

**THE RIGHT TO NOT BE REFUSED EMERGENCY  
MEDICAL TREATMENT IN SOUTH AFRICA**

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# CHAPTER 1

## INTRODUCTION

### I. INTRODUCTION

Access to healthcare or medical attention is vital for every person in South Africa. It is unavoidable regardless of age, race, gender or citizenship. Every human being needs to have access to some form of healthcare at some stage of his or her life. In appreciation of this necessity, the Constitution recognises the right of everyone to have access to healthcare.<sup>1</sup> The state has a duty to ensure the realisation of this right.<sup>2</sup> Guaranteeing every person in the country the right to have access to healthcare has proven to be a formidable challenge for the government in South Africa and sub-Saharan Africa in general.<sup>3</sup> Despite South Africa being regarded as a ‘middle-income country’, the state of the country’s healthcare is much worse than many countries that are deemed ‘lower-income’.<sup>4</sup>

A specific focus in this study is emergency medical treatment and how one’s socioeconomic status affects access to such treatment. Section 27(3) of the Constitution provides that nobody ‘may be refused emergency medical treatment’. Likewise, the Patient Rights Charter makes specific provision for the right of everyone to receive ‘timely emergency care at any health care facility that is open, regardless of one’s ability to pay’.<sup>5</sup> The sad reality is that this right is often not realised for many people due to their inability to pay for expensive private healthcare facilities.

### II. BACKGROUND

In the event of sickness or trauma that may require medical treatment, 71.5 per cent of South Africans have indicated in a recent General Household Survey that the first place they would go to is a public healthcare institution, including public clinics and hospitals.<sup>6</sup> In comparison, 27.1 per cent of South Africans have expressed that their first point of contact in times of medical need is a private healthcare facility.<sup>7</sup> The overwhelming majority of South Africans are reliant on the public healthcare sector.

When asked about their experiences at public healthcare institutions, only 53.8 per cent of South Africans said that they were ‘very satisfied’ and 26.5 per cent said that they were ‘somewhat satisfied’.<sup>8</sup> The level of satisfaction with private healthcare facilities was much higher with 92.6 per cent of South Africans who used these services, demonstrating that they were ‘very satisfied’, with only a tiny margin expressing some level of dissatisfaction.<sup>9</sup> This on its own can be construed as an

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<sup>1</sup> S 27(1) of the Constitution of the Republic of South Africa, 1996 (hereafter Constitution).

<sup>2</sup> S 27(2) Constitution.

<sup>3</sup> DM Chirwa ‘Access to medicines and health care in Sub-Saharan Africa: a historical perspective’ (2016) 31 *Maryland Journal of International Law* 21.

<sup>4</sup> H Coovadia *et al* ‘The health and health system of South Africa: historical roots of current public health challenges’ (2009) 347 *The Lancet* 817.

<sup>5</sup> Item 2.3 (a) of the Patients’ Rights Charter (2000).

<sup>6</sup> Statistics South Africa ‘General household survey’ 28 May 2019 at 25, available at <http://www.statssa.gov.za/publications/P0318/P03182018.pdf> accessed on 15 August 2020.

<sup>7</sup> Statistics South Africa (n 6 above) 25.

<sup>8</sup> As above.

<sup>9</sup> As above.

indication of superior medical care being provided to those who can afford private healthcare facilities in comparison to those who do not have the privilege of relying on private healthcare services.

