treatment. This

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<sup>26</sup>Gwyther L and Cohen J *Legal Aspects of Palliative Care* (2009) 9.

<sup>27</sup> Albertus, C 'Palliative care for terminally ill inmates: Does the state have a legal obligation' *SACJ* 2012 (1), 78.



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right may also be indicative of the existence of a right to palliative care as the withholding of such care, particularly in cases where terminally ill persons suffer from severe physical pain could potentially be regarded as a violation of article 5.

### *International Covenant on Economic, Social and Cultural Rights (ICESCR)*

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) affords to ‘everyone the right to the highest attainable standard of physical and mental health.’ In the International Covenant on Economic, Social and Cultural Rights’ (CESCR) Committee General Comment No. 14, the right to health is described as being ‘closely related to and dependent upon the realization of other human rights’.<sup>28</sup> The rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, freedom of association, assembly and movement are furthermore integral components of the right to health, according to the General Comment. The right extends beyond health care and includes a wide range of socio-economic factors which promote conditions in which people can at least lead a dignified life.

General Comment No. 14 also outlines the different dimensions of the right to health. It distinguishes between a ‘freedom’ and an ‘entitlement’ dimension. The former relates to the right to have control over one’s own health and body. It includes *inter alia*, the right to be free from torture and not the subjected to non-consensual medical experimentation or treatment. ‘Entitlement’ includes the right to a system of health protection which provides equal opportunity for people to enjoy the highest attainable level of health. It covers *inter alia* the right to emergency medical services, the right to the underlying determinants of health, such as adequate sanitation, safe and potable water, adequate food and shelter and a healthy environment. These underlying health determinants must be met as without it the right cannot be properly protected.<sup>29</sup>

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<sup>28</sup> Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14 on the right to the highest attainable standard of health*, 11 August 2000, UN Doc. E/C.12/2000/4 at para 3.

<sup>29</sup> Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14 on the right to the highest attainable standard of health*, 11 August 2000, UN Doc. E/C.12/2000/4 at para 8.

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More relevant to the claim of the existence of an international right to palliative care, is that the CESCR has confirmed that access to essential drugs (as mentioned earlier fourteen of these drugs are palliative care medications), as defined by the WHO Action Programme on drugs, is part of the minimum core content of the right to health. The CESCR has observed that a State party ‘... cannot ... justify its non-compliance with the core obligations ... which are non-derogable’.<sup>30</sup> In General Comment No 14 it is asserted that State parties must respect the right to health by refraining from denying or limiting equal access for all persons, to preventative, curative and palliative health services. This denotes that the aforementioned services are all of equal importance.

It must also be added here that the United Nations Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment reported that the *de facto* denial of access to pain relief, ‘if it causes severe pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment.’<sup>31</sup> He recommended that ‘all measures should be taken to ensure full access and to overcome regulatory, educational and attitudinal obstacles to ensure full access to palliative care.’<sup>32</sup> Based on this recommendation as well as the earlier discussions on access to palliative care medication it seems that a claim for palliative care medication cannot be easily rejected even if arguments for the existence of a right to palliative care are initially not supported.

The right to health, as interpreted by the CESCR contains four essential and interrelated elements, namely, Availability, accessibility, acceptability and quality (The AAAQs).<sup>33</sup> It is argued here that if all these elements are present the provision of palliative care can be accommodated by states without much difficulty. These elements will be discussed below.

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<sup>30</sup> Lohman D, Schleifer, R, Amon J ‘Access to pain treatment as a human right’ (2010) *BCM Medicine* 6.

<sup>31</sup> M Nowak ‘Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, including the right to development’ A/HRC/10/44, 14 January 2009 at para 72.

<sup>32</sup> M Nowak ‘Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, including the right to development’ A/HRC/10/44, 14 January 2009 at para 74.

<sup>33</sup> Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14 on the right to the highest attainable standard of health*, 11 August 2000, UN Doc. E/C.12/2000/4 at para 12 a-d. See also Office of the United Nations Commissioner for Human Rights, World Health Organization ‘The Right to Health’ *Fact Sheet No. 31*, 3-4.

