

**‘DON’T SEND YOUR SICK HERE TO BE TREATED, OUR OWN PEOPLE
NEED IT MORE’: IMMIGRANTS’ ACCESS TO HEALTHCARE IN SOUTH
AFRICA**

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Introduction

In 2000, journalist Khadjia Magardie from the South African newspaper *Mail & Guardian* reported that a South African nurse chased an Angolan refugee seeking immunization of her child away from a Mpumalanga clinic, shouting that “‘she, a foreigner, was eating South African medicines.’”¹ Medicine and medical care are scarce resources and fourteen years later, in the *IOL news*, journalist Zelda Venter reported that a 27 year-old Ethiopian man was refused dialysis at the Helen Joseph Hospital in Johannesburg and died soon after because as non-South African citizen, he did not qualify for an organ transplant. This story, unfortunately, is not unique. The on-line version attracted posts echoing the same sentiments that the nurse expressed a generation earlier. One person commented: ‘Ethiopian president should take note of this. Don’t send your sick here to be treated, our own people need it more.’ Another person posted: ‘So now we must treat the whole damn world for free????’² Although these articles are fourteen years apart, they highlight the ongoing tension between native South Africans and foreign nationals regarding access to healthcare. The 1996 South African Constitution, Section 27, states that ‘everyone has the right to have access to health care services,’³ yet there is a dearth of information on how refugees, migrants and other non-citizens exercise this right to healthcare in South Africa. (The term refugee refers to someone lawfully present in South Africa who is fleeing political or social persecution in his/her home country. The South African nomenclature is, however, to call most migrants ‘refugees’ whether they have achieved this status or not. People seeking refugee status apply for asylum seeker permits that can be renewed varies times before an actual status determination is made by the Department of Home Affairs.) How South Africans negotiate their socio-economic rights, and access to healthcare in particular, in the post-apartheid era has been adjudicated in the courts resulting in precedents such as giving mothers and new-born children with HIV free anti-retroviral medications.⁴ As

¹ K Magardie *Mail & Guardian* (25 September 2000).

<http://www.queensu.ca/samp/sampresources/migrationdocuments/commentaries/2000/foreigner.htm> (Accessed 17 January 2015).

² Z Venter ‘Refugee dies before court challenge,’ *IOL news* (25 November 2014)

<http://www.iol.co.za/news/crime-courts/refugee-dies-before-court-challenge-1.1785858#.VH4HM9YVcUU> (Accessed 17 January 2015).

³ *The Constitution of the Republic of South Africa* 12th Edition (Updated March 13, 2013) 14.

⁴ *Minister of Health v Treatment Action Campaign* (2) 2002 (5) SA 721 (CC). The case involved government policy and the right to access healthcare. The use of the anti-retroviral drug Nevirapine (which could prevent mother-to-child transmission of the HIV virus) was limited to a number of

the legal establishment has pushed for the implementation of universal access to healthcare, foreign nationals, estimated at between 1.6 and 2 million people in 2010,⁵ have largely been sidelined.

That socio-economic rights have not been systematically applied to foreigners does not seem particularly surprising in the global climate of xenophobia; but South Africa's progressive Constitution which enshrines socio-economic rights makes the interaction between foreign nationals and native-born citizens significant with regard to public health and progressive realisation. This minor dissertation argues that there is more than a disjuncture between theory and practices, particularly for refugees and migrants and doctors in South Africa. The core idea of the Bill of Rights is that socio-economic rights are for *everyone*. Yet, its application suggests everyone means all citizens in the post-apartheid period, rather than all residents in South Africa. In the international domain, the human rights discourse calls on states to recognise responsibility extending to all peoples residing in a sovereign nation-state; but progressive realisation can hamper this aspiration. By employing progressive realisation within South African law, the idea that the state pays for what it can and makes future efforts to change, socio-economic rights for everyone currently cannot be achieved. This dissertation examines how Constitutional Court rulings on access to healthcare and relevant statutes have not been uniformly granted to everyone causing a disjuncture between law and practice. Moreover, the Department of Home Affairs' management of asylum seekers, refugees, and cross-border migrants through its 89 per cent rejection rate of asylum seekers leaves thousands without legal status. This has inadvertently empowered hospital administrators to decide who is legal and worthy of limited resources and who, for practical purposes, has access to healthcare. This creates an untenable situation for doctors who seek to honor their Hippocratic Oath while trying to obey South African law and international norms as they confront patients of uncertain, undocumented and/or liminal status.

research and training sites. The Courts ordered that Nevirapine be made available to infected mothers giving birth in state institutions and that the government present to the court an outline of how it planned to extend provision of the medication to its birthing facilities, country-wide.

⁵ T Polzer 'Population Movements in and to South Africa' *Migration Fact Sheet 1* (Forced Migration Studies Programme, June 2010) 3, https://www.academia.edu/296416/Migration_Fact_Sheet_1_Population_Movements_in_and_to_South_Africa (Accessed 17 January 2015).

In 2008, headlines in the global press described violent acts of xenophobia in South Africa, particularly in the Provinces of Gauteng and of the Western Cape. In the Cape Town area alone, an estimated 20,000 non-nationals were internally displaced by xenophobic violence.⁶ The anti-foreign sentiment reportedly often stems from poor South Africans who—disenfranchised by economic circumstances—unleash their frustrations on Zimbabweans, Somalis, Malawians and other African migrants. This caused the death of 63 foreigners in 2008.⁷ Why? How could this happen in South Africa with one of the most progressive and inclusive of constitutions on socio-economic rights?

Although the South African Constitution was conceived for everyone in the sovereign territory of South Africa, the law, it seems is primarily for its citizens because of limited resources. The Courts aim to bring dignity to all the marginalised and create equality, but have mixed results in adjudicating cases involving socio-economic rights because of an incompatible economic system (and subsequent difficulty in resource allocation).

Chapter I entitled, ‘Can Everyone Access Health and Emergency Care in South Africa?’, examines healthcare as a human right in international doctrines and in South African law. The Constitution combined with the Refugees Act 130 of 1998, the Immigration Act 13 of 2002, the National Health Act of 1998, and Immigration Regulations 2014 provide the legal framework from which refugees, asylum seekers, immigrants try to navigate their healthcare options. The Constitutional Court cases of *Soobramoney*, the *Treatment Action Campaign*, and *Khosa* are examined for their interpretations of the Bill of Rights and how questions of resource availability permeate much of the Court’s discourse, particularly regarding access to healthcare. The analysis follows from Cardinal Francis Spellman’s observation that access to healthcare for refugees and migrants provides a pillar of world peace and to some extent domestic peace. This chapter anchors the evaluation in Chapter 2 of how international and domestic laws governing access to healthcare are applied in Cape Town, in the Western Cape Province in South Africa.

⁶ J Cohen ‘Chapter 3: Security and the Constitution: Xenophobia. Whose rights? Whose safety?’ in K Bentley, L Nathan & R Calland (eds) *Falls the Shadow: Between the promise and the reality of the South African Constitution* (2013) 63.

⁷ IRIN Africa (19 October 2012) <http://www.irinnews.org/report/96589/south-africa-foreigners-still-at-risk> (Accessed 18 January 2015).

Chapter 2, entitled “‘Foreigners are eating South African medicines’”: Divergence between Law and Healthcare,’ investigates how asylum seekers, refugees, and cross-border migrants access emergency and healthcare. Chapter 2 delivers a view of the law from its implementation at the level of everyday practice. It aims to pair legal analysis to the practical terrain of who can access healthcare, how, where, and on what basis. The chapter begins with an overview of how the Department of Home Affairs determines the status of refugees and asylum seekers, and how these processes impact healthcare providers. This overview is followed by a demographic sketch of asylum seekers in Cape Town, and the effect of the closing of the Refugee Reception Office to new asylum seekers. The chapter illustrates the divergence between law and healthcare with two cases of an asylum seeker and an undocumented person, each being denied care by a hospital administrator at a tertiary hospital, and each dying. The chapter concludes with a description of how civil society organisations (CSOs) have come forward to advocate for refugees and immigrant communities in Cape Town to illustrate how the aspirations of socio-economic rights to everyone is failing the marginalised cross-border migrants.

The concluding chapter argues that legal authority has been misplaced onto hospital administrators who are not authorised to decide people’s legal standing. In the South African context, these hospital administrators violate human dignity for refugees, asylum seekers and immigrants. In the process of hospital administrators determining patients’ status, doctors are largely unclear about whom they can treat and to what degree, and patients are not getting the healthcare that they are entitled to receive. In turn, doctors go to CSOs for clarification on the law and how they can help their patients. Through their cooperation, these doctors and CSOs are advocating that ‘civil society...influence social policy and hold government accountable through social and economic rights litigation.’⁸ Although no litigation is pending on refugee and migrant access to health and emergency care, this circumstance speaks more to the resources necessary to litigate than the need to advocate for change. This minor dissertation suggests that the National Health Act of 1998 be amended to include migrants as a vulnerable group and empower doctors and nurses in South Africa to treat their patients regardless of their legal status.

To conduct research in support of this dissertation, the author spoke to people

⁸ LA Williams ‘The Role of Courts in the Quantitative-Implementation of Social and Economic Rights: A Comparative Study’ (2010) 3 *Constitutional Court Review* 144.

in their professional capacities on an informal basis – no conversations were recorded in compliance with UCT Standards for Ethical Research. No human subjects data were recorded with privately identifiable information. In an effort to better understand the demographic profile of refugees and asylum seekers in Cape Town, the author asked the UCT Law School Research Ethics Committee for (and complied with) an exemption from full ethics review to examine the UCT Refugee Rights Unit’s database. Attorney Justin De Jager deleted the column with names so as to create a de-identified dataset.⁹ These data inform the analysis presented in Chapter 2.

⁹ Email correspondence 20 May 2014 with Dr. Shane Godfrey, REC Chair, on file with author.

Chapter 1: Can Everyone Access to Health and Emergency Care in South Africa?

ABSTRACT

This chapter asks who can access health and emergency care in South Africa as a legal right. With attention to immigrants, it argues refugee law and immigration law should not be read in isolation of each other. To evaluate the adjudication of socio-economic rights in South Africa, and the right of access to health and emergency care in particular, this chapter begins with how international doctrines shape such rights. It then turns to an illustrative set of Constitutional Court cases. Three cases are analysed— *Soobramoney*, *the Treatment Action Campaign*, and *Khosa* – to evaluate how access to healthcare rights and the treatment of foreign nationals were handled with respect to upholding the spirit of the South African Bill of Rights. International refugee law and South African constitutional law shed light on the difficulties of resource allocation and state obligations. The difficulty of resource allocation has been exacerbated by legislation that seemingly contradicts the constitutional right; thereby giving healthcare providers unclear guidance on whether and how they can treat patients and under what circumstances.

I INTRODUCTION

In 1945, then Archbishop of New York (and later Cardinal) Francis Spellman, stated that ‘medicine is one of the pillars of peace.’¹⁰ The following year the 1946 Constitution of the World Health Organization adopted Spellman’s notion and included the right to healthcare as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’¹¹ The right to healthcare covers a range of health-related issues; the right to healthcare may be considered part of the more general right to health.¹² The 1948 Universal Declaration of Human Rights, however, did not explicitly address the right to health. Rather Article 25(1) of the Declaration states, ‘everyone has the right to a standard of living adequate for the health and well-being of himself and of his family.’¹³ Not until 1966, nearly 20 years later, did the United Nations’ International Covenant on Economic, Social and Cultural Rights (ICESCR) incorporate Article 12 that recognizes the right

¹⁰ The World Health Organization Constitution was implemented in 1948 by the members of the United Nations. <http://www.who.int/about/history/en/> (Accessed 18 January 2015).

¹¹ Constitution of the World Health Organization (July 1946) <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1> (Accessed 18 January 2015).

¹² This is paraphrasing Brigit C.A. Toebes’ discussion in *The Right to Health as a Human Right in International Law* (1999) 19. She also notes that ‘the historically evolved notion that health cannot be improved solely by the provision of health care services, governments should protect and promote peoples’ health,’ 16.

¹³ AM Gross ‘The Right to Health in an Era of Privatisation and Globalisation: National and International Perspectives’ in D Barak-Erez and AM Gross (eds) *Exploring Social Rights: Between Theory and Practice* (2007) 293.

to health and mandates that all peoples receive health services and medical care in the event of illness. Brigit Toebes suggests that ‘disagreements on the content and implementation’ caused the delay.¹⁴ For refugee rights and access to healthcare internationally, the ICESCR, the Convention on Elimination of all Forms of Discrimination, the UN Convention on the Rights of the Child, and the African Charter on Human and Peoples’ Rights frame the issues and challenges. In South Africa, the Constitution follows much of the international norms.

Historians have suggested various reasons as to the drafting of human rights in the twentieth century and the apparent delay in articulating the right to healthcare.¹⁵ G. Daniel Cohen challenges the Holocaust as an explanatory factor in human rights, suggesting that in 1945 the first international evocation of human rights was still a few weeks from the final liberation of Europe, and the full details of Nazi horrors had not been revealed.¹⁶ Perhaps most importantly, the nexus between human rights and healthcare has evolved over the last two centuries with roots in preventive care and disease control, and with xenophobic beliefs that foreigners are often inscribed with disease.¹⁷

The notion that foreigners and refugees are carriers of disease who can infect native populations is not an uncommon diatribe, and becomes manifest in xenophobic violence. With South Africa hosting an estimated 1.6 and 2 million foreign nationals in 2010,¹⁸ native-born South Africans have become sensitized to the increasing population of foreigners. An estimated 20,000 non-nationals were displaced in the Cape Town area alone by xenophobic violence in 2008.¹⁹ The presence of so many foreign nationals calls attention to human rights and the right to access healthcare in particular.

¹⁴ Toebes (1999) 40-41.

¹⁵ See A Iriye, P Goedde, and WH Hitchcock (eds) *The Human Rights Revolution: An International History* (2012).

¹⁶ GD Cohen ‘The Holocaust and the “Human Rights Revolution”: A Reassessment’ in A Iriye, P Goedde, and WH Hitchcock (eds) *The Human Rights Revolution: An International History* (2012) 56.

¹⁷ AM Kraut *Silent Travelers: Germs, Genes, and the ‘Immigrant Menace’* Reprint (1995).

¹⁸ T Polzer ‘Population Movements in and to South Africa’ *Migration Fact Sheet 1* (Forced Migration Studies Programme, June 2010), 3, https://www.academia.edu/296416/Migration_Fact_Sheet_1_Population_Movements_in_and_to_South_Africa (Accessed 18 January 2015).

¹⁹ J Cohen ‘Chapter 3: Security and the Constitution: Xenophobia. Whose rights? Whose safety?’ In K Bentley, L Nathan & R Calland (eds) *Falls the Shadow: Between the promise and the reality of the South African Constitution*, (2013) 63.

As James Hathaway examines refugees in South Africa, he notes that, ‘many refugees are finding a vast chasm between theory and practice....’²⁰ This chapter examines how international law has shaped South African law, yet legal norms appear inconsistent in application of the law. Although the right to health and emergency care has been incorporated in various international doctrines, whether and how the right is practiced in each nation-state with regard to foreign nationals and refugee populations varies. In the specific case of South Africa, the Refugee Act 130 of 1998 and the National Health Act 61 of 2003, and Section 27 of the Constitution guarantees ‘everyone the right to access to healthcare services,’²¹ yet there is a dearth of information about how legislation and regulation that is relevant to how access to healthcare is granted or not to refugees and migrants in South Africa. For clarity, asylum seekers and refugees are defined as peoples fleeing persecution from their home country. Foreign nationals and migrants (referring to cross border, not internal migrants) are those who have chosen to migrate to South Africa for other reasons.

In this context of vulnerable people seeking access to healthcare, refugee law and immigration law should not be read in isolation of each other. To evaluate the adjudication of socio-economic rights in South Africa and the right of access to healthcare, this chapter begins with how international doctrines shape such rights, and then turns to an illustrative set of Constitutional Court cases. In examining lower court rulings on refugees and migrants,²² the cases tended to focus on the Department of Home Affairs’ inefficiencies and failures to provide documentation in a timely way (often under Section 33 of the Constitution).²³ Three cases are therefore analysed—*Soobramoney*, *the Treatment Action Campaign*, and *Khosa* – to evaluate how access to healthcare and foreign nationals are treated in the application of the South African Bill of Rights. How international refugee law and South African constitutional law have been interpreted regarding access to health and emergency

²⁰ J Hathaway *The Rights of Refugees under International Law* (2005) 509, n1077.

²¹ *The Constitution of the Republic of South Africa*. 12th Edition (Updated March 13, 2013) 14

²² In particular, case law searches in the South African Legal Information Institute (SAFLII) yielded some hits under ‘refugee access health’ and ‘migrants health access.’ The cases generally relate only to infractions of administrative law.