Private healthcare services can be expensive, which is why some people opt for medical aid cover. As of 2018, only 16.4 per cent of South Africans had medical aid cover.<sup>10</sup> Less than a quarter of households in South Africa had a minimum of one person covered belonging to a medical aid.<sup>11</sup> Provinces in South Africa where there is a higher probability of people belonging to some form of medical scheme include Gauteng, with 23.9 per cent, and the Western Cape leading with 25.1 per cent.<sup>12</sup> South Africans in Limpopo and the Eastern Cape have been found least likely to be covered by medical aid.<sup>13</sup> There are extreme inequities when it comes to race and medical aid coverage in South Africa. While 72.9 per cent of white people in South Africa are covered by a medical aid scheme, only about half of the Indian or Asian demographic are members and 17.1 per cent of coloured South Africans have such cover.<sup>14</sup> Despite making up a majority of approximately 80.7 per cent of the South African population,<sup>15</sup> only 9.9 per cent of the black African demographic in South Africa are covered by a medical aid scheme.<sup>16</sup>

The South African Department of Health derives its responsibilities in terms of the provision of health services in the country from the National Health Act 61 of 2003.<sup>17</sup> In the public healthcare sector, a budget of R238.3 million has been allocated towards primary healthcare for the 2020/2021 period by the Department of Health.<sup>18</sup> ‘Emergency medical services and trauma’ are included under primary healthcare in this budget allocation.<sup>19</sup> Out of this amount, R9 million was set aside as an estimated budget specifically for emergency medical services and trauma.<sup>20</sup>

There has been a steady decline in emergency healthcare workers registered with the Health Professions Council of South Africa (HSPCA) in recent years.<sup>21</sup> There were 70 051 emergency healthcare workers registered with the HSPCA in April 2016 compared to 59 721 workers being registered in April 2019.<sup>22</sup> Of this number, 2 062 of those emergency care workers registered with the HPSCA in 2019 were students still completing their training.<sup>23</sup> It is important to note that this total amount of

<sup>10</sup> Statistics South Africa (n 6 above) 26.

<sup>11</sup> As above.

<sup>12</sup> As above.

<sup>13</sup> As above.

<sup>14</sup> Statistics South Africa (n 6 above) 27.

<sup>15</sup> Statistics South Africa ‘Mid-year population estimates’ 29 July 2019 at 6, available at <https://www.statssa.gov.za/publications/P0302/P03022019.pdf> accessed on 6 June 2020.

<sup>16</sup> Statistics South Africa (n 6 above) 27.

<sup>17</sup> National Treasury Republic of South Africa ‘Estimates of national expenditure 2020’ at 1, available at <https://data.vulekamali.gov.za/dataset/2b66dba0-fa8e-42e8-9a0e-cff4a3ce94b9/resource/47725eba-3e67-4fb3-96be-a95c8c11f44f/download/vote-18-health.pdf> accessed 23 May 2020.

<sup>18</sup> National Treasury Republic of South Africa (n 17 above) 1.

<sup>19</sup> National Treasury Republic of South Africa (n 17 above) 14.

<sup>20</sup> As above.

<sup>21</sup> Health Professions Council of South Africa ‘Annual report’ 2019 at 32, available at <https://www.hpcs.co.za/Uploads/Publications%202019/Annual%20Report/HPCSA%20Annual%20Report%202018-19%2010102019.pdf> accessed 23 May 2020.

<sup>22</sup> As above.

<sup>23</sup> As above.

emergency healthcare workers registered with the HPSCA includes both the private and the public sector, as well as those who are retired or are working abroad.<sup>24</sup>

The disparities between the human resources within the public and private healthcare sectors are concerning. Out of the 15 008 medical specialists registered with the HPCSA in 2015, only 4 986 operated in the public healthcare sector with the remainder of specialists working in the private sector.<sup>25</sup> The existence of private healthcare facilities has resulted in far better healthcare being provided to the well-to-do while the poor cannot access such healthcare and are left to rely on state healthcare.<sup>26</sup>

In the event of a medical emergency, receiving the necessary medical treatment immediately, or as soon as possible, can make the difference between life or death and any delay in treatment can have serious lasting consequences, including permanent disability and impaired quality of life.<sup>27</sup> Unfortunately for countless people in South Africa, many hurdles must first be faced before they can access emergency medical treatment.