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### 1. *Availability*

For the right to health to be fulfilled state parties must ensure that adequate health facilities, goods and services are available. The nature of the facilities, goods, services and programmes will depend on *inter alia* the state party's level of development. The underlying determinants of health must be included, however. 'Availability' can also be defined as the 'measurement of the degree to which the health provider can meet the patient's need with resources such as personnel and technology'.<sup>34</sup> In South Africa, terminally ill persons will not have their needs met unless sufficient facilities, trained care-givers and appropriate medication are made available to provide palliative care to them.

### 2. *Accessibility*

Health facilities, goods and services must be accessible to everyone within the jurisdiction of the state party without discrimination. The 'accessibility' element of the right to health has four overlapping elements. These elements are:

- a) Non-discrimination: Health facilities, goods and services must be accessible to all without discrimination. The most vulnerable and marginalised persons, in law and fact, must not be discriminated against. This is debatably important when it comes to persons who are terminally ill. In practice they may be treated differently or deemed ineligible to benefit from certain resources due to the fact that they have life-threatening conditions.
- b) Physical accessibility: Health facilities, good and services must be within safe reach of everyone including minorities and the most vulnerable groups in society. Both medical services and the underlying determinants of health must be accessible to everyone. Persons with disabilities must for example have access to buildings. Transport time to health facilities and the time waiting for such transport are also relevant to the question of accessibility.<sup>35</sup> In South Africa it has been found that the distance to health care facilities has a significant impact on health outcomes; 'Geographic accessibility to health care facilities is likely to be a crucial determinant in the take-up of and adherence to anti-retroviral drugs for HIV therapy.'<sup>36</sup> Indications are that where the travel time to a health facility exceeds one hour the utilisation of such facilities tend to decline rapidly. There are currently no standards or guidelines for the distance to health care facilities in South Africa. Arguably, vulnerable groups such as persons who are terminally ill may be gravely affected by excessive geographical distances between themselves and health facilities.

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<sup>34</sup> Butler, M, Plaks, 'Access to public healthcare in South Africa' 2012 *South African Actuarial Journal* 131.

<sup>35</sup> Butler, M, Plaks, 'Access to public healthcare in South Africa' *South African Actuarial Journal* 2012 (12) at 130

<sup>36</sup> Butler, Plaks, 2012 *South African Actuarial Journal* 134.

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- c) Economic accessibility (affordability): Health facilities, goods and services must be affordable to everyone including socially disadvantaged groups. 'Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.'
- d) Information accessibility: This includes the right to seek, receive and impart information and ideas about health. Personal health data should be treated confidentially though.

### 3. *Acceptability*

Health facilities, goods and services must be respectful of medical ethics and sensitive to cultural diversity as well as to gender and life-cycle requirements. 'Acceptability' also relates whether the patient is content with certain features of the health provider, such as the provider's race, gender, age and culture.<sup>37</sup> In turn the service provider must also be 'comfortable with such characteristics of the patient as well as with the patient's method of payment.'<sup>38</sup>

### 4. *Quality*

Health facilities, good and services must be medically and scientifically appropriate and of good quality.

The instruments discussed above are some of the main sources of international law which contain the right to health. These are, however, not the only international instruments that recognize the right to health. The right to health has been firmly established in more international, regional and domestic instruments, which are equally important as the ones discussed above.<sup>39</sup> The scope of this paper, however, does not permit a detailed discussion of all the instruments. Some of these instruments will thus be briefly mentioned below in order to provide a more comprehensive idea of the extent to which the right has been acknowledged in international law.

Articles 57 and 62 of the United Nations Charter refer to 'health' as one of the fields of responsibility of the Economic and Social Council (ECOSOC). Article 5(e)(iv) of the

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<sup>37</sup> Butler, M, Plaks, 'Access to public healthcare in South Africa' *South African Actuarial Journal* 2012 (12) at 131.

<sup>38</sup> *Ibid.*

<sup>39</sup> See Riedel, E, *The Human Right to Health: Conceptual Foundations in Realizing the Right to Health* ed Clapham, A., Robinson, M, Publisher Rüffer & Rub 2009 Switzerland at 22.