²³ Just administrative action (1) Everyone has the right to administrative action that is lawful, reasonable and procedurally fair. (2) Everyone whose rights have been adversely affected by administrative action has the right to be given written reasons. (3) National legislation must be enacted to give effect to these rights, and must—(a) provide for the review of administrative action by a court or, where appropriate, an independent and impartial tribunal; (b) impose a duty on the state to give effect to the rights in subsections (1) and (2); and (c) promote an efficient administration. *Constitution of RSA* 17.

care sheds light on the difficulties of resource allocation and state obligations. The challenge of resource allocation has been further complicated by inconsistent legislation giving healthcare providers unclear guidance on how they can treat and under what circumstances. How does a state such as South Africa honor its international duties on refugee rights and simultaneously provide for everyone?

II REFUGEE HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW²⁴

Refugee rights derive from the status of persons as refugees. According to the 1951 United Nations Convention Relating to the Status of Refugees, a refugee is someone who ‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country.’²⁵ If these conditions are met, refugees can invoke rights to the basic entitlements of a host country. As James Hathaway states, ‘refugee rights remain, however, inchoate until and unless the refugee comes under the de jure or de facto jurisdiction of a state to the Convention.’²⁶

Although there are many international doctrines that help to inform those working with refugees and public health, there is a lack of practical detail; in law, states are only obligated to provide a service or benefit if the law directs state attention to do so. The United Nations Convention of 1951 states in Article 5 that ‘nothing in this Convention shall be deemed to impair any rights and benefits granted by a Contracting State to refugees apart from this Convention.’²⁷ This suggests that the 1951 UN Convention is essentially silent on the right to healthcare. In examining UNHCR Handbook, it is also suspiciously quiet with regard to the right to healthcare. One UNHCR policy paper states, ‘the public health role of UNHCR is more complex

²⁴ For a thorough discussion on the ICESCR and its benefit-focus, see Marius Pieterse, ‘A Benefit-Focused Analysis of Constitutional Health Rights’ (PhD diss, University of Witwatersrand, December 2005) 25-48. Pieterse cautions, ‘the right to health may be understood as mandating at least the existence of a health system, an overarching legislative and policy framework facilitating health protection and promotion, as well as a national health strategy and plan of action,’ 29-30 n22.

²⁵ See Chapter 1, Article 1 <http://www.unhcr.org/3b66c2aa10.html> (Accessed 28 May 2014).

²⁶ Hathaway (2005) 278.

²⁷ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/StatusOfRefugees.aspx> (Accessed 3 June 2014).

and less well defined in non-camp settings.²⁸ Complexity and a lack of definition seem unlikely to support efficacy. The Organization of African Unity (OAU) Convention of 1969 also and similarly lacks a provision that explicitly addresses access to healthcare.²⁹

Why is access to healthcare absent in these international instruments? The absence could be explained by the difficulty of trying to motivate states to implement domestic laws regarding resource allocation (especially among refugees dispersed throughout a host country, as in South Africa, versus those located in a centralised refugee camp). The UN Convention and the OAU Convention focus primarily on status determination of refugees, rather than defining refugee entitlements in host countries. Another explanation could be cultural norms and the concept of ‘third generation rights.’ As Danwood Chirwa writes (about the African Charter), ‘third generation rights are the newest set of rights to be recognized by the international community. They include the right of all people to freely dispose of their wealth and natural resources (Article 21)...also described as “solidarity rights.”’³⁰ These rights, as Danwood Chirwa describes, come from a demand by the Third World countries for global redistribution of power, wealth, and other important standards. Yet, the Charter has received criticism for this approach, especially for its weak enforcement and lack of specificity in content.³¹ Among international doctrines, then, four emerge as particularly instructive to those working with refugees and public health.

²⁸ ‘Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas,’ UNHCR (March 2008) <http://www.unhcr.org/4e26c9c69.html> (Accessed 18 January 2015).

²⁹ http://www.au.int/en/sites/default/files/OAU_Charter_1963_0.pdf (Accessed 4 June 2014) Also see <http://www.unhcr.org/45dc1a682.html> enforcement in 1974 (Accessed 4 June 2014).

³⁰ Danwood Mzikenge Chirwa ‘Toward Revitalizing Economic, Social and Cultural Rights in Africa: Social and Economic Rights Action Centre and the Center for Economic and Social Rights v. Nigeria’ (Fall 2002) *Human Rights Brief* 10, 14: 15.

³¹ Chirwa (2002) 15.

Table 1.1: International Laws regarding Access to Healthcare

International Covenant on Economic, Social & Cultural Rights (Article 12)	Convention on Elimination of all Forms of Discrimination (Art 5)
UN Convention on the Rights of the Child (Article 24)	African Charter on Human and Peoples' Rights (Article 16)

The notion that health is a socio-economic right became recognised in Article 55 of the United Nations Charter which states, ‘...the United Nations shall promote (b) solutions of international economic, social, health, and related problems...’³² The idea was that health is of ‘all peoples’ and should be embodied in the Constitution of the World Health Organization.³³ The most influential doctrine is the United Nations’ International Covenant on Economic, Social, and Cultural Rights (ICESCR) of 1966 Article 12 which states:

- (1) The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- (2) (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.³⁴

Although South Africa signed the Covenant in 1994, it has yet to be ratified. Approximately 130 other states have already ratified the Covenant. According to Danwood Chirwa, of the 44 African countries that have ratified it, only four are up to

³² <http://www.yale.edu/lawweb/avalon/un/unchart.htm#art55> (Accessed 28 May 2014).

³³ ‘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.’
http://www.who.int/governance/eb/who_constitution_en.pdf (Accessed 28 May 2014).

³⁴ *International Covenant on Economic, Social, and Cultural Rights* (Article 12)(adopted 16 December 1966 and goes into force 3 January 1976.
<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx> (Accessed 28 May 2014).

date on their reporting.³⁵ Once it becomes ratified in South Africa, the Covenant will be binding and likely affect the continued development of socio-economic rights jurisprudence.³⁶ The enforcement of the Covenant lies with the UN Committee on Economic, Social and Cultural Rights, which was established in 1987 to monitor the compliance of states and their obligations under the Covenant.³⁷³⁸ The role of UN Committee and its reports have been used for guidance in the Constitutional Court because South Africa is one of a few countries to incorporate a list of directly enforceable socio-economic rights into its Constitution.³⁹

The UN Committee on Economic, Social and Cultural Rights states, ‘health is a fundamental right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.’⁴⁰ The Committee continues to recognize the limitation in providing such services, and states: ‘The committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.’⁴¹ Under ‘General Legal obligations’ paragraphs 30-31, General Comments No. 14 (2000) state,

while the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect....progressive realization means that States parties have a specific and

³⁵ Danwood Chirwa ‘An Overview of the Impact of the International Covenant of the Economic, Social and Cultural Rights in Africa’ (1976) http://www.communitylawcentre.org.za/projects/socio-economic-rights/Research%20and%20Publications/research/Socio-Economic%20Rights%20International%20and%20comparative%20law/Socio-economic_rights_in_Africa.pdf, 11.

³⁶ Ian Currie & Johan de Waal *The Bill of Rights Handbook* 6th Ed (2014) 570.

³⁷ Currie & de Waal (2014). ‘The Committee consists of eighteen independent experts, elected by the Economic and Social Council of the UN for four-year terms. The Committee does not have adjudicative functions. Its principal activities are the adoption of “General Comments” on the content of the ICESCR and the examination of reports submitted by state parties. Since 1991, the Committee has been drafting a draft optional protocol to the ICESCR intended to permit communications (complaints) by individuals or groups alleging violations of their economic, social and cultural rights,’ 571 n35.

³⁸ UN Committee on Economic, Social and Cultural Rights, ‘General Comment No. 14: The right to the highest attainable standard of health.’ (2000) http://www.nesri.org/sites/default/files/Right_to_health_Comment_14.pdf para 9. Hathaway 511-512, n1094.

³⁹ Currie & de Waal (2014), 571 n37.

⁴⁰ UN Committee on Economic, Social and Cultural Rights (CESCR), ‘General Comment No. 14: The right to the highest attainable standard of health.’ (2000)

http://www.nesri.org/sites/default/files/Right_to_health_Comment_14.pdf para 1.

⁴¹ CESCR ‘General Comment No. 14’ (2000) para 5.

continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12.⁴²

In bridging health rights and economic constraints, the General Comment No. 14 asserts, ‘the right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfill*.’⁴³ States parties are offered guidance on how to implement these obligations, and are encouraged to seek international cooperation and to look to the Alma-Ata Declaration.⁴⁴ Although paragraphs 46-52 mention violations of the obligations, the General Comment does not indicate the level of recourse available to those who suffer in these circumstances.⁴⁵ Danwood Chirwa adds that ‘the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (Maastricht Guidelines) stipulate that a state party violates the minimum essential level of the right to health if a significant number of its people are deprived of ‘essential primary health care.’⁴⁶

Another critical international instrument is the African Charter on Human and Peoples’ Right (Article 16). It states that, ‘every individual shall have the right to enjoy the best attainable state of physical and mental health...[and] State Parties to 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.’⁴⁷ Chirwa indicates that the African Charter gives direct entitlements to individuals or groups rather than to the states. Accordingly, the ICESCR emphasizes rights in the framework of economic, social, and cultural rights ‘as ideals to be attained depending on the availability of resources, as opposed to civil and political rights, which are deemed to be precise and immediately claimable.’⁴⁸ In examining the

⁴² CESCR ‘General Comment No. 14’ (2000) paras 30-31.

⁴³ CESCR ‘General Comment No. 14’ (2000) para 33.

⁴⁴ Alma-Ata Declaration (1978) http://www.who.int/publications/almaata_declaration_en.pdf (Accessed 18 January 2015). The International Conference on Primary Health Care in September 1978 states that health ‘...is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.’

⁴⁵ For a full discussion of implementation ICESCR reporting procedures, see Chapter III and Annex 2 Reporting Guidelines, Toebes (1999) 367-371.

⁴⁶ Danwood Mzikenge Chirwa ‘The Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine’ (2003) *South African Journal on Human Rights* 19: 549.

⁴⁷ <http://www.achpr.org/instruments/achpr/#a16> (Accessed 18 January 2015).

⁴⁸ Danwood Mzikenge Chirwa ‘Toward Revitalizing Economic, Social and Cultural Rights in Africa: Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v. Nigeria’ (Fall 2002) *Human Rights Brief* 10, 14: 15.

applicability of the African Charter as international law, Currie and de Waal call it a ‘soft law’ instrument.⁴⁹ In short, the African Commission and UN legal instruments provide interpretations of socio-economic rights to healthcare, but with little teeth for enforcement.

There are several other international doctrines relating to access to healthcare. For instance, the European Social Charter (Article 11) guarantees the right to protection of health.⁵⁰ The Convention on Elimination of all Forms of Discrimination (Article 5[e]iv) calls for the ‘right to public health, medical care, social security, and social services.’⁵¹ The UN Convention on the Rights of the Child, Article 24 states:

- (1) State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services...
- (4) State Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.⁵²

The spirit of trying to accommodate socio-economic rights in developing countries is reiterated throughout these doctrines with regard to progressive realisation.

Hathaway asserts, ‘the affirmative element of the right to health is by and large subject to the usual duty of progressive implementation.’⁵³

When analysed in light of South African socio-economic rights, these international instruments tend to define access to healthcare as a negative right—‘there is a negative obligation not to interfere with someone who is doing something that they have a constitutional right to do.’⁵⁴ However, access to healthcare also implies a positive obligation because socio-economic rights ‘are subject to progressive realisation... Paradoxical as it sounds, there is also a positive aspect to negative enforcement; not only is the state prohibited from interfering in people’s attempts to exercise their socio-economic rights, but is also has a duty to take steps to protect against interference by private individuals.’⁵⁵ At the center of the issue is how to provide healthcare in societies where socio-economic rights for citizens are

⁴⁹ Currie & de Waal (2014) 573.

⁵⁰ <http://conventions.coe.int/Treaty/en/Treaties/Html/163.htm> (Accessed 10 May 2014).

⁵¹ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx> (Accessed 10 May 2014).

⁵² <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx> (Accessed 10 May 2014).

⁵³ Hathaway (2005) 511.

⁵⁴ Currie & de Waal (2014) 568.

⁵⁵ Currie & de Waal (2014) 569.

difficult, progressive realisation, the notion that a right is acknowledged and the state parties are making progress to realize such a right.⁵⁶

In determining how international law can be applied, Section 39 (1c) of the South African Constitution⁵⁷ asserts that a court may consider foreign law, and must consider international law (1b) in interpreting legislation. From an international perspective and according to the UN Committee, ‘a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations [to provide healthcare] which are non-derogable.’⁵⁸ As James Hathaway opines, ‘even states with insufficient resources must nonetheless give priority to the realization of the right to health without discrimination of any kind.’⁵⁹ In developing socio-economic rights in the Bill of Rights, Sandra Liebenberg (as one of the advisors to the constitutional assembly) notes the reliance on the United Nations’ International Covenant on Economic, Social, and Cultural Rights (ICESCR) of 1966.⁶⁰ The spirit of trying to accommodate socio-economic rights in light of the constraints of developing countries is reiterated in international doctrines and South African law with regard to progressive realisation.

III SOUTH AFRICAN CONSTITUTION

III.I HISTORICAL CONTEXT, ‘EVERYONE’, AND A TRANSFORMATIVE PURPOSE

The legal-historical context in South Africa is inextricably linked to black people being denied citizenship and being forcibly removed to areas designated as bantustans (homelands).⁶¹ Blacks were required to carry passes showing their permission to work and reside in urban areas.⁶² ‘In terms of policy of apartheid, all black South Africans were allocated the citizenship of an ethnic homeland (irrespective of whether they lived in the area assigned to that ethnic homeland), and

⁵⁶ See Currie & de Waal (2014) 580 for a thorough discussion of progressive realisation.

⁵⁷ *Glenister v President of the Republic of South Africa and Others* 2011 (3) SA 347 (CC) para 106.

⁵⁸ UN Committee on Economic, Social and Cultural Rights, ‘General Comment No. 14: The right to the highest attainable standard of health.’ (2000)

http://www.nesri.org/sites/default/files/Right_to_health_Comment_14.pdf paragraph 47.

⁵⁹ Hathaway (2005) 512 n1096.

⁶⁰ Liebenberg notes ‘the Court has adopted a flexible approach to the sources that may be referred to during the process of interpreting the Bill of Rights [with respect to the use of international law],’ (2010) 103, 106.

⁶¹ Bantu Self-Government Act, Act 46 of 1959.

⁶² Hoosen Coovadia, Rachel Jewkes, Peter Barron, David Sanders, Diance McIntyre, ‘Health in South Africa 1: The health and health system of South Africa: historical roots in current public health challenges,’ www.thelancet.com (Published online 25 August 2009): 3.

were eventually to lose their South African citizenship once that homeland was granted full independence.⁶³ Not only was the stripping of citizenship unjust, but the homelands themselves were not economically viable. Therefore, the Restoration of South African Citizenship Act 73 of 1986 was passed to restore South African citizenship to some previously denied. Restoration was based on birth, descent, registration or naturalisation. Scholars reflected in 1989 that the 1986 statute was, ‘...possibly indicating an intention on the part of the government to create a single citizenship for all South Africans at some stage in the future.’⁶⁴

The prediction of a single citizenship for all South Africans was realised in 1994 in the drafting of the Interim Constitution and, later, the 1996 Constitution. In certifying the final Constitution, the Constitutional Court noted that the Bill of Rights states: ‘**everyone [author’s emphasis]** shall enjoy the universally accepted fundamental rights and civil liberties, which shall be provided for and protected by entrenched and justiciable provisions in the Constitution...’⁶⁵ The Constitutional Court also explained that the drafters of the Constitution, ‘...were avowedly determined...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 their fundamental rights and freedoms.’⁶⁶ As the idea of ‘everyone’ is described, it appears the initial intent was for South African residents of all races to be entitled to socio-economic rights, not necessarily foreign nationals.

It is also important to note that the term citizenship is used sparingly in the 1996 Constitution —Section 19 on political rights and Section 20 on citizenship explicitly. Throughout the Bill of Rights and large parts of the Constitution, the term ‘everyone’ is used to describe the rights enshrined to those residing in South Africa. And this stems from the institutionalisation of racism. Judge Mahomed in *Makwanyane* wrote: ‘The past was redolent with statutes which assaulted the human

⁶³ Laurence Boule, Bede Harris and Cora Hoexter *Constitutional and Administrative Law: Basic Principles* (1989) 232.

⁶⁴ Boule, Harris, and Hoexter (1989) 237.

⁶⁵ *Certification of the Constitution of the Republic of South Africa* 1996 (10) BCLR 1253 (CC) para 48.