### III. RESEARCH QUESTIONS

The main research aim of this study is to establish the extent to which the right to not be refused emergency medical treatment is protected and realised in South Africa, particularly for the poor. There are several research questions which stem from this. The first question is: how is this right recognised? Is it recognised under international law and comparative constitutional law, and if so, how is this done? What is the meaning of this right? This will be considered along with the implications that go hand-in-hand with the various interpretations of what constitutes a ‘medical emergency’. Furthermore, this dissertation aims to determine the obligations of states as well as non-state entities arising from this right. The dissertation further seeks to determine whether the current legislative framework in place in South Africa is adequate, whether it is being effectively implemented in practice, and if not, what challenges stand in the way of effective implementation.

The main argument to be made in this dissertation is that although there may be a right to not be refused emergency medical treatment in South Africa, this right remains unrealised for many in South Africa. This study aims to highlight, in particular, the many challenges the poor in South Africa experience in accessing emergency medical treatment.

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<sup>24</sup> D McIntyre & J Ataguba ‘Access to quality health care in South Africa: is the health sector contributing to addressing the inequality challenge?’ October 2017 at 15, available at [https://www.parliament.gov.za/storage/app/media/Pages/2017/october/High\\_Level\\_Panel/Commissioned\\_reports\\_for\\_triple\\_challenges\\_of\\_poverty\\_unemployment\\_and\\_inequality/Diagnostic\\_Report\\_on\\_Access\\_to\\_Quality\\_Healthcare.pdf](https://www.parliament.gov.za/storage/app/media/Pages/2017/october/High_Level_Panel/Commissioned_reports_for_triple_challenges_of_poverty_unemployment_and_inequality/Diagnostic_Report_on_Access_to_Quality_Healthcare.pdf) accessed 26 June 2018.

<sup>25</sup> As above.

<sup>26</sup> Chirwa (n 3 above) 35.

<sup>27</sup> South African Human Rights Commission (SAHRC) *Hearing report: Access to emergency medical services in the Eastern Cape* (2015) 99.

#### IV. SIGNIFICANCE OF THE STUDY

The World Health Assembly has emphasised that emergency healthcare is an overlooked part of healthcare services despite how vital it is.<sup>28</sup> This study seeks to shed light on the hurdles many poor South Africans face to realise their right of access to healthcare in general and emergency medical treatment in particular.

Access to emergency medical treatment in South Africa, or a lack thereof, has not been sufficiently considered from a legal standpoint. The challenges that the poor in South Africa encounter when faced with dire emergency medical situations has been overlooked from a legal academic perspective. A few medical journals have touched on it, and there have been isolated headlines from the media, but not enough literature exists that considers the barriers millions of people in South Africa face in realising this (often life-or-death) right to not be refused emergency medical treatment. There is a lack of case law reporting on the gross violations of thousands of people's rights to healthcare, dignity and life in medical emergencies. Not enough has been reported on patients who are not able to afford medical aid cover.

There are severe gaps in South African legislation relating to emergency medical treatment. The current legislative framework that is in place is vague and inadequate. The South African Human Rights Commission (SAHRC) has remarked that there is not enough clarity on the right to not be refused emergency medical treatment in the Constitution and other legislation.<sup>29</sup> The National Health Act,<sup>30</sup> for example, is silent when it comes to defining emergency medical treatment or medical emergencies.<sup>31</sup> The current policies and legislation governing emergency medical treatment need to be scrutinised to identify those gaps in the law that are hindering the realisation of the right to not be refused emergency medical treatment, for all.

This study aims to contribute to legal research on the right to not be refused emergency medical treatment, to highlight the violations of this right that occur daily in South Africa and explore the responsibilities of various stakeholders in the public and private sectors towards all people in South Africa with a specific focus on the rights of indigent patients.