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International Convention on the Elimination of All Forms of Racial Discrimination of 1956 and articles 11.1 and 12 of the Convention on the Elimination of All Forms of Discrimination Against Women of 1979 recognises the right to health. Many regional instruments also explicitly recognise the right to health. Examples of such instruments include: European Social Charter of 1961; the African Charter on Human and Peoples' Rights of 1981; the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988.

In addition to the recognition of the right to health in international and regional instruments some of the Millennium Development Goals (MDGs) under the UN Millennium Declaration of 8 December 2000, relate to health.<sup>40</sup> MDGs 4, 5 and 6 respectively are aimed at: reducing child mortality; improving maternal health; and combatting HIV/AIDS, malaria and other diseases. It is also significant that target 17 of MDG 8, to develop global partnership for development, calls for cooperation with pharmaceutical companies in order to provide access to affordable essential drugs in developing countries.<sup>41</sup>

The preceding discussions demonstrate that the acceptance and recognition of the right to health in international law creates awareness and an obligation for states to meet citizens' health needs. Though there is no express right to palliative care there appears to be a realization that people's health needs are diverse and that actual needs ought to be given consideration to in designing responses aimed at fulfilling health rights. To some extent cognizance has been taken of the plight of those who are terminally ill. More needs, however, to be done to effectively uphold their rights to health and dignity. The explicit acceptance of a right to palliative care can arguably improve the experience of everyone affected by terminal illnesses.

Below the right to health in South African law is briefly discussed with a view to determining the current legal position of terminally ill persons. Importantly, it is also argued that express recognition should be given to the right to palliative care at the domestic level.

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<sup>40</sup> Millennium Project *What are they* <http://www.unmillenniumproject.org/goals/index.htm> [Accessed 3 July 2013].

<sup>41</sup> *Ibid.*

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### 3.1.2 Constitution

The provision of palliative care is not currently regulated by law in South Africa.<sup>42</sup> The state's duty to offer palliative care to terminally ill persons can, however, debatably be inferred from the right to have access to health care.<sup>43</sup> Section 27(1)(a) of the Constitution requires that the state introduce reasonable legislative and other measures to ensure the progressive realization of the right to have access to health care. Importantly 'reasonable realization' must also occur within the state's available resources. Historically, 'resources' have always been said to be limited in South Africa. Thus, in the *Soobramooney* case where the terminally ill, applicant required expensive renal dialysis treatment to prolong his life and relied on the right to emergency medical treatment in section 27, the Constitutional Court considered the limited resources available to state hospitals.

*In casu* the Court held that the state's plan for providing the requested treatment to patients was not unreasonable to the extent that only persons whose condition could be remedied were eligible for such treatment. Patients who requested the treatment solely to extend their lifespan and whose condition had already deteriorated to the extent that it could not be remedied were thus not suitable candidates for such treatment. The Court held that to give them access would in all likelihood have ruined the state's carefully designed plan.

Though the applicant in *Soobramooney* was terminally ill, the case ought not to be seen as authority on the issue of the provision of palliative care by the state. The claim for palliative care does not involve a similar financial burden on the state as that of expensive renal dialysis treatment. The aim of palliative care is also not to prolong the life of a terminally ill person, but rather to ensure that his or dignity is respected as far as possible. The Court held that there will be times when the needs of the populace must be prioritized over those of an individual. Considering the vast number of persons who had been and are currently affected by life-threatening health problems, it may be reasonably contended that government policies are needed to introduce and expand on programmes aimed at the provision of palliative care. The need for palliative care can after all not be labeled as an 'individual's' needs only.

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<sup>42</sup> D McQuoid-Mason & M Dada *A-Z Medical Law* (2011) 312.

<sup>43</sup> Albertus 2012 *SACJ* 74.

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The lack of a national law and/or policy which specifically addresses palliative care and other health related needs of terminally ill persons may be regarded as discriminatory.<sup>44</sup> It appears to prioritise curative and preventative health services. Whilst such services are warranted, the omission of or limited focus on palliative services is cause for concern. It appears to create the impression that the right to health applies only to those who are healthy or capable of attaining improved health.