⁶⁶ *Certification of the Constitution of the Republic of South Africa* 1996 (10) BCLR 1253 (CC) para 48, n45.

dignity of person on the grounds of race and colour alone...and the Constitution expresses in its preamble the need for a ‘new order...’⁶⁷

This new order includes socio-economic rights for everyone, such as the right to access health and emergency care. Article 27 (1) (a) states: ‘*everyone* has the right to have access to health care services...2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights; 3) No one may be refused emergency medical treatment.’⁶⁸ Emphasis on ‘everyone’ in the above quote raises the question of whether the original framers of the Constitution meant to include foreign nationals to have such socio-economic rights. The ‘Constitutional Assembly, Constitutional Committee Sub-Committee Draft Bill of Rights, Volume One: Explanatory Memoranda (entire document embargoed until 9 October 1995),’ states that, ‘what is ‘reasonable’ will be judged against the capacity and available resources of the state.’ Under Section 20 on Health, the Draft Bill of Rights reads, s(1)(a) ‘everyone has the right to health care which the state must take responsible and progressive measures to improve and make accessible to all; [and] (2) ‘any measures taken by the state in terms of s(1)(a) must include, at least necessary medical attention for anyone without adequate resources.’⁶⁹ Again, the key provision links the availability of resources to providing access to healthcare to everyone.

Below the section on health, there is the section entitled ‘social assistance, food, and water,’ and this section notes that ‘everyone’ refers to those ‘...unable to support themselves and their dependents has the right to receive reasonable and appropriate social assistance from the state.’⁷⁰ It can be inferred that the intent of the Constitution was indeed to provide everyone (including refugees, asylum seekers, and migrants) some access to health and emergency care; however, the provision of access to health and emergency care would need to be evaluated in relation to the

⁶⁷ *S. v. Makwanyane* 1995 (3) SA 391 (CC) para 65. Bilchitz (2013) 49 n23.

⁶⁸ *The Constitution of the Republic of South Africa*. 12th Edition (Updated March 13, 2013) 14

⁶⁹ Professor Halton Cheadle shared with the author his original copy of ‘Constitutional Assembly, Constitutional Committee Sub-Committee Draft Bill of Rights, Volume One: Explanatory Memoranda (entire document embargoed until 9 October 1995),’ 156. (Meeting with author 30 April 2014).

⁷⁰ *Ibid.*

available resources of the state.⁷¹ Moreover, the access to healthcare could be adjudicated under the limitations clause (Section 36).

The South African Constitution of 1996 has been described as a transformative document that aims to heal the past wounds of apartheid with an attempt to create more socio-economic equality.⁷² The framers of the Constitution leaned on ideals of democracy and the value of dignity to move this transformation of the country forward. As Judge Dennis M. Davis at the Cape Town High Court, South Africa wrote in 2007,

South Africa's Constitution has been described as a transformative document, one that embraces a long-term vision for the transformation of the country's political and economic institutions and the structures of power. In this regard, the instrument represents essential pillars in the construction of a democratic and egalitarian society.⁷³

Building on this notion of the transformative power of the constitution, Karl E. Klare states that transformative constitutionalism implies a 'long-term project of constitutional enactment, interpretation, and enforcement committed ... to transforming a country's political and social institutions and power relationships in a democratic, participatory, and egalitarian direction.'⁷⁴ Klare continues to deconstruct the thinking behind transformative constitutionalism to suggest that, 'it is not a neutral concept, but is frankly intended to carry a positive valence to connote a social good.'⁷⁵ The notion that socio-economic rights 'oblige the state to do as much as it

⁷¹ Ibid.

⁷² Although this essay does not address democracy directly, it assumes as Political Scientist Philippe Schmitter argues, that democracies can be reformed in accordance with 'two enduring core principles: the sovereign equality of citizens and the political accountability of rulers.' Philippe Schmitter, 'The Future of "real-existing" Democracy' (no date), 15.

<http://www.eui.eu/Documents/DepartmentsCentres/SPS/Profiles/Schmitter/FutureOfDemocracy.pdf> (Accessed 18 January 2015)

⁷³ DM Davis 'Socio-Economic Rights: The Promise and Limitation: The South African Experience' in Daphne Barak-Erez and Aeyal M. Gross (eds) *Exploring Social Rights: Between Theory and Practice* (2007) 195 n5. K Klare 'Legal Culture and Transformative Constitutionalism' (1998) *South African Journal on Human Rights* 14: 146.

⁷⁴ KE Klare 'Legal and Culture and Transformative Constitutionalism' *South African Journal on Human Rights* (1998) 14: 150, 146.

⁷⁵ Klare (1998) 150. Karl Klare notes that South African legal culture is inherently conservative thereby jeopardizing the Constitution's 'transformative aspirations,' 151. For a more in-depth discussion on the transformative power of the South African Constitution, see the following: D Moseneke 'Transformative Adjudication' (2002) *South African Journal on Human Rights*, 18, 309; N Ngcobo 'South Africa's Transformative Constitution: Towards and Appropriate Doctrine of Separation of Powers' (2011) *Stellenbosch Law Review* 1; Pius Langa 'Transformative Constitutionalism' (2006) *Stellenbosch Law Review* 17,3, where it is argued that the transformative constitution is about reconciliation and healing the wounds of the past, 358, 352; Geoff Budlender

can to secure for all members of society a basic set of social goods—education, health care, food, water, shelter, access to land and housing⁷⁶ clearly aims to create equality; however, South African society suffers from insufficient resources to allocate to everyone, in particular access to healthcare.

III.II SOCIO-ECONOMIC RIGHTS

The balancing between the judicial, legislative and executive branches of government to create a sustainable democracy that can ultimately serve a transformative purpose in South Africa has been challenged by ‘weakened jurisprudence.’ Bilchitz contends, ‘the approach to content in the Constitutional Court of South Africa show a failure to achieve greater specification of the progressive ideals in a Constitution can jeopardize their realisation and meaningfulness for the poor and vulnerable.’⁷⁷ This balance limits what the Constitutional Courts can do. This, in turn, limits who can meaningfully exercise rights of access to health and emergency care. Iain Currie and Johan de Waal describe that the two strains against judicial enforcement and socio-economic rights are ‘the separation of power problem and the problem of polycentricity (that is, the co-ordination of mutually interacting variables).’⁷⁸ This polycentricity can be accommodated through the reasonableness review. Sandra Liebenberg argues that the ‘reasonableness review is capable of accommodating a broad range of challenges to the design and implementation of the State’s socio-economic programmes. It promotes dialogic engagement on the content and purposes of socio-economic rights which accords the deliberative aspects of South Africa’s constitutional democracy.’⁷⁹

The historical context of the implementation of the 1996 Constitution explains the underlying tension of the adjudication of socio-economic rights. In 1992, A Charter for Social Justice was circulated that proposed the inclusion of socio-economic rights in the Bill of Rights in the form of directives of state policy (versus inclusion of socio-economic rights as directly justifiable rights in the Bill of Rights) warning that it ‘would force the courts to dictate on budgetary questions to the executive and legislative branches. In addition, it argued that socio-economic rights

‘People’s Power and the Courts: Bram Fischer Memorial Lecture, 2011’

http://www.casac.org.za/?wpfb_dl=1 (Accessed 18 January 2015).

⁷⁶ Ian Currie & Johan De Waal *The Bill of Rights Handbook* 6th Ed (2014) 564.

⁷⁷ D Bilchitz (2013) 74.

⁷⁸ I Currie & J De Waal (2014) 565-566.

⁷⁹ S Liebenberg *Socio-Economic Rights: Adjudication under a transformative constitution* (2010) 223.

entailed polycentric questions which courts were institutionally ill-suited to determine.⁸⁰ Departing from the Charter for Social Justice, Davis ‘focused more on the politics of adjudicating socio-economic claims rather than on the institutional competence of the judiciary to enforce these rights...[finding that] entrusting the enforcement of socio-economic right to an unelected, unaccountable judiciary would give the judiciary too much power and erode both representative and participatory democracy.’⁸¹ The idea that directly justifiable right would ‘undermine, rather than facilitate the project of democratic transformation.’⁸² Davis has commented, ‘since the introduction of the South African Constitution in 1996, tensions have arisen between its transformative vision and the macro-economic policy adopted by the South African government in which economic growth has been preferred over social reconstruction as the key policy objective.’⁸³

This history places the adjudication of socio-economic rights in a social and historical context,⁸⁴ and illuminates how the Constitutional Court has not consistently used its judicial power to contribute to the transformation of South African society as designed by the Constitutional drafters. Dennis Davis points out that, ‘the record of adjudicating these rights over the first decade since the advent of democracy in South Africa reveals both a judicial and academic retreat into administrative law and the occasional, mechanistic application of international law.’⁸⁵ Linda Stewart also criticizes the Constitutional Court for its reluctance ‘to provide normative clarity on specific socio-economic rights.’⁸⁶ Although she argues that the South African Constitution and its academic discourse support the positive adjudication of socio-economic rights, she pushes the courts to consider academic recommendations.⁸⁷

⁸⁰ S Liebenberg (2010) 12 n72-73. H. Corder, S. Kahanovitz, J Murphy, C Murry, C O’Rega, J Sarkin, H Smith and N Steyter *A Charter for Social Justice: A Contribution to the South African Bill of Rights Debate* (1992).

⁸¹ S Liebenberg (2010), 13. D Davis states, ‘it elevates judges to the role of social engineers, concentrates power at the centre of the state and consequently erodes the influence of civil society,’ D Davis ‘The case against the inclusion of socio-economic demands in a Bill of Rights except as directive principles,’ (1992) *South African Journal on Human Rights* 8: 486.

⁸² S Liebenberg (2010) 13.

⁸³ D Davis (2007) 202.

⁸⁴ See Hugh Corder on the role and importance of the socio-historical context in South Africa and its nexus to healthcare. H Corder ‘Judicial Activism of a Special Type: South Africa’s Top Courts Since 1994,’ in B. Dickson (ed) *Judicial Activism in Common Law Supreme Court* (2008) 343.

⁸⁵ DM Davis ‘Adjudicating the Socio-Economic Rights in the South African Constitution: Towards ‘Deference Lite’?’ (2006) *South African Journal on Human Rights* 22: 304.

⁸⁶ Linda Stewart ‘Adjudicating Socio-Economic Rights Under a Transformative Constitution’ (2010) *Penn State International Law Review* 28: 490 n17.

⁸⁷ L Stewart (2010) 488, 490.

Lucy Williams in this same vein notes that, ‘scholars have spent hundreds of hours debating the pros and cons of various standards of review, but most of the general formulation – “reasonableness,” “rationality,” “least restrictive means,” “proportionality,” “strict scrutiny” – are too vague and indeterminate to predictably constrain judicial decision making.’⁸⁸ The point is acutely relevant to the right of access to health and emergency care because of the stark difference between admission and denial at health facilities, and the life and death consequences that potentially result. Williams argues that the separation of powers doctrine is too abstract, and it raises the issue about how ‘civil society may influence social policy and hold government accountable through social and economic rights litigation.’⁸⁹

As David Bilchitz describes, ‘constitutions straddle the boundary between the ideal and the real. As the foundational text of a society, they give us an indication of the values that lie at a society’s heart.’⁹⁰ He adds that the ‘distribution of resources [is often] at the heart of constitutional enterprise.’⁹¹ To evaluate the adjudication of socio-economic rights in South Africa, the chapter now turns to the Constitutional Court – *Soobramoney*, *the Treatment Action Campaign*, and *Khosa*. The cases illustrate how the availability of resources is relevant to reasonableness – ‘...socio-economic rights are internally qualified by the availability of resources.’⁹² With respect to resources, ‘minimum core obligations’ (that is the ‘minimum essential levels’ of the rights of food, health, housing and education)⁹³ are also examined in ‘how different socio-economic needs should be prioritized and ranked.’⁹⁴

⁸⁸ LA Williams ‘The Role of Courts in the Quantitative-Implementation of Social and Economic Rights: A Comparative Study’ (2010) *Constitutional Court Review* 3: 142.

⁸⁹ LA Williams (2010) 144.

⁹⁰ David Bilchitz ‘Constitutionalism, the Global South, and Economic Justice,’ in Daniel Bonilla Maldonado (ed) *Constitutionalism of the Global South: The Activist Tribunals of India, South Africa, and Colombia* (2013) 41.

⁹¹ *Ibid.*

⁹² Nick Ferreira ‘Feasibility Constraints and the South African Bill of Rights: Fulfilling the Constitution’s Promise in Conditions of Scarce Resources’ (2012) *The South African Law Journal* 129: 292. He writes, ‘the availability of resources is therefore always relevant to reasonableness,’ 279.

⁹³ Katharine G. Young ‘The Minimum Core of Economic and Social Rights: A Concept in Search of Content’ (2008) *The Yale Journal of International Law* 33: 113.

⁹⁴ S Liebenberg (2010) 167.

IV A CONSIDERATION OF CASES⁹⁵ RELATING TO ACCESS TO HEALTHCARE AND FOREIGN NATIONALS

Building on international doctrines and the South African Constitution, three cases—*Soobramoney*, *the Treatment Action Campaign*, and *Khosa*—best illustrate the various interpretations of the Bill of Rights and how resource availability permeates much of the Court’s discourse, particularly regarding access to healthcare. As a basis for evaluating the rights of foreign nationals to healthcare, the Constitutional Court’s ruling in *Dawood* about the issuing of temporary resident permits to the spouses of South African citizens and how the applications were being processed shows how DHA created illegal foreigners by denying and or not expeditiously granting permits to these applicants. This thereby forced these families to obtain temporary residence permits from their home countries and created divided households. The Constitutional Court ruled that foreign nationals (i.e. the spouses of South Africans) were entitled to human dignity (Section 10 of the Constitution) and this had been violated unnecessary through family separation.⁹⁶ The case shows an example of

⁹⁵ The Mazibuko case will not be fully explored in this paper. However, its minimum core of every person being entitled to 25 litres of water is an important issue. The Court concluded, in contrast to the High Court and the Supreme Court of Appeal, that it is not appropriate for a court to give a quantified content to what constitutes ‘sufficient water’ because this is a matter best addressed in the first place by the government. The national government has adopted regulations which stipulate that a basic water supply constitutes 25 litres per person daily; or 6 kilolitres per household monthly (upon which the City’s Free Basic Water policy is based). The Court concluded that it cannot be said that it is unreasonable for the City not to have supplied more, particularly given that, even on the applicants’ case, 80 percent of the households in the City will receive adequate water under the present policy. The Court noted that 100 000 households within Johannesburg still lack access to the most basic water supply, defined as a tap within 200m of their household. The Supreme Court of Appeal held that 42 litres of water per day would be ‘sufficient water’ within the meaning of the Constitution, and directed the City to reformulate its policy in light of this conclusion. The Constitutional Court held that the obligation placed on government by section 27 is an obligation to take reasonable legislative and other measures to seek the progressive realisation of the right. O’Regan (paras 160-61), ‘challenged as to its policies relating to social and economic rights, the government agency must explain why the policy is reasonable.’ *Mazibuko and Others v City of Johannesburg and Others (CCT 39/09)* [2009] ZACC 28; 2010 (3) BCLR 239 (CC); 2010 (4) SA 1 (CC) (8 October 2009). Liebenberg complains that the Mazibuko judgement shows, ‘the weaknesses of the existing model of reasonableness review for adjudicating positive socio-economic rights.’ Liebenberg (2010) xxiv, 480.

⁹⁶ In *Dawood*, the DHA abandoned their appeal and their opposition to the confirmation proceedings and withdrew the day prior to the Constitutional Court hearing. O’ Regan J, writing for a unanimous Court, said the abandonment was ‘inconvenient and discourteous’ and that DHA’s disregard of the Constitutional Court would ‘not put an end to the proceedings,’ para 14-15. O’Regan also notes the limitations clause (paras 40-42) but the judgment ultimately discusses the lack of legislative guidance to assist the DHA functionaries in determining such situations. She writes, if broad discretionary powers contain no express constraints, those who are affected by the exercise of the broad discretionary powers will not know what is relevant to the exercise of those powers or in what circumstances they are entitled to seek relief from an adverse decision. In the absence of any clear statement to that effect in legislation, it would not be obvious to a potential applicant, para 47. O’Regan also writes that, ‘conferring broad discretion upon an official, who may be quite untrained in

foreign nationals having the standing to advance constitutional claims in South Africa.