#### V. LITERATURE REVIEW

The Preamble of the controversial National Health Insurance Bill (B11 2019 GG 42598 of 26 July 2019) (NHI Bill), which was introduced into the National Assembly in 2019, explicitly seeks to redress the severe divisions in the healthcare sector which stem from the 'inequities of the past' in South Africa.<sup>32</sup> The work of various authors will be used to highlight the injustices perpetrated in the South African healthcare system in the past. To look forward to finding solutions to the challenges our healthcare system currently faces, it is important to consider the reasons why our

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<sup>28</sup> World Health Organisation, Sixty-Eighth World Health Assembly Resolution WHA68.15 'Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage' 26 May 2015, available at [https://apps.who.int/gb/ebwha/pdf\\_files/WHA68/A68\\_R15-en.pdf?ua=1&ua=1](https://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_R15-en.pdf?ua=1&ua=1), accessed on 16 November 2020 (hereafter WHA68.15).

<sup>29</sup> SAHRC (n 27 above) 87.

<sup>30</sup> National Health Act 61 of 2003 (NHA).

<sup>31</sup> DJ McQuoid-Mason 'Emergency medical treatment and 'do not resuscitate' orders: when can they be used?' (2013) 103 (4) *South African Medical Journal* 223.

<sup>32</sup> The 'National Health Insurance Bill' (B11 2019 GG 42598 of 26 July 2019) (NHI Bill).

healthcare system is the way it is today. This is relevant to determining the extent to which emergency healthcare is accessible by South Africans from all walks of life and what accounts differences of such access.

In the book, *An ambulance of the wrong colour: health professionals, human rights and ethics in South Africa*, Baldwin-Ragaven et al report on the healthcare sector during the apartheid era in South Africa.<sup>33</sup> This book recounts factual stories of the lived experiences of South Africans during apartheid as they were told during the health sector hearings as part of the Truth and Reconciliation Commission.<sup>34</sup> Of most relevance to this study is the book's discussion on 'ambulance apartheid', which highlights the fundamentally racist policies of the healthcare sector in South Africa during the apartheid era and the horrific ramifications thereof.<sup>35</sup> In this work there are real-life testimonies of people who experienced discrimination, where ambulances and other emergency medical services were designated according to race, resulting in gross violations of fundamental human rights.<sup>36</sup> It is because of the race-based policies at the time that many South Africans did not receive emergency medical treatment in times of need.<sup>37</sup> This work is significant to the discussion at hand, as it not only showcases the cruelty of the apartheid government at the time, but also the failures of the medical profession in ensuring that all people in South Africa received the necessary treatment that they required during medical emergencies.<sup>38</sup>

The work of Chirwa also focuses on the history of healthcare in sub-Saharan Africa and highlights that historically, superior healthcare was provided to citizens and residents of European origin while lesser quality healthcare was provided to those of African origin.<sup>39</sup> The article discusses the problem of access to healthcare and portrays the negative sentiments people have towards public healthcare institutions in Southern Africa.<sup>40</sup> Chirwa also discusses how the inequalities in healthcare, which were previously based on race, are now shifting to be based on one's economic status as well as geographical positioning.<sup>41</sup> This is significant to this dissertation as the notion of inequality in the provision of healthcare will be a recurring theme throughout the discussions that follow.

The case of *Soobramoney v Minister of Health, KwaZulu Natal 1998 (1) SA 765 (CC)* (hereafter *Soobramoney*) is arguably the most significant case in South African legal history insofar as the right to not be refused emergency medical treatment is concerned. In this case, the Constitutional Court set a precedent with its interpretation of what constitutes a medical emergency and this has had a knock-on effect on how this right has been implemented in South Africa.<sup>42</sup> This is echoed in Kramer's findings which scrutinise the implications of the precedent set by the Constitutional Court in *Soobramoney* and what can subsequently be regarded as a

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<sup>33</sup> L Baldwin-Ragaven et al *An ambulance of the wrong colour: health professionals, human rights and ethics in South Africa* (1999) 4.

<sup>34</sup> Baldwin-Ragaven et al (n 33 above) 5.