Some may argue that terminally ill persons have equal access to the same health services as persons who are not terminally ill and that the former are thus not discriminated against. It must be recognised though that ‘sameness’ of treatment does not ensure true (or substantive) equality.<sup>45</sup> As Dworkin puts it ‘we must take care not to use [the constitutional equality clause] to cheat ourselves of equality.’<sup>46</sup> Thus ‘. . . realising equal access to health care for disadvantaged groups in society requires that health care institutions must take into consideration the peculiar circumstances of these groups. In essence a substantive equality approach in health care services is imperative to meeting the special needs of vulnerable and marginalised groups’<sup>47</sup> like those who are terminally ill.

‘Equality or lack of it affects the capacity of one to enjoy many other rights [including the right to health].’<sup>48</sup> Similarly, the Committee on Economic, Social and Cultural Rights has held that the enjoyment of the right to health is dependent on other rights such as rights to life, privacy, dignity and non-discrimination.<sup>49</sup> The Committee has also expressed the view that the International Covenant on Economic, Social and Cultural Rights (ICESCR) prohibits discrimination<sup>50</sup> in accessing health care and the underlying determinants of health on grounds of

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<sup>44</sup> The Health Care Act 61 of 2003 does not make any reference to the specific provision of palliative care. It has also been noted that the National Health Insurance has a strong focus on ‘health promotion and prevention services’. Palliative care seems not to be a priority. See Matsoso M & Fryatt R ‘National Health Insurance: The first 18 months’ *South African Medical Journal* 103 (3) 2013 at 1.

<sup>45</sup> Dworkin R *Taking rights seriously* (1978 ) 209.

<sup>46</sup> *Ibid.*

<sup>47</sup> Durojaye E ‘Realising Equality in access to HIV treatment for vulnerable and marginalised groups in Africa’ (2012) 15 *Potchefstroom Electronic Law Journal* 218.

<sup>48</sup> See *Legal Resource Foundation v Zambia* 2001 AHRLP 84 (ACHPR).

<sup>49</sup> Committee on ESCR *General Comment 14* para 12.

<sup>50</sup> Committee on ESCR *General Comment 14* para 18.

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*inter alia* health status. Though South Africa has only signed, but not ratified this instrument<sup>51</sup>, it seems that the principle regarding equality in accessing health care has been endorsed. This can be inferred from the Constitutional Court's judgment in *Minister of Health v Treatment Action Campaign and Others* where it held that a government policy which fails to address the needs of those who were in dire need of antiretroviral therapy is unreasonable and gives a rise to government being in breach of its duty to realise the right to health of its citizens.<sup>52</sup> The same principle should also be applied to persons diagnosed with terminal diseases. If government continues to neglect the duty to provide palliative care to persons who are desperately ill and facing death, then such an omission is unreasonable.

### 4. CONCLUSION

It must be realised that '[i]nitiatives to improve the health of a country's citizens are ineffective if they do not reach those in greatest need . . . .'<sup>53</sup> Though great strides have been made in South Africa to give effect to health needs that can be addressed through curative and preventative measures a substantial number of citizens require palliative care. The fact that states already have an obligation in terms of international law to ensure that there is access to palliative care drugs and that there are concrete indications of the emergence of the right to palliative care provides the basis and motivation for such care to be given greater priority by the South African state. Policy-makers and legislators must also address barriers to access to the health system as increased expenditure by itself does not necessarily enhance access.<sup>54</sup> It ought also to be remembered that '[a]t the end of life, we are far more alike than different from one another [and] that [h]ow we care for others may well determine how we are cared for ourselves.'<sup>55</sup> Though infirmity and death are some of the least popular subjects for ordinary people, it is the reality for thousands of others.

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<sup>51</sup> Despite the failure to ratify South Africa has an obligation in terms of the Vienna Convention on the Law of Treaties 1969 not to defeat the object of any treaty that it (South Africa) is signatory to.

<sup>52</sup> 2002 10 BCLR 1033 (CC).

<sup>53</sup> Butler, M, Plaks, 2012 *South African Actuarial Journal* 130.

<sup>54</sup> *Ibid.*

<sup>55</sup> Byock 2002 *Journal of Correctional Health* 110.