The case of *Soobramoney* came before the Constitutional Court in 1998. The appellant, Mr. Soobramoney, was a diabetic who suffered from ischaemic heart disease. In 1996, his kidneys had failed, and his condition was diagnosed as irreversible. He therefore sought admission to a state hospital for dialysis treatment. Meanwhile, the hospital adopted a policy that it would only admit patients who could be cured within a short period including those patients who suffered from chronic renal failure, if they were eligible for a kidney transplant. Soobramoney was ineligible because of his condition. Soobramoney then brought an application, claiming that he had a right to receive treatment from the hospital in the South African Constitution s 27 (3), namely the right to emergency medical treatment.⁹⁷ The Court confined the scope of s 27(3) to a right to receive immediate remedial treatment that is ‘necessary and available.’⁹⁸ The right did not extend, the Court held, to ‘ongoing treatment of chronic illness for the purpose of prolonging life.’⁹⁹

The Court also held that the right had to be construed in the context of the general availability of health services. As Judge Albert ‘Albie’ Sachs wrote, ‘the inescapable fact is that if governments were unable to confer any benefit on any person unless it conferred an identical benefit on all, the only viable option would be to confer no benefit on anybody.’¹⁰⁰ Accordingly, the hospital, within its available resources, could not be expected to provide treatment to patients who matched Soobramoney’s health profile. The Court was therefore slow to interfere with the kind of decisions made within the context of scarce resources and compelling

law and constitutional interpretation, and...expecting that official, in absence of direct guidance’ to comply with the Bill of Rights may not be appropriate in busy work environments,’ para 46. Accordingly, the legislature needs to identify explicitly the policy considerations that would render a refusal of a temporary residence permit justifiable, and limit the risk of an unconstitutional exercise of the discretionary powers it confers,’ paras 49, 54. Although the ‘inconsistency with the Constitution...lies in a legislative omission,’ the Court recognises the ‘need to respect the separation of powers,’ paras 61-62. The Court offered substantive remedies to assist the DHA, confirming that the legislature needs to provide clearer statutes—but deferring to the legislature to do so. *Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others* (CCT35/99) [2000] ZACC 8; 2000 (3) SA 936; 2000 (8) BCLR 837 (7 June 2000).

⁹⁷ *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC), para 7. Dennis M. Davis, ‘Adjudicating the Socio-Economic Rights in the South African Constitution: Towards “Deference Lite”?’ (2006) *South African Journal on Human Rights* 22: 305.

⁹⁸ *Soobramoney*, para 20.

⁹⁹ *Soobramoney*, para 13.

¹⁰⁰ *Soobramoney*, para 53.

demands and exhibited a clear reluctance to impose an obligation on the State to extend or create emergency facilities.¹⁰¹ Chaskalson P. said in *Soobramoney*: ‘what is apparent from these provisions is that the obligations imposed on the State by ss 26 and 27 in regard to housing, health care, food, water, and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources.’¹⁰² The ruling concluded:

the provision of the bill of rights should furthermore not be interpreted in a way which results in courts feeling themselves unduly pressurized by the fear of gambling with the lives of claimants into ordering hospitals to furnish the most expensive and improbably procedures, thereby diverting scarce medical resources and prejudicing the claims of others... Unfortunately, the resources are limited, and I can find no reason to interfere with the allocation undertaken by those equipped than I to deal with the agonizing choices that had to be made.¹⁰³

Within days of this ruling, *Soobramoney* died leading the *Mail & Guardian* to report: ‘what befell *Soobramoney* was more or less what, in apartheid’s heyday, used to befall black people in search of medical treatment.’¹⁰⁴ As Sandra Liebenberg concludes, ‘by failing to engage seriously with health care as a human right, the Constitutional Court missed an opportunity to promote the transformative potential of socio-economic rights.’¹⁰⁵ The difficulty of balancing one individual’s healthcare needs against limited resources cannot be easily resolved.

The case of the *Minister of Health v Treatment Action Campaign (TAC)* (hereafter) involved government policy and the right to access healthcare. The use of the anti-retroviral drug Nevirapine (which could prevent mother-to-child transmission of the HIV virus) was limited to a number of research and training sites. Judge Chris Botha of the High Court ruled in favour of *TAC*, ordering that Nevirapine be made available to infected mothers giving birth in state institutions and that the government present to the court an outline of how it planned to extend provision of the medication to its birthing facilities, country-wide. The Government appealed the decision to the Constitutional Court. Judge Botha granted interim relief

¹⁰¹ *Soobramoney*, para 29.

¹⁰² *Soobramoney*, para 8. *Government of the Republic of South Africa v Grootboom* (2001) (1) SA 46 (CC), para 46.

¹⁰³ *Soobramoney*, paras 58-59.

¹⁰⁴ ‘The high cost of living’ *Mail & Guardian* (5 December 1997) <http://mg.co.za/article/1997-12-05-the-high-cost-of-living> (Accessed 18 January 2015).

¹⁰⁵ S Liebenberg (2010) 146.

pending the appeal. The Constitutional Court rejected the appeal, finding that the restrictions of Nevirapine to pilot sites excluded those who could reasonably be included in the program. The Court ordered the Government to extend availability of Nevirapine to hospitals and clinics, to provide counselors; and to take reasonable measures to extend the testing and counseling facilities throughout the public health sector.¹⁰⁶

Some of the key issues surrounding the *TAC* case were the minimum core content of the right to healthcare and the obligations imposed on the state in section 27(2) that are subject to progressive realization and available resources. According to paragraph 38,

the State needs 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 the judicial, legislative and executive functions achieve appropriate constitutional balance.¹⁰⁷

Overall, the judgment shows, according to both Davis and Bilchitz, a ‘reluctance to find that s 27(1) constituted a self-standing right to healthcare and further the refusal by the Court to grant a structural interdict as a key element of the order.’¹⁰⁸ Furthermore, the Court was hesitant to engage s 27 (1) – an independent right to health, noting that ‘the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them...All that is possible, and all that can be expected from the State, is that it act reasonably to process access to the socio-economic rights...’¹⁰⁹ In the end, the High Court required that the appellants revise their policy and to submit it to the Court to enable it to be able to satisfy that the policy was consistent with the Constitution, and to expeditiously reduce the transmission of HIV.¹¹⁰ Constrained by economic conditions, the Constitutional Court’s recognition of the most vulnerable—children with the HIV virus—does not support permanent socio-economic rights, specifically access to healthcare, to all South Africans equally. In writing about the *TAC* case, Liebenberg observes, ‘in cases where there has been a failure to make provision for a

¹⁰⁶ *Minister of Health v Treatment Action Campaign* (2) 2002 (5) SA 721 (CC) para 38; D Davis (2006) 308.

¹⁰⁷ *TAC*, para 38.

¹⁰⁸ D Davis (2006) 308; D Bilchitz (2007) 157.

¹⁰⁹ *TAC*, paras 34-35.

¹¹⁰ *TAC*, paras 129-130.

particular group, but there are a range of reasonable policy options that could remedy the constitutional defect, the Court prefers remedies that allow the State a degree of latitude in designing an appropriate policy solution.¹¹¹ This latitude can be seen as necessary but also frustrating in securing socio-economic rights for everyone.

In *Khosa v Minister of Social Development*, a number of Mozambican citizens (the applicants) who had acquired permanent residency in South Africa since 1980 were destitute and challenged the Social Assistance Act 59 of 1992 that limited social assistance to grants to South African citizens. They argued that social security was guaranteed to ‘everyone,’ including permanent residents. In particular, these permanent residents were entitled to pension grants and child-support grants. The Court concluded that the exclusion of permanent residents from social security programmes enjoyed by South Africans had ‘a serious impact on [their] dignity’ and accordingly found that the applicable legislation violated both the right to equality and the right to social security of permanent residents.¹¹² According to Judge Yvonne Mokgoro (in somewhat contradictory tones), permanent residents are part of the South African community and worthy of constitutional protection; yet she also writes ‘that non-citizens may become a financial burden on the country is a legitimate one and I accept that there are compelling reasons why social benefits should not be made available to all who are in South Africa irrespective of their immigration status.’¹¹³

In this case, although the Constitutional Court focused on whether the concepts of dignity and equality to extend social benefits to permanent residents, the concern over the state’s financial responsibility and ability to provide socio-economic rights continues. According to paragraph 126, Constitutional Court recognizes the needs, ‘to reduce the rising costs of operating social security systems, the need to prevent the availability of social security benefits from constituting an incentive for immigration and the need to encourage immigrants to be self-sufficient.’¹¹⁴ Judge Sandile Ngcobo wrote the minority opinion finding the exclusion of permanent residents justifiable.

Davis contends the *Khosa* case, ‘was unfettered by the reasonableness standard which had dominated the earlier cases brought under sections 26 and 27 of

¹¹¹ S Liebenberg (2010), 157 n144.

¹¹² *Khosa v Minister of Social Development* (2004) (6) SA 505 (CC), para 114. D Davis (2007) 208.

¹¹³ *Khosa*, paras 58, 74.

¹¹⁴ *Khosa*, para 126.

the constitution.’¹¹⁵ Sandra Liebenberg asserts that, ‘it remains to be seen whether the *Khosa* decision represents the first step in a gradual process of extending socio-economic rights to those marginalised by an intersection of poverty and nationality, or the outer limits of the Court’s willingness to expand access to socio-economic rights to non-nationals.’¹¹⁶ This debate over how far to push socio-economic rights for non-South African citizens continues. Will the debate compel a distinction between general access to health and emergency care, a distinction between acute and chronic disease, or other distinctions that may be perceived to support progressive realisation?

Together, the three cases illustrate the tension between everyone’s socio-economic rights and the state’s ability to pay for them within reason. ‘Placing an obligation on the State to ensure that everyone has access to socio-economic rights will therefore require a degree of intervention which has significant implications for pre-existing policy and resource allocation,’ and Liebenberg identifies this as an ‘unavoidable consequence of a constitutional commitment to the fulfillment of socio-economic rights.’¹¹⁷ It could also be suggested that in the current economic context, the Constitutional Court is not consistently upholding socio-economic rights as imagined in the Constitution. Returning to the refugees and migrants’ access to health and emergency care, there has been little tested at the High Courts to better interpret who ‘everyone’ is meant to include. In some cases, NGOs, such as Lawyers for Human Rights, assist clients by trying to pressure the Minister of Health to resolve issues – such as a kidney transplant— for expediency over setting legal precedents. The legal issues await legislative action.

V STATUTES

The emerging case law about access to healthcare will continue to draw not only on the South African Constitution but also on South Africa legislation specifically. Moreover, the importance of reading refugee and immigration law together and not in isolation of one another helps to show the divergence between the Constitution and South African legislation. There are three laws and immigration regulations that guide South Africans on questions relating to refugee and migrants’ access to health and emergency care. Among these, the National Health Act of 1998, the Refugee Act

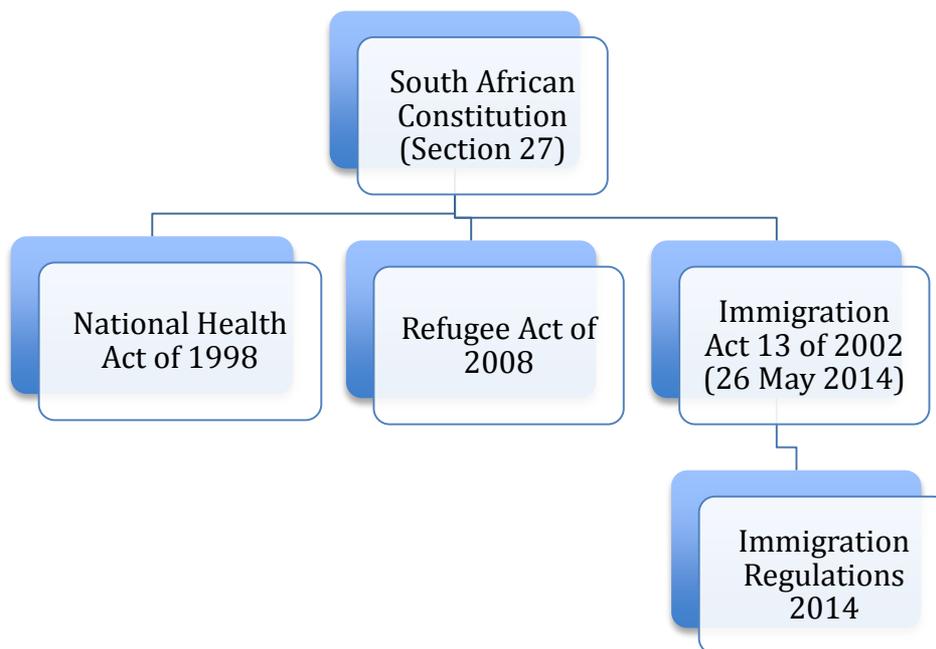
¹¹⁵ D Davis (2007) 208.

¹¹⁶ S Liebenberg (2010) 161.

¹¹⁷ S Liebenberg (2010) 191.

of 2008, and the Immigration Act 13 of 2002 should better specify the intent of the South African Constitution with respect to socio-economic rights and access to health and emergency care. Upon examination, the laws are not consistent and create contradictory and confusing situations for medical practitioners.

Table 1.2: South African Statutes on Healthcare



The National Health Act provides some of the most comprehensive language with respect to administering care to South African residents. According to the National Health Act 61 of 2003, under Chapter 1 (2)(c) states:

- (i) protecting, respecting, promoting and fulfilling the right of the people of South Africa to progressive realisation of the constitutional right of access to health care services;
- (iv) vulnerable groups such as women, children, older persons and persons with disabilities.¹¹⁸

What is distinctly missing from the vulnerable group is asylum seekers, refugees, and indigent migrants. This lacuna places medical providers, such as doctors and nurses, in a difficult situation when evaluating a patient's needs and the level of care they can afford he/she with limited resources. In the National Health Act, the language suggests an aspiration to care for the South African population. Accordingly the National Health Act 3(1):

¹¹⁸ http://www.saflii.org/za/legis/consol_act/nha2003147.pdf (Accessed 3 June 2014).

- (a) the Minister must, within the limits of available resources endeavor to protect, promote, improve and maintain the health of the population;
- (b) promote the inclusion of health services in the socio-economic development plan of the Republic.¹¹⁹

Consistent with the National Health Act, the Refugees Act reinforces the notion that refugees are also entitled to basic health services; but it is not explicit in referring to asylum seekers or other foreign nationals. The South African Legislature passed the Refugees Act 130 of 1998 in which Chapter 5, Section 27 (g) states, ‘a refugee is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time.’¹²⁰

The National Health Act and Refugees Act are both undermined by the Immigration Act of 2002. In the Immigration Act, medical care providers are to ascertain the legal status of patients before administering care. According to section 44 of the Immigration Act:

when possible, any organ of state shall endeavor to ascertain the status or citizenship of the persons receiving its services and shall report to the Director-General any illegal foreigner, or any person whose status or citizenship could not be ascertained, provided that such requirement shall not prevent the rendering of services to which illegal foreigners and foreigners are entitled under the Constitution or any law.¹²¹

Furthermore, the statute indicates under section 49 (4) that, ‘anyone who intentionally facilitates an illegal foreigner to receive public services to which such illegal foreigner is not entitled shall be guilty of an offence and liable on conviction to a fine.’¹²²

The Immigration Act 13 of 2002 clearly contradicts South African doctors’ Hippocratic Oath in which doctors swear to uphold ‘the health of patients and the health of their communities,’ and ‘...will not permit considerations of age, gender, race, religion, ethnic origin, and sexual orientation, disease, disability or any other factor to adversely affect the care’ to be given.¹²³ Doctors and nurses are thus compromised in their ability to provide care to their patients if they adhere to these

¹¹⁹ http://www.saflii.org/za/legis/consol_act/nha2003147.pdf (Accessed 3 June 2014) 14.

¹²⁰ South African Refugees Act 130 of 1998, 20. The Refugee Amendment Bill of 2007 (No. 29976 GG 07 June 2007) reiterates many of the principles of the 1967 Protocol Relating to the Status of Refugees.

¹²¹ Immigration Act 13 of 2002 (Section 44 substituted by section 42 of Act 19 of 2004) 51.

¹²² Immigration Act 13 of 2002 (Section 44 substituted by section 42 of Act 19 of 2004) 52.

¹²³ Faculty of Health Sciences Declaration, the University of Cape Town https://www.uct.ac.za/downloads/uct.ac.za/apply/handbooks/fac_health_UG_2013.pdf 243. (Accessed 8 December 2014).

laws. They are not well positioned to confront a rule of law that may itself be illegal in South Africa's Constitutional democracy.¹²⁴

To further compound the situation, hospital administrators, in trying to keep to budget restrictions, have conflated indigent migrants with medical tourists. Medical tourists are those foreign nationals with the means to pay for their healthcare services. According to the Immigration Act of 2002, Immigration Regulations 16(1); these medical tourists need the following documentation before entering South Africa: letter from a registered medical practitioner, estimated costs of treatment, proof of financial means to cover medical costs, valid return flight tickets, and proof of sufficient financial means or provisions for the costs indirectly related to the treatment.¹²⁵ As Chapter 2 will discuss, doctors have become easily confused by the legislation demarcating asylum seekers, refugees, migrants, and medical tourists who are all seen to be competing for limited South African resources.

This legal disjunction among the Constitution's socio-economic aspirations, the adjudication of these rights, and statutes places healthcare providers in an untenable situation. Between the judicial and legislative branches in South Africa, there is nevertheless a theoretical commitment to refugees and their access to health and emergency care, a commitment that acknowledges the need for progressive realisation. How the right to healthcare gets practiced depends on resource availability.