<sup>35</sup> Baldwin-Ragaven et al (n 33 above) 42.

<sup>36</sup> Baldwin-Ragaven et al (n 33 above) 43.

<sup>37</sup> Baldwin-Ragaven et al (n 33 above) 42.

<sup>38</sup> Baldwin-Ragaven et al (n 33 above) 46.

<sup>39</sup> Chirwa (n 3 above) 28.

<sup>40</sup> Chirwa (n 3 above) 21.

<sup>41</sup> Chirwa (n 3 above) 30.

<sup>42</sup> E Kramer, 'No one may be refused emergency medical treatment' – ethical dilemmas in South African emergency medicine' (2008) 1 (2) *South African Journal of Bioethics and Law* 53.

medical emergency.<sup>43</sup> Kramer makes several interesting points in his discussion on Section 27(3), which will be referred to in this dissertation, particularly relating to medical emergencies for those in disadvantaged communities.<sup>44</sup> Consideration will be made to Kramer's discourse on the ethical considerations of patient refusal during medical emergencies based on one's ability to pay for treatment.<sup>45</sup>

McQuoid-Mason discusses the ethics of making payment requests before patients receive treatment.<sup>46</sup> This discussion on payment is relevant to how one's economic standing and inability to pay for costly medical assistance affects the realisation of the right to access to healthcare. This study elaborates on the duties of healthcare professionals during medical emergencies and evaluates the legislation and policies that govern such conduct.<sup>47</sup> This is significant to this dissertation in consideration of the policies of various role players in the implementation of the right to not be refused emergency medical treatment.

With inequalities in the healthcare sector in mind, the work of McIntyre and Ataguba is significant to this discussion.<sup>48</sup> This literature will be relied on for its discussions on inequities in access to healthcare in South Africa and the reasons therefore, such as disparities in resources, geographical location and transport obstacles.<sup>49</sup> These obstacles will further be explored in the analysis of the SAHRC report on emergency healthcare in rural areas of the Eastern Cape.<sup>50</sup> McIntyre and Ataguba's study provides relevant information to this study with regards to funding and resources in the healthcare sector in South Africa, particularly in emergency services.<sup>51</sup> It is also significant in its findings on access to quality healthcare and the inequalities that are prevalent in the South African healthcare system.<sup>52</sup>

McIntyre's research critically analyses the private healthcare sector and the impact it has on the health system as a whole.<sup>53</sup> McIntyre's study on the funding in the healthcare sector and the provision of healthcare services and inquiry into private hospital groups will be referred to when addressing persistent inequities in the provision of medical care.<sup>54</sup> Of particular interest is the discussion on who owns and controls the private emergency medical services in South Africa.<sup>55</sup> This will be used to expand further on the persistent inequities that exist in accessing emergency healthcare.<sup>56</sup>

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<sup>43</sup> As above.

<sup>44</sup> As above.

<sup>45</sup> Kramer (n 42 above) 55.

<sup>46</sup> D McQuoid-Mason 'Medical ethics and the payment of fees before treatment' (2011) 101 *The South African Medical Journal* 798.

<sup>47</sup> McQuoid Mason (n 46 above) 799.

<sup>48</sup> McIntyre & Ataguba (n 24 above) 15.

<sup>49</sup> McIntyre & Ataguba (n 24 above).

<sup>50</sup> SAHRC (n 27 above).

<sup>51</sup> McIntyre & Ataguba (n 24 above) 29.

<sup>52</sup> McIntyre & Ataguba (n 24 above) 7.

<sup>53</sup> D McIntyre 'Private Sector Involvement in funding and providing health services in South Africa: implications for equity and access to health care' July 2010 at 19, available at <https://www.equinafrica.org/sites/default/files/uploads/documents/DIS84privfin%20mcintyre.pdf> accessed on 15 August 2020.

<sup>54</sup> McIntyre (n 53 above) 12.

<sup>55</sup> McIntyre (n 53 above) 13.