VI CONCLUSION

Emerging case law including—*Soobramoney*, *the Treatment Action Campaign*, and *Khosa*—demonstrates how economic realities challenge the South African Constitution and its guarantee of access to health and emergency care. As Constitutional framer Halton Cheadle and Judge Dennis Davis warned, neoliberal market economics may not support the underpinnings of a constitution that confers socio-economic rights, and making courts a site of struggle, and demobilising democratic energy.¹²⁶ The consequence is a disjuncture between the law and

¹²⁴ Ugo Mattei and Laura Nader (2008) *Plunder: When the Rule of Law is Illegal*.

¹²⁵ Immigration Act, 2002 Immigration Regulations (22 May 2014) Section 16 (1), 25.

¹²⁶ G Budlender (2011) 14 n23. See D Davis 'The Case against the Inclusion of Socio-Economic demands in a Bill of Rights except as directive principles' (1992) *South African Journal on Human Rights* 8: 475.

practices, and this has been particularly acute with regard to refugees and migrants in South Africa as will be seen in Chapter 2.

Questions remain as to whether and how South Africa can afford to provide socio-economic rights to everyone. Is South Africa's Bill of Rights for its citizens or is it for all of those present in its sovereign territory? Can South Africa afford to bring dignity to all of its marginalised people, and if so, who are they?

Darrel Moellendorf underscores the phrase 'available resources' in sections 26(2) and 27(2) to signify, 'the protection of these rights are more sensitive to budgetary limitations than is the protection of other rights..[they] must have some role in guiding policy rather than being merely dependent upon it, if they are to be real rights and not mere priorities.'¹²⁷ Liebenberg thus queries, 'how should the courts fulfill their constitutional mandate to enforce these rights without usurping the role of the other branches and spheres of government to distribute resources equitably among various legitimate priorities under South African democratic constitution?'¹²⁸ She concludes by stating the 'Constitutional Court remains hesitant to endorse structural mandatory relief in the context of socio-economic rights cases,'¹²⁹ thereby showing that the transformatory purpose of the Constitutional Court has only been marginally achieved. If democracy is to succeed, then, everyone needs the access to health and emergency care. As Geoff Budlender states, 'it is not only in South Africa that minorities or vulnerable groups require protection from majorities. The enforcement of those rights is part of the process of democracy, and essential for democracy.'¹³⁰

¹²⁷ D Moellendorf 'Reasoning about resources: *Soobramoney* and the future of socio-economic rights claims' (1998) *South African Journal on Human Rights* 14: 332.

¹²⁸ S Liebenberg (2010) 195.

¹²⁹ S Liebenberg (2010) 489.

¹³⁰ G Budlender 'People's Power and the Courts: Bram Fischer Memorial Lecture, 2011' http://www.casac.org.za/?wpfb_dl=1 (Accessed 18 January 2015) 5.

Chapter 2: ‘Foreigners are eating South African medicines’: When Law and Access to Healthcare Diverge

ABSTRACT

Chapter 2 investigates how asylum seekers, refugees, and immigrants access emergency and healthcare. The chapter begins with an overview of how the Department of Home Affairs determines the status of refugees and asylum seekers and the effects of this process and its outcomes on healthcare providers. This is followed by a demographic sketch of asylum seekers and refugees in Cape Town, and the impact of the closing of the Refugee Reception Office to new asylum seekers. The chapter then addresses two cases of an asylum seeker and an undocumented person being denied care by a hospital administrator at a Tertiary Hospital, and each dying. A description of how civil society groups have come forward to advocate for refugees and immigrant communities in Cape Town brings the chapter to its conclusion.

I INTRODUCTION

In 2008, more than 20,000 foreign nationals were displaced in the Western Cape Province because of xenophobic violence. Although much has been written about this anti-foreign violence in South Africa (and more recently in Soweto), there has been a relative dearth of research conducted specifically on the Western Cape Province and Cape Town. Furthermore, the nomenclature used in Cape Town to describe migrants as ‘refugees’ both conflates legal categories of migrants (both cross-border and internal) and has muddled how scholars and the general public view ‘migrants.’ This conflation of categories regarding asylum seekers (those applying for refugee status), refugees (those fleeing persecution), economic migrants (those coming for work), illegal migrants (those who do not have papers), and internal migrants (those migrating from within South Africa) has hampered analyses of how many foreign nationals reside in the area and what services they access.

This chapter investigates how asylum seekers, refugees, and immigrants access emergency and healthcare. The chapter begins with an overview of how the Department of Home Affairs determines refugees and asylum seekers and its affects on healthcare providers. This is followed by a demographic sketch of asylum seekers and refugees in Cape Town and the impact of the closing of the Refugee Reception Office to new asylum seekers. The chapter addresses two cases of an asylum seeker and an undocumented person being denied care by a hospital administrator at a tertiary hospital, and each patient dying. A brief description of how civil society groups have come forward to advocate for refugees and immigrant communities in

Cape Town brings the chapter to its conclusion. The discussion is rooted in the notion of transformative democracy can move society forward through socio-economic rights for everyone, such as access to health and emergency care.

By analysing democratic principles enshrined in the South African Constitution, the divergence between laws and healthcare becomes pronounced. Political Scientist Philippe Schmitter explains that democracies can be reformed in accordance with ‘two enduring core principles: the sovereign equality of citizens and the political accountability of rulers.’¹³¹ Cora Hoexter builds on this conceptualisation of citizenship in her analysis of South African law to suggest, ‘the principle of citizenship is important to the theory of civic republicanism because it seeks to decentralize power and decision-making to a local level where citizens, as part of a community, can participate in the decision-making process.’¹³² The notion that citizens hold equal rights and participate undergirds the South African Constitution of 1996, and public participation helps administrators become more politically accountable.¹³³ Although Hoexter speaks from an administrative law perspective, the importance of citizen participation through civil society organization (CSOs) and doctors’ collaboration is central to the articulation of the right to healthcare. This collaboration is emerging as a means to make the government agencies more accountable with respect to the socio-economic right of access to health and emergency care.

Building on Chapter 1, the issue of democratic legitimacy and the Courts’ role has been challenged to the degree that CSOs or non-governmental organizations (NGOs) and citizen groups are coming together to press for the implementation of socio-economic rights. These groups are also advocating for international refugee law and human rights to be read and interpreted in conjunction with South African norms and practices. They have given a voice to the disjuncture between the law and access to health and emergency care for refugees, asylum seekers and migrants. As

¹³¹ Philippe Schmitter, ‘The Future of ‘real-existing’ Democracy,’ (no date)15.

<http://www.eui.eu/Documents/DepartmentsCentres/SPS/Profiles/Schmitter/FutureOfDemocracy.pdf> (Accessed 13 October 2014)

¹³² Cora Hoexter *Administrative Law in South Africa* 2 ed (2012) 81.

¹³³ C Hoexter (2012) 82. D Davis and H Corder draw on *Doctors for Life* and Ngcobo’ statement that: ‘the participation by the public...encourages citizens...to be actively involved in public affairs, identify themselves with the institutions of government and become familiar with the laws...’para 115, 78. They also assert, ‘the bold assertion of public participation in the national legislative process as central to deliberative democracy...’ Dennis Davis & Hugh Corder ‘Globalisation, National Democratic Institutions and the Impact of Global Regulatory Governance in Developing Countries’ in Hugh Corder (ed) *Global Administrative Law* (2009) 79-80.

Liebenberg notes, ‘the ability of individuals, groups and CSOs to submit petitions alleging violations of socio-economic rights to international and regional human rights supervisory bodies enables international jurisprudence on these rights to develop in the context of concrete cases.’¹³⁴ Moving beyond the Constitutional Court cases that address healthcare and foreign nationals, this chapter examines how refugees, asylum seekers, and poor foreign nationals fail to get life-saving healthcare, detailing the stories of two patients who failed to get access to medical care and died.

II THE DEPARTMENT OF HOME AFFAIRS

II.I BETWEEN STATUS AND CATEGORY

Understanding the resource allocation question at the heart of healthcare access in South Africa depends on accounting for the population of foreign nationals. According to data in 2010, there are between 1.6 and 2 million foreign nationals residing in South Africa. Of those foreign nationals, some have applied for asylum seeker status; these individuals have identified themselves as refugees fleeing persecution. In order to obtain asylum seeker status, such an individual needs to go to one of three Refugee Reception Offices—Musina, Durban, and Pretoria—that accept new applications to receive a Section 22 permit.¹³⁵ With this permit, the individual can remain in South Africa legally and move about the country freely until a hearing to determine whether his or her situation fits the definition of a refugee fleeing persecution due to race, tribe, religion, nationality, political opinion, social group, external aggression, and/or disturbing public order. After this first hearing, the asylum seeker can be granted refugee status or deemed unfounded (a determination subject to appeal), or manifestly unfounded. If the individual is found to have a manifestly unfounded, fraudulent claim, then he/she needs to leave the country within 30 days or face deportation. At this moment, the individual then becomes ‘illegal.’ The sequence associated with adjusting legal status in South Africa confuses almost everyone—the asylum seekers, immigrants, police, officials in detention centres, and the general public. Moreover, one’s legal standing is not fixed and can be changed swiftly by the Department of Home Affairs. This is important to

¹³⁴ Sandra Liebenberg *Socio-Economic Rights: Adjudication under a transformative constitution* (2010) 117.

¹³⁵ <http://www.cormsa.org.za/wp-content/uploads/2009/05/HOW-TO-APPLY-FOR-ASYLUM-IN-SOUTH-AFRICA-Brochure.pdf> (Accessed 8 December 2014).

note not only for deconstructing the use of the terms – refugee, asylum seeker, and illegal foreigner—but also because it shapes the basis of South Africans’ interactions with foreign nationals.

The South African Department of Home Affairs (hereafter the DHA) released its ‘Asylum Statistics 2013’ in March 2014 in which the DHA indicated that a ‘total of 70,010 new arrivals were registered as asylum seekers between January and December 2013. The data were broken down by region with 58,465, 84 per cent, from the African continent.’¹³⁶ The report also indicates that 68,241 registered asylum seekers were adjudicated in 2013, and 35,402, 52 per cent, were deemed as manifestly unfounded, abusive and fraudulent asylum claims. Another 25,553, 37 per cent, were deemed unfounded asylum claims, a mere 7,286, 11 per cent, were approved.

In the examination of DHA asylum statistics in 2012-2013, summarised in Table 2.1, 68,241 out of 70,010 asylum seeker cases were adjudicated.¹³⁷ Of these 68,241 cases, 89 per cent were rejected. The largest immigrant populations are listed in the table to illustrate that many of the cases can be mapped to primarily four sending states – Somalia, Zimbabwe, Ethiopia, and the Democratic Republic of Congo (DRC). Decision-making that consists of rejecting the majority of asylum seekers illustrates that there is little to no discretion being exercised by DHA administrators with respect to individual asylum seeker cases and/or it could suggest an immigration system that is woefully misaligned in terms of policy objectives. According to the DHA mission statement, the agency is committed to, ‘the efficient determination and safeguarding of the identity and status of citizens and the regulation of immigrants to ensure security, promote development and fulfil our international obligations.’¹³⁸ The overwhelming number of rejections is not efficient because the subsequent, direct appeals by asylum seekers create more administrative burdens. Moreover, when a substantial number of appeals come from bona fide asylum seekers, the agency appears to break domestic and international obligations, and undermines its own refugee adjudication process.

In *Katabana* in 2012, Davis J in the High Court of the Western Cape ordered that the DHA issue ‘the applicant recognition of refugee status in terms of 27(a) of

¹³⁶ ‘Asylum Statistics,’ Department of Home of Affairs (March 2014), 3.

¹³⁷ ‘Asylum Statistics,’ Department of Home of Affairs (March 2014), Table 1, 3.

¹³⁸ *Department of Home Affairs Annual Report (2012-2013)* 21.

the Refugees Act 130 of 1998 read with Regulation 15(1) within 14 days of the date of this order.¹³⁹ He stated: ‘I consider that this a case for exceptional circumstances and that the interests of justice dictate that this court should make the decision.’¹⁴⁰ His decision rendered a determination of refugee status, conferring it directly to Katabana, not returning the case to DHA for correction and a new, revised outcome. Although the Court should respect the jurisdiction of the legislative and executive branches and avoid such extremes, the DHA has not followed court orders and has acted with brazen disregard.

Table 2.1: Department of Home Affairs Asylum Statistics for 2013

Asylum Outcome	Number of Cases	Percentage of Cases
Approved¹⁴¹	7286	11%
Somali	3579	
Ethiopia	2055	
DRC	1104	
Manifestly Unfounded¹⁴²	35402	52%
Zimbabwe	13679	
Nigeria	5794	
Mozambique	3175	
Rejected as Unfounded¹⁴³	25533	37%
DRC	5214	
Ethiopia	5148	
Bangladesh	3685	
Total Rejections	60935	89%
TOTAL	68241	100%

The 89 per cent rejection rate has clear implications for South African society

¹³⁹ *Katabana v Chairperson of Standing Committee for Refugee Affairs and Others* (25061/2011) [2012] ZAGPPHC 362 (14 December 2012) para 28.

¹⁴⁰ *Katabana* para 27.

¹⁴¹ Applications Approved and Refugee Status Granted in terms of Section 24(3)(a) of the Refugees Act No 130 of 1998. ‘Asylum Statistics,’ Department of Home of Affairs (March 2014), Table 4, 8.

¹⁴² Applications Rejected as Manifestly Unfounded, Abusive and Fraudulent in terms of Section 24(3)(b) or the Refugees Act No 130 of 1998. ‘Asylum Statistics,’ Department of Home of Affairs (March 2014), Table 2, 5.

¹⁴³ Applications Rejected as Unfounded in terms of Section 24(3)(c) of the Refugees Act No 130 of 1998. ‘Asylum Statistics,’ Department of Home of Affairs (March 2014), Table 3, 6. According to Section 26(1) of the Refugees Act, ‘any asylum seeker may lodge an appeal with the Appeal Board in the manner and within the period provided for the in the rules if the Refugee Status Determination Office has rejected the application in terms of section 24(3)(c).’ For transparency, the author has volunteered at the UCT Refugee Rights Clinic since May 2014 drafting appeals for approximately 40 refugees under this provision.

because there are ambiguities about who has legal standing and who does not. Moreover, these legal standings seem fluid and inconsistent for employers and service providers, such as doctors and nurses who are not well positioned to monitor them. The issue of legal standing becomes further compromised by South African Police detentions of individuals deemed ‘undocumented illegals.’ There are numerous accounts of legitimate asylum seekers who possess Section 22 permits only to have these permits torn up by police officers for no apparent reason. The asylum seekers are left vulnerable to detention and deportation.

The question that then arises is how do or how should the 70,000 new arrivals register in South Africa. DHA data indicate that the Cape Town office handled the majority of the refugee identity documents with 8,161, 38 per cent, followed by the Pretoria office handling 7,147 out of the total 21,761 from January through December 2013.¹⁴⁴ The report further indicates that 4,325 Refugee ID books were dispatched to Cape Town out of 10,055; the highest number followed by Pretoria with 2,991. It also shows that 5,580 refugee identity documents per Refugee Reception Office were uncollected out of 8,015. This could mean asylum seekers flee, get detained, and are possibly deported before picking up their papers.

The DHA’s inability to process manage immigration compromises South African constitutional rights. The on-line media site *GroundUp* (based in Cape Town) reported on 22 December 2014 of a case of a Somali refugee who was so desperate for papers to show a local hospital that he ‘paid R2,500 for papers for his first son’s documents because he [the son] was sick and needed urgent medical care.’¹⁴⁵ This story of a bona fide refugee purchasing papers from DHA officials for access to healthcare is commonly acknowledged among refugee service providers.

Immigrants who are detained have socio-economic rights, and their detention requires provisions of food, shelter, medicine and care by the state. Section 35(2) of the Constitution further provides that everyone who is detained by the state ‘must be held in a way that respect his or her dignity and provides him or her with legal representation, adequate nutrition and medical treatment as state expense.’¹⁴⁶ The Immigration Regulations also lay out minimum standards for health care while in

¹⁴⁴ ‘Asylum Statistics’ (2014) 9.

¹⁴⁵ Joyce Xi ‘Need that bullet removed from your arm? Then show us your papers’ *GroundUp* (22 December 2014) http://groundup.org.za/article/need-bullet-removed-your-arm-then-show-us-your-papers_2568 (Accessed 1 February 2015) 2.

¹⁴⁶ Jo Vearey (October 2011) ‘Deportation and Public Health: Concerns around the ending of the Zimbabwean Documentation Process’ *Migration Issue Brief #9 ACMS* 5.

immigration detention.