<sup>56</sup> McIntyre (n 53 above) 5.

## VI. METHODOLOGY

The principal research method used in this dissertation is a desktop analysis. The point of departure in this study on the right to emergency medical treatment in South Africa is to identify and analyse the relevant constitutional and legislative provisions that provide for this right. Section 27(3) of the Constitution provides that ‘no one may be refused emergency medical treatment’. As the section does not elaborate on what this emergency medical treatment entails, a further investigation into the legislative and regulatory framework relating to emergency medical treatment in South Africa will be done.

Such legislation includes the NHA, the Medical Schemes Act and the Emergency Medical Services Regulations which came into force in 2017.<sup>57</sup> They will be studied to identify not only the definition of a medical emergency but also the duties of the state and private healthcare providers in the realisation of this right. In considering this legislative framework, the NHI Bill will also be critically assessed to identify whether it has addressed any gaps in the existing legislation and regulations insofar as the provision of emergency healthcare services for the poor is concerned.

To ascertain the meaning of the right to not be refused emergency medical treatment, the Constitutional Court decision of *Soobramoney* will be heavily relied on for the court’s interpretation of what qualifies as a medical emergency for the purposes of Section 27(3) of the Constitution.<sup>58</sup> This interpretation of a medical emergency by the court has had a significant effect on how ‘medical emergencies’ are defined in South Africa and the subsequent provision of emergency medical treatment and the enforcement of policies surrounding this right. To highlight the weight of this judicial interpretation, journal articles by authors such as Kramer will be relied on for their case analysis on criticisms of the court’s decision and the implications thereof.<sup>59</sup> The case of *Ereselo* will also be used to discuss the lasting effect of this precedent on other persons who have approached the court to enforce their right to not be refused emergency medical treatment.<sup>60</sup>

In considering the implication of the right to not be refused emergency medical treatment and the duties it places on the state as well as private healthcare providers towards the poor, the standards set in international law concerning the provision of emergency medical treatment will be highlighted. To differentiate between the obligations of the private entities to ensure access to emergency medical treatment as opposed to the state under international law, reliance will be made on General Comment 24 on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities (General Comment 24).<sup>61</sup>

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<sup>57</sup> National Health Act: Emergency Medical Services Regulations in GN 1320 GG 41287 of 1 December 2017 (hereafter EMS Regulations).

<sup>58</sup> *Soobramoney v Minister of Health, KwaZulu Natal* 1998 (1) SA 765 (CC) (hereafter *Soobramoney*).

<sup>59</sup> Kramer (n 42 above).

<sup>60</sup> *Ereselo v Chief Executive Officer Helen Joseph Hospital and Others* 2019 JOL 46088 (GJ) (hereafter *Ereselo*).

<sup>61</sup> UN Committee on Economic, Social and Cultural Rights (CESCR) E/C.12/GC/24 ‘General comment No. 24 (2017) on state obligations under the international covenant on economic, social and cultural rights in the context of business activities’ 10 August 2017, available at <https://www.refworld.org/docid/5beaecba4.html> accessed 15 August 2020 (hereafter General Comment 24).

As the Republic of South Africa was transitioning out of the apartheid era, the Truth and Reconciliation Commission (TRC) was formed in an attempt to aid progression in the country towards a new system of democracy.<sup>62</sup> The main purpose of the TRC was to shed light on various human rights abuses that occurred during apartheid, giving perpetrators a chance to own up to their actions in exchange for amnesty while attempting to provide the victims of these abuses with some form of reparation.<sup>63</sup> The TRC was founded on the premise of highlighting all the human rights violations that took place in South Africa from 1960 until 1994.<sup>64</sup> One of the prominent issues that were raised during this process was the human rights violations that took place in the health sector during this time and it was deemed necessary to have specific health sector hearings.<sup>65</sup>

The Health Sector Hearings have been described as a way for the South African healthcare profession to recognise the role that it played in the apartheid atrocities.<sup>66</sup> The Health and Human Rights Project: Professional Accountability in South Africa was subsequently formed to assist in these hearings, creating an open discussion on the link between the health sector and human rights in an attempt to transform the healthcare sector.<sup>67</sup> In June of 1997, the Health Sector Hearings were held in Cape Town to create awareness on a national and global scale as to the impact of the apartheid system on healthcare in the country.<sup>68</sup> During these hearings, various people and organisations came forward and shared their experiences in how the profession contributed to ‘apartheid medicine’.<sup>69</sup> After these hearings, the TRC made a finding in its report that the medical profession was complacent in permitting the health and well-being of millions of people in South Africa to be neglected and in fact, put at risk whilst moral and ethical codes of practice were constantly being violated whilst human rights were infringed.<sup>70</sup> The testimonies brought forward in these hearings will be relied on to demonstrate the state of the South African healthcare system during the apartheid era, with particular emphasis on the many gross human rights violations that were committed related to the provision of emergency medical treatment.

Journal articles of various authors, such as Kramer and McQuoid-Mason will be relied on for their commentary on the ethics of payment of fees and patient refusal in medical emergencies to explore the duties of private emergency services towards those who cannot afford their services.<sup>71</sup> These discussions on payment are essential in addressing how one’s economic standing affects access to emergency medical treatment.

Those who are left to rely on public healthcare facilities are often left unattended to, or with sub-par treatment with an array of adverse effects. This will be illustrated in an analysis of investigative reports of the SAHRC on the state of public hospitals in Mpumalanga,<sup>72</sup> as well as the oncology crisis in Kwa-Zulu Natal where patients are

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<sup>62</sup> Baldwin-Ragaven et al (n 33 above) 4.

<sup>63</sup> As above.

<sup>64</sup> As above.

<sup>65</sup> Baldwin-Ragaven et al (n 33 above) 5.

<sup>66</sup> As above.

<sup>67</sup> Baldwin-Ragaven et al (n 33 above) 6.

<sup>68</sup> Baldwin-Ragaven et al (n 33 above) 5.

<sup>69</sup> As above.

<sup>70</sup> Baldwin-Ragaven et al (n 33 above) 6.

<sup>71</sup> Kramer (n 42 above) and McQuoid Mason (n 31 above).

<sup>72</sup> South Africa Human Rights Commission (SAHRC) *Investigative report: ‘Democratic Alliance, Mpumalanga v Department of Health, Mpumalanga’* (2013).

not receiving the medical treatment they so desperately need.<sup>73</sup> These reports are vital in illustrating the gross violations of South African state healthcare patients' right to access to healthcare, dignity and the right to life – all of which are enshrined in the Constitution.<sup>74</sup>

To demonstrate the barriers that hinder true access to emergency medical treatment in South Africa, this study will draw from the investigation and evidence given in the hearing report of the SAHRC on access to emergency medical services in the Eastern Cape, one of the most destitute provinces in the country.<sup>75</sup> In this report, the SAHRC highlights the harsh conditions faced by those who live in the Eastern Cape and the numerous obstacles that have to be faced to receive emergency treatment.<sup>76</sup> This report is valuable to this study, as it not only critically evaluates South African healthcare policies and legislative provisions,<sup>77</sup> it also delves into the impact that the challenges in accessing emergency medical services have on communities in rural areas.<sup>78</sup> Countless rights violations by the public healthcare sector are investigated and highlighted in this report and it further provides recommendations to address the disparities and obstacles that the poor in the Eastern Cape face in terms of access to emergency medical services.<sup>79</sup> This report will be heavily relied on in consideration of the implications of the rights bestowed by the Constitution and various healthcare legislation on the obligations of state healthcare providers towards the poor.