II.II SOCIO-ECONOMIC RIGHTS IN THE CONTEXT OF IMMIGRANT DETENTION

Often the DHA violates socio-economic rights in the detention of immigrants. An August 2014 Western Cape Refugee and Migrant Forum email communication, for example, indicated that there was a sick Zimbabwean with a colostomy that was not receiving his medical treatment at Lindela. At the same time, a *Mail & Guardian* article reported that ‘Médecins Sans Frontières (MSF) has complained about conditions in the centre for years, and also about the fact that it was simply denied access to Lindela.’¹⁴⁷ Lawyers for Human Rights reported in 2010 that there was a lack of soap, lice and a ban on books in the facility. In 2012, Constitutional Court Judge Edwin Cameron pointed out that there were no condoms available at Lindela, and two years later, the problem continued.¹⁴⁸ In an 18 September 2014 report, the South African Human Rights Commission released its findings on an investigation into violations of access to health for detainees at Lindela.

The investigation revealed that there was a lack of provision for TB testing and isolation of infected persons, and psychological care; availability of condoms and lack of VCT; unavailability of tetanus vaccines; overcrowding in rooms; and time intervals between the serving of the evening meal and breakfast not complying with the time periods prescribed in the Regulations to the Immigration Act at Lindela.¹⁴⁹

To the extent that DHA violates the socio-economic rights of detained immigrants, it ignores the South African Constitution and its detentions are illegal. In *Arse v Home Affairs*, the South African High Gauteng High Court ruled in favour of an asylum seeker from Ethiopia who had failed to obtain an asylum seeker permit because the queues were too long in the Point Elizabeth Refugee Reception Office. He was arrested as an illegal foreigner and spent a week at a police station before being transferred to Lindela. The Court reasoned that, ‘since the appellant’s asylum seeker permit has expired and has not been extended in terms of s 22(3) of the Refugees Act it is necessary to order that an asylum seeker permit be re-issued to him.’¹⁵⁰ Malan JA stated in dealing with the fundamental rights of liberty, ‘the

¹⁴⁷ Philip De Wet ‘Waiting for change at Lindela’ *Mail & Guardian* (10 October 2014) 3. <http://mg.co.za/article/2014-10-09-waiting-for-change-at-lindela> (Accessed 18 January 2015).

¹⁴⁸ P De Wet (2014) 4.

¹⁴⁹ <http://www.sahrc.org.za/home/index.php?ipkArticleID=296> (Accessed 1 November 2014).

¹⁵⁰ *Arse v Minister of Home Affairs and Others* (25/2010) [2010] ZASCA 9; 2010 (7) BCLR 640 (SCA); [2010] 3 All SA 261 (SCA); 2012 (4) SA 544 (SCA) (12 March 2010) para 22.

importance of the right “can never be overstated.” Section 12(1)(b) of the Constitution guarantees the right to freedom, including the right not to be detained without trial. This right belongs to both citizens and foreigners.’¹⁵¹ The case of *Arse* shows that the inability of an asylum seeker to obtain a permit does not give grounds for detention. DHA officials ‘have a duty to ensure the intending applicants for refugee status are given every reasonable opportunity to file an application with the relevant Refugee Reception Office.’¹⁵² However, Roni Amit found that arrests from problems getting access to Refugee Reception Offices were not uncommon.¹⁵³

In a similar case two years later, *Ersumo*, an Ethiopian asylum seeker, was arrested as an illegal foreigner and detained for not having a Section 22 permit. He was like *Arse* in trying to obtain his asylum seeker permit, but failed because of queues at the Refugee Reception Office. According to the ruling, the purpose of Immigration Regulation 2(2) is to ensure that when a foreign national indicates an intention to apply for asylum, the regulatory framework is available. ‘It is clear that the appellants, when they were detained at Lindela, communicated to the Department’s officials and enforcement officers by the letter referred to earlier in this judgment that they intended to apply for asylum.’¹⁵⁴ The Supreme Court of Appeal set down for expedited hearing and ordered the appellant be issued with an asylum transit permit valid for 14 days; that is, ‘afford him priority when he reports to the Refugee Reception Office’ of Home Affairs.’¹⁵⁵

Parallel to *Ersumo*, in the case of *Bula*, the MS Navasa J concludes, ‘the legal-technical approach adapted...for the Minister and the DG [of DHA] are fundamentally flawed’¹⁵⁶ with respect to the difficulty in obtaining a Section 22 permit. For without permits, these asylum seekers become deemed illegal foreigners and subject by DHA to detention and deportation. Yet, the judges in adjudicating *Arse*, *Ersumo*, and *Bula* cases concluded that the DHA violated these asylum seekers’ rights to file applications.

¹⁵¹ *Arse v Minister of Home Affairs and Others* para 10. *Bula v Minister of Home Affairs* 2012 (4) SA 560 (SCA) para 84.

¹⁵² R Amit (September 2012) ‘Breaking the Law, Breaking the Bank: The Cost of Home Affairs Illegal Detention Practices’ *ACMS Research Report* 31.

¹⁵³ R Amit (2012) ‘Breaking the Law,’ 32.

¹⁵⁴ *Ersumo v Minister of Home Affairs* 2012 (4) SA 581 (SCA) para 72.

¹⁵⁵ *Ersumo v Minister of Home Affairs* para 23.

¹⁵⁶ *Bula v Minister of Home Affairs* 2012 (4) SA 560 (SCA) para 82.

More recently, the UCT Refugee Rights Clinic handled the case of Hassan Gulet, a Somali asylum seeker who was arrested for not having documentation and was being detained at Pollsmoor Correctional Facility, located in the Tokai suburb of Cape Town. Gulet arrived in South Africa in July 2014 and stayed with friends for three weeks while trying to obtain an asylum seeker permit (Section 22 permit) from the Pretoria Refugee Reception Office. He ran out of money while waiting in the queues at which point a friend sent him money and encouraged him to come to Cape Town. While in Cape Town, on the evening of Thursday 14 August 2014, he was stopped with another Somali asylum seeker for a traffic violation. Four days later, on 18 August 2014, he appeared before a court magistrate and was to be deported on 25 August 2014. On 10 September 2014, an NGO, Agency for Refugee Education, Skills Training & Advocacy (ARESTA) contacted the UCT Refugee Rights Clinic for assistance – again the need for civil society to intervene to ensure human rights accountability. In Hassan Gulet’s case, not only had the DHA detained an asylum seeker wishing to apply for refugee determination, but they also used obsolete forms.

In addition to the Founding Affidavit on 16 September 2014, Attorney Popo Mfubu wrote the State Attorney advising that the regulation documents used were outdated.¹⁵⁷ The DHA officials also failed ‘to provide reasons to the magistrate on the same day on which the notice was served on him; setting the matter down before the magistrate the day after the notice was served; and to act in terms of the New Immigration Regulations.’¹⁵⁸ Eventually, DHA Immigration Officer Annelise van Dyke from the Paarl Office sent an email indicating that the asylum seeker must stay longer in Pollsmoor for possibly more than the 90 days until his case was finalized.¹⁵⁹ On 30 September 2014, Hassan Gulet was released with a UCT Refugee Rights Clinic attorney present. He then went to the Pretoria Refugee Reception Office and received his Section 22 permit bearing an expiration date of 4 November 2014.¹⁶⁰

¹⁵⁷ According to the Government Gazette No 37679 dated 22 May 2014 on the Arrest, detention, and deportation of illegal foreigners, Regulation 33 of the New Immigration Regulations came into effect on 26 May 2014 and replaced Regulation 28 of the Old Immigration Regulations. Letter to Mr. LK Ndarala, State Attorney from Attorney Popo Mfubu (19 September 2014) para 16. *Hassan Osman Gulet v The Additional Magistrate, for the District of Tulbagh, The Minister of Home Affairs, The Director-General of the Department of Home Affairs, The Officer Commanding Pollsmoor Correctional Facility*, Case No: 16570/14.

¹⁵⁸ Ibid.

¹⁵⁹ Email correspondence 19 September 2014.

¹⁶⁰ He has subsequently received refugee status.

These cases illustrate the fragility of status. Access to healthcare—despite grave medical concerns—is often subordinated to the issue of status, making the right and its implementation difficult to monitor and support.

III REFUGEE PROVIDERS

South African CSOs dot Cape Town streets and many of them work to support refugee, asylum seeker, and economic migrant rights in the Western Cape Province. However, few scholarly studies have documented the efficacy of their work, the actual number of asylum seekers, refugees and migrants in the region and how it relates to law in action. Moreover, how the CSOs are funded and by whom determine which populations they can assist. This has led to a skewed, self-selecting sample of migrants to come forward and seek legal and medical assistance. As in most global contexts, the truly destitute do not typically meet the historical record; yet, their situations can sometimes require emergency access to healthcare and challenge healthcare providers to decide assistance based on limited resources.

Questions about the number of undocumented migrants are discussed openly, yet there is not a clear sense of the actual data in South Africa. Sally Perberdy has suggested that the ‘true number to be between 1.5 and 2.5 million’ people.¹⁶¹ Segatti and Landau in 2011 estimate the undocumented to be around 3 million.¹⁶² How to interpret these national estimates to Cape Town and the Western Cape province remains unclear. According to Deborah Budlender’s report on foreign labour, she concludes, ‘provincially, [the] Western Cape has the highest omission rate for both individuals (18.6 per cent) and households (17.8 per cent)’ in the South African 2011 Census.¹⁶³ She suggests that foreigners who are illegally present in the country were probably unwilling to be counted.

In an effort to begin sketching a Cape Town refugee demographic profile, consultations were initiated with three CSOs – the Adonis Musati Project (AMP),¹⁶⁴

¹⁶¹ S Perberdy ‘Numbers of migrants in South Africa’ (2012) *Gauteng City-Region Observatory*, University of Witwatersrand. J Crush and V Williams ‘Labour Migration Trends and Policies in Southern Africa’ (Policy Brief No. 23) (March 2010) *South African Migration Project*.

¹⁶² Deborah Budlender ‘Improving the quality of available statistics on foreign labour in South Africa: existing data-sets’ (July 2013) *MiWORC Report*. <http://www.miworc.org.za/docs/MiWORC-Report-2.pdf> (Accessed 31 January 2015).

¹⁶³ *Ibid* 50.

¹⁶⁴ The Adonis Musati Project (AMP) was founded in 2007 after a Zimbabwean man died in a queue at the DHA. They are located in Observatory in Cape Town and their mission is ‘to provide humanitarian assistance to vulnerable and disenfranchised asylum seekers and refugees in Cape Town.

the Scalabrini Centre of Cape Town, and the UCT Refugee Rights Clinic. On 20 August 2014, the author met with Executive Director of AMP Laura Wylie to better understand the number of undocumented clients that AMP serves. According to Wylie, AMP helps roughly 240 asylum seekers and refugees per year through their peer counseling programme.¹⁶⁵ AMP also assists another 200 to 250 asylum seekers and refugees per year through ‘walk-ins,’ that is individuals that drop by their office seeking assistance. She noted, ‘many of these walk-ins are repeat clients. Many of these walk-in clients are undocumented and are in need of basic services, such as food and shelter.’¹⁶⁶ To date, AMP has not comprehensively monitored the number of clients served; staff note that their clients return for services and also use the services of other CSOs in Cape Town for various types of assistance. Therefore, it would be difficult to quantify or estimate the number of undocumented individuals from client services as presently structured.

In addition to AMP, the Scalabrini Centre¹⁶⁷ was approached for information. Scalabrini requires researchers to fill out a questionnaire about the research project and its objectives.¹⁶⁸ Scalabrini Director Miranda Madikane thus agreed to provide Census Reports for 2012 and 2013 and other de-identified data on the demographic profile of clients served, such as country of origin, date of entry into South Africa, and legal standing in some cases. According to author Sergio Carciotto of the Scalabrini Centre 2012 Annual Census, ‘since opening in 2002, the Scalabrini Centre has offered welfare and development assistance to an estimated 48,000 refugees or migrants. The Centre receives around 2000 people each month.’¹⁶⁹ In 2012, they administered a questionnaire with 1,021 respondents. Of the 1,021 respondents in

In doing so we aim to provide the support necessary to facilitate a transition to self reliance.’ <http://www.adonismusatiproject.org/> (Accessed 6 December 2014).

¹⁶⁵ AMP employs peer counselors to mentor and work with refugees, asylum seekers, and economic migrants to assist one another. Co-founder Gahlia Brogneri conducted focus-group research to better understand the needs of the communities AMP served. Her findings show that increased number of refugees cannot get legal standing and have difficulty accessing healthcare. See ‘Viability of Peer to Peer Counselling amongst Refugees in Cape Town,’ (Cornerstone Institute, Honors Degree in Psychology University of the Western Cape, December 2013), 22.

¹⁶⁶ Email correspondence with Laura Wylie, Executive Director of AMP (20 August 2014). On file with author.

¹⁶⁷ According to the Scalabrini Centre’s 2012 Annual Census, ‘The Scalabrini Centre operates from Cape Town’s central business district offering welfare, development and advocacy programmes for refugees, asylum seekers, migrants and local South Africans since 2002.’ Sergio Carciotto ‘Scalabrini Centre – 2012 Annual Census,’ *Scalabrini Centre of Cape Town* (15 August 2012) 2

¹⁶⁸ Author questionnaire to Director Miranda Madikane (8 September 2014). On file with author. De-identified data of 3,256 migrants was shared; however the author has yet to tabulate the data.

¹⁶⁹ Sergio Carciotto ‘Scalabrini Centre – 2012 Annual Census,’ *Scalabrini Centre of Cape Town* (15 August 2012) 2.

2012, 44.9 per cent were from the Democratic Republic of Congo (DRC), 14.6 per cent were from Zimbabwe, 10.7 per cent were from South Africa, and 7.7 per cent were from Somalia.¹⁷⁰ In 2013, survey responses changed from 1,221 respondents with 47.1 per cent from the DRC, 8.9 per cent from South Africa, 8.8 per cent from Somalia, 8.5 per cent from Zimbabwe, and 6.8 per cent from Angola.¹⁷¹ The data collected also shows that people came back to Scalabrini during the same week for different services such as English classes,¹⁷² thereby clouding the number of unique individual clients served. The 2012 report did indicate that 97.3 per cent had documentation with 2.7 per cent declaring themselves to be undocumented.¹⁷³ In 2013, the number of undocumented jumped to 18.6 percent of clients accessing Scalabrini services.¹⁷⁴ ¹⁷⁵ Through the questionnaire Scalabrini found that 75 per cent of undocumented respondents sought access to advocacy and welfare services.¹⁷⁶ Scalabrini attributes the large increase of undocumented migrants to the Cape Town Refugee Reception Office closing to newcomers in January 2012.

Recently, the issue of documenting those without papers has become more acute because of the closing of the Cape Town Refugee Reception Office (RRO) in 2012. There have been cases challenging this decision. Despite Judge Davis' interim order to ensure that the Refugee Reception Office remain open for new asylum applications, Judge R W Nugent, in the Supreme Court of Appeal, found that the Director-General and the Department of Home Affairs 'did not act impulsively but took a decision after careful deliberation on what had been a protracted and difficult matter.'¹⁷⁷ However, the RRO is only renewing previous asylum seeker permits, not

¹⁷⁰ S Carciotto, Scalabrini Centre – 2012 Annual Census, 3.

¹⁷¹ The increased number of Angolans can be explained by the Angolan Cessation Project in 2013 that aimed to voluntarily repatriate Angolan refugees who came to South Africa during the Angola Civil War from 1975 until 1990. This was officially confirmed by the 31 July 2013 Notice of Intention to Review the Refugee Status of All Angolan Refugees in the Republic of South Africa issued by the Standing Committee for Refugee Affairs. Thereafter, it was announced (albeit unofficially) by the Chief Director of the Asylum Management directorate. <http://www.enca.com/south-africa/cessation-refugee-status-leaves-angolans-troubled> (Accessed 6 December 2014).

¹⁷² S Carciotto, Scalabrini Centre – 2012 Annual Census, 9.

¹⁷³ S Carciotto, Scalabrini Centre – 2012 Annual Census, 4.

¹⁷⁴ 'Scalabrini Centre of Cape Town – Census Report 2013' (July 2013) 5.

¹⁷⁵ In 2013, the Scalabrini data also indicate that 64.4 per cent of their clients were men and 35.3 per cent were women. This gender skewing can be seen in the UCT Refugee Clinic data as well, suggesting that the migrant profile is more male and/or men tend to seek assistance more often than females. 'Scalabrini Centre of Cape Town – Census Report 2013' (July 2013) 2.

¹⁷⁶ 'Scalabrini Centre of Cape Town – Census Report 2013' (July 2013) 7.

¹⁷⁷ *Minister of Home Affairs v Scalabrini Centre, Cape Town* (735/12 & 360/13) [2013] ZASCA 134 (27 September 2013), paras 7, 89.

accepting new applicants.¹⁷⁸ This has likely resulted in an increase in undocumented migrants in Cape Town because those who arrived after 2012 cannot get an asylum seeker permit unless they have the funds to travel to another RRO to obtain it. Although research has not been done to examine the proliferation of fraudulent documents, the situation seems ripe for fraud and falsification. Moreover, bona fide asylum seeker and refugee claims are getting conflated with cases of economic migrants amidst increased backlogs and cases of persons without any legal standing.

Unlike AMP and Scalabrini, the University of Cape Town Refugee Rights Clinic serves asylum seekers and refugees in a specifically legal capacity rather than by providing social services. The Clinic often takes a leadership role on refugee matters in conjunction with Scalabrini, such as the closing of the Refugee Reception Office in Cape Town and the illegal detentions of asylum seekers at Pollsmoor¹⁷⁹ for the Western Cape Refugee and Migrant Forum.¹⁸⁰ In a preliminary examination of the University of Cape Town Refugee Rights Clinic data, Director Fatima Khan and Attorney Justin De Jager assisted the author by sharing demographic information. All client names and identifiable data were removed prior to examination.¹⁸¹

To place these data in a national and provincial context, the South African 2011 Census estimated that 3.3 per cent of total South African population was non-South African citizens, with 7.4 percent of the Gauteng population being non-South African and 3.3 per cent of the Western Cape being non-South African.¹⁸² The 2001 census calculated that 108,908 foreign nationals lived in the Western Cape out of

¹⁷⁸ Mkuseli Apleni, Director-General Home Affairs Memo to Asylum Seekers, Refugees, Asylum Seeker and Refugee Stakeholders (31 January 2014).

¹⁷⁹ Email from Fatima Khan to Western Cape Refugee and Migrant Forum (1 August 2014) explaining the arrests of undocumented asylum seekers and asylum seekers with expired permits. (On file with author.)

¹⁸⁰ The Western Cape Refugee and Migrant Forum holds meetings approximately every two months to discuss matters affecting migrants in the Cape Town area. These meetings are hosted at Scalabrini with the Cape Town Refugee Centre (CTRC) serving as the secretariat. Participants tend to be NGOs in the area including AMP, Scalabrini, United Nations High Commissioner for Refugees (UNHCR), People's Against Suffering Oppression and Poverty (PASSOP) <http://southafrica.iom.int/>; Agency for Refugee Education, Skills Training & Advocacy (ARESTA) <http://www.aresta.org.za/>; International Organization on Migration (IOM) <http://southafrica.iom.int/>; Sonke Gender Justice <http://www.genderjustice.org.za/>; Legal Resource Centre (LRC) <http://www.lrc.org.za/>; Somali Refugee Aid Agency (SORAA) <https://www.facebook.com/177048542335021/photos/a.574865662553305.1073741825.177048542335021/671193329587204/?type=1&theater> (all websites listed above accessed 6 December 2014).

¹⁸¹ In asking (and complying with) the UCT Law School Research Ethics Committee for an exemption from full ethics review to examine the UCT Refugee Rights Unit's database, Justin De Jager deleted the column with names as to create an anonymised dataset. Email correspondence 20 May 2014 with Dr. Shane Godfrey, REC Chair.

¹⁸² 'Comparing Census 2011 Geography with Previous Censuses,' Figure 2.11: Percentage of non-South African citizens in each province, 44.

1,025,077 foreign nationals in all of South Africa – thus 11 per cent of foreign-born lived in the Western Cape Province. However, within the Western Cape, 87,428 foreign-born lived in the City of Cape Town. This implies that 80 per cent of foreign nationals in the Western Cape live in Cape Town. Of those foreign-born in Cape Town, 33.5 per cent are from the Southern African Development Community (SADC)¹⁸³ and 6.5 per cent are from the rest of Africa – 40 per cent of foreign-born are African migrants in Cape Town.¹⁸⁴ These official census numbers are likely to under-represent the actual number of foreign nationals in Cape Town and the Western Cape Province. Accurate data are difficult to attain for a range of reasons including reliance by the United Nations High Commissioner for Refugees (UNHCR) on data from South African government sources that enumerate foreign nationals seeking asylum and refugee status; by not conducting its own, independent monitoring bona fide asylum seeker and refugee cases are effectively obfuscated.¹⁸⁵ What these numbers suggest is that asylum seeker and refugee stakeholders can only provide glimpses into the total population and the number of foreign nationals residing in South Africa.

In 2012, UNHCR in South Africa handled 65,520 refugee cases with an additional 230,000 asylum seekers.¹⁸⁶ The UCT Refugees Rights Clinic in 2012 handled approximately 3,589 cases – 706 refugee clients and 2,883 asylum seekers; but an estimated 4,041 consultations were handled¹⁸⁷ -- roughly 1.2 per cent of the total South African refugee and asylum seeker population. In 2013, the UCT Refugee Rights Clinic worked with approximately 4,630 clients – refugees and asylum seekers.¹⁸⁸ However, these numbers do not capture the attorneys' interactions

¹⁸³ Member states of SADC: <http://www.sadc.int/member-states> (Accessed 2 February 2015).

¹⁸⁴ Table 7.5 Foreign-born population in the Western Cape, by country of birth and district municipality (2001) Ravayi Marindo, editor, with Cornie Groenewald and Same Gaisie (2008) *The State of the Population in the Western Cape Province* (Human Sciences Research Council) 163.

¹⁸⁵ In July 2013, Loren Landau stated, 'You can be pretty sure the numbers aren't accurate. It is a total mess. UNHCR are totally reliant on what Home Affairs gives them as they don't have any independent monitoring systems.' Julian Rademeyer 'Is South Africa the largest recipient of asylum-seekers worldwide? The numbers don't add up' *Africa Check* (11 July 2013) 5.

¹⁸⁶ *UNHCR Operation in South Africa, Lesotho and Swaziland Fact Sheet* (1 March 2014) <http://unhcr.org/524d87689.pdf> (Accessed 26 May 2014).

¹⁸⁷ 'UCT Refugee Rights Clinic-Statistical Report – Cape Town' Population of Concern, Demographic Characteristics and location for 2012. On file with author.

¹⁸⁸ The United Nations High Commissioner for Refugees (UNHCR) in 2012 handled 65,520 refugee cases with an additional 230,000 asylum seekers making the total of 295,520. <http://unhcr.org/524d87689.pdf> (Accessed 26 May 2014). Based on UNHCR estimates for all of South Africa, the UCT Refugee Right Clinic serviced approximately 1.5 percent of the total asylum seeker and refugee population in South Africa in 2012.

with clients informally giving them advice in the reception area, distributing information, and arranging future appointments. (To the author's knowledge, these informal transactions have not been collected; client reporting is therefore very conservative relative to the services offered.)¹⁸⁹

Of the 4,630 cases in 2013, the UCT Refugee Rights Clinic had 18 files labeled 'health' as the type of matter to come to the clinic for assistance—of those, the majority were related to women and from the Democratic Republic of the Congo (DRC) and Somalia.¹⁹⁰ Table 2.2 breaks down the information between men and women—56 per cent were women, and 44 per cent were men. Of the 18 individuals, 83 per cent (15) were between the ages of 18 and 59, and 17 per cent (3) were over 60 years old. Refugees and asylum seekers from the Democratic Republic of Congo (DRC) were 39 per cent followed by 33 per cent from Somalia. Those from Burundi and Malawi were 11 per cent and Rwanda was 5 per cent.

Table 2.2: Health Cases for Refugees and Asylum Seekers from the University

¹⁸⁹ If a client is deemed an economic migrant and not likely to qualify for refugee status, then he/she is advised to seek services at another NGO/CSO or given precursory information. The Clinic strives to maintain its good relations with DHA and UNHCR to assist bona fide asylum seekers and refugees. Therefore, the free advice given at the front desk does not always make the timesheet database.

¹⁹⁰ The author did not see any of the case files and only had broad demographic data corresponding to the UCT Law School Research Ethics Committee.

of Cape Town's Refugee Rights Clinic 2013 (hereafter UCT)

Health Cases	Numbers UCT	UCT Total	UNHCR in RSA ¹⁹¹	Percentage
<i>A/Seekers Total</i>		3,825	233,100	1.6%
Female				
DRC	4			
Somalia	2			
Burundi	2			
Male				
DRC	2			
Malawi	2			
Rwanda	1			
Somalia	1			
<i>Refugees Total</i>		749	67,500	1.1%
Female				
Somalia	2			
Male				
DRC	1			
Somalia	1			
TOTAL	18	4,630	300,600	1.5%

From these data, some tentative findings include the possibility that refugees and asylum seekers seek to regularise their status in South Africa before handling health issues. Another important consideration is that in 2007, a 'Revenue Directive – Refugees/Asylum Seekers with or without a Permit' was issued by the Department of Health. This document was circulated on 19 September 2007 to Provincial Health Revenue Managers and HIV/AIDS Directorates to remind them of the refugees and asylum seekers' rights according to the South African Constitution Article 27 and the Refugee Act, Act. No. 130 of 1998. Therefore, those working in the UCT Refugee Rights Clinic may have resolved many of the healthcare issues by giving refugees and asylum seekers a copy of the Revenue Directive to present at a healthcare facility.¹⁹² Fatima Khan and Tal Schreier point out, in *Refugee Law in South Africa*, that the South African Health Department's Directive of 2007 corresponds with Hathaway's notion that refugees, particularly those in the less developed world, have the right to 'essential primary health care.'¹⁹³

¹⁹¹ <http://www.unhcr.org/pages/49e485aa6.html> (Accessed 26 May 2014).

¹⁹² Conversation with Fatima Khan on 29 May 2014 with author.

¹⁹³ Fatima Khan and Tal Schreier (2014) *Refugee Law in South Africa* 228-229. Also see Hathaway (2005) *The Rights of Refugees*, 513.

It should also be highlighted that foreign nationals have different identification cards than South Africans, which can confuse medical service providers. For example, asylum seekers are issued a ‘Section 22 Permit’—an asylum seeker permit. Someone who has been granted refugee status in South Africa will be issued a ‘Section 24 permit,’ and a United Nations Convention Travel Document. These are quite different than South African identity documents, and there has been little training to explain these documents to medical service providers and others these documents.¹⁹⁴ For instance, South Africa’s population register is not updated regularly and it only includes citizens and permanent residents (not asylum seekers or refugees).¹⁹⁵ By not understanding the documents and rights of refugees and asylum seekers, administrators or medical service providers can inadvertently deny migrants rights to health and emergency care.¹⁹⁶

As the future of the Refugee Reception Office in Cape Town diminishes its capacity, CSOs in Cape Town will continue to see an increased number of undocumented immigrants and an elevated need for basic services, especially with respect to access to healthcare.

IV HEALTHCARE PROVIDERS

The South African Constitutional right to access health and emergency care under section 27 has been a challenge for healthcare providers at the national, provincial, and municipal levels. What follows then is a brief sketch of how migrants navigate healthcare, and how healthcare providers, in turn, struggle to understand the issues of their patients’ legal status.

In 2012, the International Organization for Migration (IOM) produced ‘Your Guide to Government Health Services: learn how clinics and hospitals work, Understand your rights as a patient, Know what health services expect from patient’ to explain how clinics treat common health needs and problems, and hospitals are for

¹⁹⁴ Fatima Khan, ‘Patterns and policies of migration in South Africa: Changing patterns and the need for a comprehensive approach,’ University of Cape Town, Refugee Rights Project (3 October 2007).

¹⁹⁵ Deborah Budlender ‘Improving the quality of available statistics on foreign labour in South Africa: existing data-sets’ (July 2013) *MiWORC Report*. <http://www.miworc.org.za/docs/MiWORC-Report-2.pdf> (Accessed 31 January 2015).

¹⁹⁶ ‘It is important to keep in mind that at present asylum-seekers are registered in a national refugee database administered by the Department of Home Affairs. This national refugee database exists separately from the National Population Register; in other words, despite being issued with identity documents that have a thirteen-digit bar-code number, as is the practice with citizens and permanent residents, recognized refugees are not included in the National Population Register.’ Belvedere, Pigou & Handmaker (2008) 276 n100.

serious emergency treatment that cannot be treated at the Clinic.¹⁹⁷ The 36-page-how-to-guide also cites the 2007 Department of Health letter indicating that refugees and asylum seekers, with or without a permit, that ‘do access public health should be assessed according to the current means test.’¹⁹⁸ This is quite different than medical tourists who enter South Africa to receive specific medical treatment and are expected to pay in full their medical costs. Medical tourists need proof of financial means to cover medical costs and proof of sufficient financial means or provisions for the costs indirectly related to the treatment.¹⁹⁹ The IOM Guide also clearly states, ‘you cannot be refused medical treatment just because you do not have an identity document.’²⁰⁰ This also extends to refugees and asylum seekers, with or without a permit, who are exempted from paying for antiretroviral treatment (ART). Although this IOM guide is legally accurate, practices diverge. Patients, healthcare providers, and CSOs struggle to navigate an ambiguous space between theory and practice.

This divergence between access to healthcare and patients’ legal standing becomes more difficult under the Western Cape provincial guidelines and the efforts of Cape Town City officials to secure funding for resource-strapped clinics and hospitals. In the Western Cape Provincial ‘2030: Road to Wellness’ and Western Cape Government Health Annual Report (2013), government officials describe their effort to provide wellness in the context of ‘burdening diseases.’ Migrants, foreign nationals, and changing demographics are scantily noted; yet for Cape Town 2030 under key demographic trends, the report notes that Cape Town’s population will continue to grow each year because of migration.²⁰¹ The document states, ‘the nature and extent of migration, both internal and trans-national, are the most prominent unknown variables. The number of refugees and displaced persons is likely to increase adding to Cape Town’s population growth through migration.’²⁰² This concern with migration (internal and cross-border), foreign nationals, and government’s limited resources plays out in access to health and emergency care. In examining Cape Town’s projected trends from 2010- 2030, a 2010 ‘Demographics

¹⁹⁷ ‘Your Guide to Government Health Services: Learn how clinics and hospitals work, Understand your rights as a patient, Know what health services expect from patients,’ *IOM International Organization for Migration* (2012) 5.

¹⁹⁸ IOM Guide (2012) 15.

¹⁹⁹ Immigration Act, 2002 Immigration Regulations (22 May 2014) Section 16 (1) 25.

²⁰⁰ IOM Guide (2012) 23.

²⁰¹ *Healthcare 2030: The Road to Wellness: Western Cape Government* (March 2014) 157.

²⁰² *Healthcare 2030* (2014) 157.

Scenario Discussion Paper,’ noted, ‘the number of refugees and displaced persons is likely to increase possibly adding to Cape Town’s in—migration into the future.’²⁰³

This nexus between refugee and migrant rights in South Africa and access to health and emergency care is in some measure driven (and sometimes hampered) by the healthcare providers themselves. Laurel Baldwin-Ragaven, Jeanelle de Gruchy and Leslie London have advocated for accountability to their patients, and the need to ‘recognise and empower vulnerable groups. Health professionals need to be sensitive to the needs not only of vulnerable patients but also vulnerable groups.’²⁰⁴ According to the National Public Service Access Survey conducted in 2007-2008 with 3,000 international migrants²⁰⁵ by the Migrant Rights Monitoring Project (coordinated by the African Centre for Migration and Society [ACMS hereafter] at the University of Witwatersrand), ‘thirty per cent of respondents who reported ever needing healthcare experienced challenges when attempting to access public healthcare services.’²⁰⁶ This builds on earlier work from the National Refugee Baseline Survey in 2003 in which 17 per cent of African asylum seekers and refugees who sought emergency services were refused access, and of these cases 45 per cent indicated that administrative personnel at public hospitals were identified as those refusing care. The 2003 study also showed that 26 per cent of asylum seekers and refugees were refused medical service because they were unable to pay, while 14 per cent argued that the medical facility did not accept their documents.²⁰⁷ Subsequently, the asylum seekers and refugees relied on their own income to pay for services or would approach friends and family for assistance.²⁰⁸ Although these two studies are limited by their sample size and do not necessarily reflect the current situation, they do illustrate the disjuncture between the intent of the South African constitution, the right to access to healthcare, and the practices.

The 2007 Revenue Directive suggests that some changes have been

²⁰³ ‘Demographics Scenario Discussion Paper’ (27 August 2010) City of Cape Town, Strategy and Planning, Strategic Information and GIS, 15.

²⁰⁴ Laurel Baldwin-Ragaven, Jeanelle de Gruchy, and Leslie London *An ambulance of the wrong colour: Health Professional, human rights, and ethics in South Africa* (Cape Town: University of Cape Town Press, 1999) 211.

²⁰⁵ The five cities included Cape Town, Durban, Johannesburg, Port Elizabeth, and Pretoria. Joanna Vearey ‘Migration and Health in South Africa: Implications for Development’ in Aurelia Segatti and Loren B. Landau (eds) *Contemporary Migration to South Africa: A Regional Development Issue* (2011) 127-128.

²⁰⁶ Vearey (2011) 128.

²⁰⁷ Belvedere, Pigou & Handmaker (2008) 272-273 n37.

²⁰⁸ Belvedere, Pigou & Handmaker (2008) 273 n46.

implemented in the Cape Town area; however, in Gauteng, access to healthcare issues seem to be more widespread as evidenced by the existence and work of the Migrant Health Forum. Scholars at the African Centre for Migration and Society (ACMS), such as Joanna Vearey, have been pushing for the recognition of migrant health issues and have established the Migrant Health Forum to circulate guidelines on how to advocate for basic healthcare rights, and how to document complaints and difficulties in accessing healthcare. The Migrant Health Forum illustrates a convergence of CSOs, scholars, and citizen groups to press for the rights of ‘everyone’ in South Africa, push the boundaries of public spaces, and call for a reexamination of public health responses to migrants, especially in the cases of João and Joy.²⁰⁹

VI JOÃO AND JOY²¹⁰

The stories of João and Joy represent the growing number of indigent foreign nationals in Cape Town, both with and without legal status, who face grave medical conditions and need access to health and emergency care. In both of their situations, the cost of their respective treatments was determined by an authority, a hospital administrator, who denied them access. Both died as a result of not receiving adequate, timely care.

In 2010, João, a 27 year-old patient from Angola was denied life-saving treatment in Cape Town and died, wrote his attending physician.²¹¹ In a District Hospital on 25 October 2010, he had signs of severe aortic regurgitation and was treated with diuretics and vasodilator therapy. João was then transferred to a Tertiary Hospital for work up for aortic valve replacement. The cardiology unit declined assess to João because it was their understanding that they could not provide healthcare to a foreign patient until the Medical Superintendent had given approval. He did not receive the replacement and died shortly thereafter.

In corresponding with João’s doctor, a ‘Protocol for the provision of Health Services for Foreign Nationals’ dated 13 December 2010 from the Tertiary Hospital was communicated. This circular appears to serve as a rubric for a doctor’s care for foreign nationals seeking ‘elective’ health services. However, the document also

²⁰⁹ Vearey (2011) 121-135.

²¹⁰ The patients’ names have been changed to respect their families’ privacy.

²¹¹ Letter on file with author (3 June 2014).

states under ‘General Principles,’ that care for foreign nationals without permanent residency or refugee status, ‘an evaluation of the optimal conservative treatment that can be provided.’²¹² It can be read to instruct conservation of health resources to the point of restricting physicians in the exercise their best medical judgments in treating foreign patients. The document further notes under ‘Admission and Treatment Protocol’ that other than an emergency, only those foreign patients specifically referred to the hospital and authorized by the respective Medical Superintendent...may be admitted and treated.’²¹³ Three pages later the document, instructs the following:

4.5 Staff should be aware that if they do not comply with the procedures as outlines, and foreign patients are admitted without the necessary consent and deposit, the responsible staff member **may be held liable for the account [author’s emphasis]**. This applies to Administrative Reception staff who admit foreign patients, and doctors who arrange to admit a foreign patient without having obtained the necessary Manger: Medical Services authority.²¹⁴

Informal conversations with clinicians working at this Tertiary Hospital suggest that they have heard about such protocols from medical supervisors, but have never seen them.²¹⁵ The 2010 protocol not only put legal authority into medical administrators’ hand, but it puts doctors in an untenable position of trying to help patients while ascertaining their legal status and making the doctors financially liable for such decisions. João was a bona fide asylum seeker with a Section 22 Permit; however, his care was too costly, under progressive realisation, for the hospital to give the treatment João required.

The story of Joy came to the author’s attention on 27 August 2014. The Adonis Musati Project emailed to inquire about how to get Joy papers in order to receive chemotherapy. Joy was a 26 year-old Zimbabwean, spoke no English, and entered South Africa without documents in 2012. She was diagnosed with Kaposi Sarcoma, a type of cancer related to her HIV infection. Kaposi is treatable with chemotherapy and patients can have a good prognosis; however, without treatment, Joy was likely to die. She was also diagnosed with HIV during her second pregnancy

²¹² ‘Protocol for the provision of Health Services to Foreign Nationals, General Principles (B3) 2.

²¹³ Ibid, 3.

²¹⁴ Ibid, 6.

²¹⁵ On 20 November 2014, the author gave a talk in Public Health and mentioned this topic. When the audience was queried about whether such a Protocol existed and circulated, a few members of the audience approached the author and mentioned that they were given instructions along these lines. These doctors wanted to see the Protocol themselves.

in South Africa, and had not taken anti-retroviral therapy. She first went to a District Hospital and was referred to a Tertiary Hospital for chemotherapy. The Tertiary Hospital administered her first round of chemotherapy, but denied her second treatment on 2 September 2014 because the hospital administrator determined Joy had ‘no papers.’ This hospital administrator is the same person, who had previously denied João treatment.²¹⁶

On 8 September 2014, Joy went the UCT Refugee Clinic to discuss her options. She decided her best option was to return to Zimbabwe and seek chemotherapy there. (She had a translator from AMP to assist her.) However, on 12 September 2014, Joy experienced chest pains and returned to the District Hospital where she stayed a number of days. On 16 September 2014, she returned to the Tertiary Hospital for the second round of chemotherapy on the basis that she would soon be returning to Zimbabwe. On 27 September 2017, Joy, her husband, and 18 month-old son returned to Chipange, Zimbabwe. She died on 10 November 2014.

Joy’s case illustrates the problematic nature of healthcare providers trying to determine someone’s legal standing along with accessing appropriate medical treatment. Joy’s doctors reached out to AMP for guidance and several individuals worked with Joy to provide her legal and medical assistance. Yet, a few issues were not addressed. It was never clear (probably because of her lack of English) how Joy contracted HIV. If, for example, she was raped at the South African-Zimbabwean border, this might have supported an asylum claim.²¹⁷ Instead, Joy self-identified as someone who came to South Africa looking for work – an economic migrant. As such, she could not attain legal status in South Africa (or would have to seek a work

²¹⁶ This individual is an officer in the South African Society of Medical Managers. The mandate of the organisation is: ‘...to represent Medical Managers to serve its members and strives to create an environment where all health care workers can work together to improve the health of the nation. The Society requires the active support of the Medical Managers to make Medical Managers a recognised speciality in South Africa.’ <http://www.medicalmanager.org.za/> (Accessed 10 December 2014).

²¹⁷ According to Doctors without Borders (Médecins Sans Frontières), from May 2008 through April 2009 ‘more than 75% of clients seen by MSF in April were raped while crossing the border [Zimbabwean-South African border], and nearly 60% were raped by more than one perpetrator. Seventy percent of the time, rapes were perpetrated with an armed threat (gun, knife, etc.) and almost 50% of clients had injuries due to associated violence.’ ‘No Refuge, Access Denied: Medical and Humanitarian Needs of Zimbabweans in South Africa’ (June 2009)

<http://www.doctorswithoutborders.org/news-stories/special-report/no-refuge-access-denied-medical-and-humanitarian-needs-zimbabweans-south>

(Accessed 1 February 2015) 14. Many of the guma guma gangs intentionally try to infect women with HIV. Rosalind Elphick and Roni Amit *Border Justice: Migration, Access to Justice and the Experiences of Unaccompanied Minors and Survivors of Sexual and Gender-Based Violence in Musina* ACMS (2012) 22. <http://www.migration.org.za/uploads/docs/report-36.pdf>

visa). Also in retrospect, her treatment of care did not seem economically optimal. After she was denied the second round of chemotherapy, she ended up in the District Hospital for several days. What would have happened if the Tertiary Hospital had administered her second round of chemotherapy as scheduled? Would she have been strong enough to return back to Zimbabwe without the additional time spend in the District Hospital? In speaking with the doctors, Joy's case was extreme, and it is difficult to ascertain the different outcomes with certainty. However, it is worth asking the question of whether an initial denial because of legal status truly yielded cost savings in the end.

When conflating patient treatment with a person's status, medical administrators allocate limited resource questions in the name of progressive realisation. This practice does not comport with the spirit of the South African Constitution and its aspiration to treat everyone. Moreover, according to the Physicians for Human Rights' *Dual Loyalty & Human Rights: In Health Professional Practice* (2002):

- (1) The health professional should recognize that refugees and immigrants have a human right to equal access to health care;
- (2) Health professionals should not report immigrants who lack legal status to government authorities;
- (3) Health professionals should not disclose information gained in the course of treatment of refugees to state authorities;
- (4) Health professionals should not participate in medical examinations on behalf of the state for the purpose of refugee's eligibility for entering into the country....;
- (5) Health professionals should insist that medical services for refugees and immigrants, and examination for determination of status include interpreters;
- (6) Health professionals acting as evaluators in asylum procedures and court procedures should be aware of potential dual loyalty conflicts if providing treatment to refugees as well.²¹⁸

As physicians struggle to fulfill their obligation to treat everyone to a high standard of health services, they are also keenly aware of state policies to limit access to healthcare, through 'either legal requirements or limitations on reimbursements for services.'²¹⁹ The Dual Loyalty document aims to offer guidance and support for health professionals, but clearly, law in action falls shorts of the socio-economic

²¹⁸ 'Dual Loyalty & Human Rights: In Health Professionals Practice; Proposed Guidelines & Institutional Mechanisms' International Dual Loyalty Working Group *Physicians for Human Rights* (2002).

²¹⁹ Ibid.

aspirations of the South African Constitution and international norms. In returning to Cape Town and the Western Cape Province specifically, asylum seekers, refugees, and cross-border migrants often encounter medical service providers facing dual loyalties of patient care and hospital constraints.

VII CONCLUSION

According to the Western Cape Government in examining a percentage of total admission to hospitals, foreign nationals represented only 1.6 per cent.²²⁰ This figure is artificially low because hospital admissions require that postal codes in the Western Cape be given for follow-up, thereby reducing the patient's ability to list two addresses. As Nesbert Zinyakatira from the Directorate of Health Impact Assessment of the Western Cape Government Health indicates, 'but from the limited data available and small studies that have been undertaken, it would be safe to assume that there will be an increase in the use of public health services by people from outside the province...'²²¹ As the Western Cape faces the 'quadruple burden of disease',²²² the migrants are also affected by this, hence they will ultimately end up using public health facilities that are in the province thereby increasing the strain on the services.'²²³

With this additional strain on services and questions of resource allocation, the divergence between law and healthcare will become more acute for refugees, asylum seekers, and other migrants. Their legal standing is complicated by the Department of Home Affairs' 89 per cent rejection rate that makes an accurate assessment of the bona fide number of asylum seekers and refugees difficult to ascertain. The inability to understand how many undocumented migrants are in Cape Town and the Western Cape Province more generally hampers policy because data points are not clear. Lastly, hospital administrators have become self-appointed 'gate keepers' forcing doctors to turn to CSOs and civil society for assistance to administer care. In discussing this situation, James Hathaway notes that medical personnel

²²⁰ 'The Impact of Migration on health system of the Western Cape Province' Western Cape Government Health (March 2014). 'Not for wide circulation.' 10.

²²¹ 'The Impact of Migration on health system of the Western Cape Province' Western Cape Government Health (March 2014). 'Not for wide circulation.' 11.

²²² These are: pre-transitional diseases and poverty related conditions, emerging chronic diseases, an extremely high burden of injuries and the HIV/AIDS epidemic.

²²³ Ibid.

sometimes act as ‘gatekeepers’ among refugees and other vulnerable patients in medical facilities. In 2000, journalist Khadija Magardie from the South African newspaper *Mail & Guardian* reported that a South African nurse chased an Angolan refugee seeking immunization of her child away from a Mpumalanga clinic, shouting that “‘she, a foreigner, was eating South African medicines.’”²²⁴ Ultimately, as Geoff Budlender explains, ‘democracy...needs rights which are guaranteed to everyone, particularly when they are in a minority, and particularly where they are marginalised or powerless.’²²⁵ Indeed, the fate of asylum seekers, refugees and cross-border migrants in South Africa and their access to healthcare test South Africa’s commitment to its democracy.

²²⁴ Khadija Magardie *Mail & Guardian* (25 September 2000).

<http://www.queensu.ca/samp/sampresources/migrationdocuments/commentaries/2000/foreignne.htm> (Accessed 6 July 2014).

²²⁵ Geoff Budlender ‘People’s Power and the Courts: Bram Fischer Memorial Lecture, 2011’ http://www.casac.org.za/?wpfb_dl=1 (Accessed 1 February 2015) 4.

Conclusion: ‘Don’t send your sick here to be treated’

I SUMMATION

In conclusion, this minor dissertation has argued that access to healthcare as granted to everyone has led to inconsistent court rulings and obtuse legislation. Moreover, native South Africans are resentful of foreigners depleting scarce resources. As noted earlier, a 27 year-old Ethiopian man was refused dialysis and died in November 2014 because he did not qualify for an organ transplant as a non-South African. The on-line posts are telling. One person commented: ‘Ethiopian president should take note of this. Don’t send your sick here to be treated, our own people need it more.’²²⁶ Can South Africa afford to grant everyone socio-economic rights?

Chapter 1, entitled, *Can Everyone Access Health and Emergency care in South Africa?*, asks who can access health and emergency care in South Africa as a legal right. It argues that refugee law and immigration law should not be read in isolation of each other. How international doctrines shape such rights, and in turn, how the Constitutional Court has adjudicated the three cases of *Soobramoney*, *the Treatment Action Campaign*, and *Khosa* illustrate this attempt to respect state obligations and limited resources. The challenge of resource allocation has been compromised specifically by the Immigration Act 13 of 2002 and the Immigration Regulations of 2014, and to some extent by National Health Act of 1998. Read together, these laws fail to give healthcare providers clear guidance about who they can treat and under what circumstances.

Chapter 2, entitled, ‘Foreigners are eating South African medicines’: *When Law and Access to Healthcare Diverge*, demonstrates increased confusion about distinguishing refugees and asylum seekers from economic migrants, and how this relates to the Department of Home Affairs’ 89 per cent rejection rate of asylum seekers. By the DHA not properly managing migration, South Africans are unclear about who is legal (has papers) and who is not. This obscuration directly affects healthcare providers and how they can treat their patients. As the cases of João and Joy illustrate, overzealous hospital administrators over step their roles in the name of

²²⁶ Zeldá Venter ‘Refugee dies before court challenge,’ *IOL news* (25 November 2014) <http://www.iol.co.za/news/crime-courts/refugee-dies-before-court-challenge-1.1785858#.VH4HM9YVcUU> (Accessed 2 December 2014).

limited resources, barring treatment from doctors to patients in needs of life-sustaining care.

Ultimately, this dissertation has argued that legal authority has been misplaced onto hospital administrators who are not authorized to decide people's legal standing. In the South African context, their practices violate human dignity for refugees, asylum seekers and immigrants. In the process of hospital administrators determining patients' status, doctors are largely uninformed about whom they can treat and to what degree, and patients are not getting the healthcare that they are entitled to receive. In turn, doctors go to CSOs for clarification on the law and how they can help their patients.

II POLICY RECOMMENDATIONS

By way of conclusion, three policy recommendations emerge from the research herein to improve access to health and emergency care for asylum seekers, refugees, and migrants.

- 1) The National Health Act of 1998 should be amended to include migrants as a vulnerable group. *Outcome:* This would empower doctors and nurses to focus on medical treatment protocol of their patients regardless of their legal standing.
- 2) It is important to reach out to the South African Society of Medical Managers to help them better understand that they do not have the authority to determine an individual's legal standing and whether they can/cannot access health and emergency care. This training would need to include an in-depth discussion of the Department of Home Affairs. *Outcome:* This could help medical superintendents at Tertiary Hospitals to better assist doctors and patients rather than creating barriers to access healthcare.
- 3) It is the author's hope to create a Migrant Health Forum in Cape Town, the Western Cape Province with academics, CSO stakeholders, city, provincial and ideally DHA functionaries. This type of Forum has been created in Johannesburg; however, stakeholders tend to be CSOs and academics versus city and government officials. The aim would be to create a dialogue about how to better assist indigent migrants (both internal and cross border foreign nationals) with acute chronic medical conditions. *Outcome:* By bringing stakeholders together, a regional discussion can begin on the demographic

profile of asylum seekers, refugees, and migrants trying to access healthcare and how best to help them with the resource constraints.

These recommendations are by no means the only recommendations possible and they are modest; however, they could be a start to recognise the increased presence of migrants in Western Cape Province. Moreover, as the Cape Town Refugee Reception Office's continues to refuse applications to new asylum seeker permits, both bona fide asylum seekers and economic migrants will be conflated as undocumented immigrants. This puts the immigrant population at risk of detention and deportation.

Although no litigation is pending on refugee and migrant access to health and emergency care, the need for change emanating from the courts is critical. To return to the aspiration of the South African Constitution to grant everyone the access to health and emergency care, perhaps future cases will have to tackle the notion of everyone receiving socio-economic rights versus South African citizens. Until then—as South Africans look to the celebration of 20 years of the Constitution and democracy—asylum seekers, refugees, migrants and citizens can aspire to the equitable and just consumption of medicine and access to health and emergency care as a means to stabilize the pillar of peace for all residents in South Africa.

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