## VII. CONCLUSION AND CHAPTER OUTLINE

This chapter has briefly introduced the main research aims of this study, namely to which extent the right to not be refused emergency medical treatment is realised in South Africa and what challenges are faced in the effective implementation of this right. Unfortunately, this right is not properly realised for many people in South Africa and it is therefore important to highlight the challenges that prevent proper implementation of this right, and to identify the gaps in the law that need to be addressed to ensure proper realisation of this right for all.

Chapter 2 is a conceptual chapter and looks at the status of the right to not be refused emergency medical treatment in international law and comparative constitutional law. This chapter discusses the ways in which this right is recognised and aims to begin to determine what would be the most preferable way to recognise the right. The chapter looks at the obligations created under international law and international comparative law in terms of the provision of emergency medical treatment and whether these international instruments recognise it as a positive or negative right. The chapter further elaborates on the obligations of states, as well as non-state actors in the provision of emergency medical treatment. The main aim of this chapter is to pinpoint the international standards which the South African right should be measured against.

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<sup>73</sup> South Africa Human Rights Commission (SAHRC) *Investigative report: 'Dr Imran Keeka, Democratic Alliance v Addington Hospital Kwa-Zulu Natal'* (2017).

<sup>74</sup> SAHRC (n 73 above) 64 at para 9.3.

<sup>75</sup> SAHRC (n 27 above).

<sup>76</sup> SAHRC (n 27 above) 17.

<sup>77</sup> SAHRC (n 27 above) 22.

<sup>78</sup> SAHRC (n 27 above) 20.

<sup>79</sup> SAHRC (n 27 above) 87.

In chapter 3, the history of emergency medical treatment is discussed along with the inequities that existed and human rights violations that occurred in the South African healthcare system before the introduction of the 1996 Constitution and the Bill of Rights. This brief overview gives an insight into why the healthcare system is in the position it is today. The chapter further looks at whether the right to not be refused emergency medical treatment was recognised or protected in any way prior to 1994. In contrast, the current constitutional and legislative framework governing emergency medical treatment in South Africa is considered.

Chapter 4 is a deeper analysis of the right to not be refused emergency medical treatment in terms of Section 27(3) of the Constitution. This chapter looks at this right in the South African context, particularly looking at the different elements of the right. The chapter discusses who the intended beneficiaries of the right are and who it aims to protect. The chapter further assesses what is meant by emergency medical treatment and how this term has been interpreted by the Constitutional Court. The nature of the obligations created by this right will be analysed along with what is meant by the concept of refusal of emergency medical treatment. The chapter also discusses who is bound by the right and who bears these obligations.

Chapter 5 takes the form of a critical analysis of the current legislative framework governing emergency medical treatment in South Africa. The chapter considers to what extent these statutes implement the right to not be refused emergency medical treatment and to what extent this legislation protects the interests of 'everyone'. The chapter looks again at which obligations are imposed on the state by this legislation. This chapter aims to identify the gaps in the law that may lead to the improper implementation of the right to not be refused emergency medical treatment. This chapter also considers the debate surrounding the proposed NHI Bill, paying particular attention to whether or not this Bill will overcome any possible failures of the current statutes that are in place regarding the provision of emergency medical treatment.

Chapter 6 discusses the extent to which the right is being implemented in practice. This chapter considers how the current legal framework impacts the provision of emergency medical treatment in real life. The main focus of this chapter is to highlight the challenges faced by many people in South Africa in realising their right to not be refused emergency medical treatment. The chapter particularly focuses on the hurdles faced by the poor in South Africa in realising this right.

Chapter 7 is a concluding chapter, summarising the main arguments made in the dissertation and providing recommendations on how the challenges and gaps in the law that have been identified in the dissertation can be rectified.

## CHAPTER 2

# EMERGENCY MEDICAL TREATMENT UNDER INTERNATIONAL LAW AND COMPARATIVE CONSTITUTIONAL LAW

### I. INTRODUCTION

This chapter considers the right to not be refused emergency medical treatment as an emerging right under international law and comparative constitutional law. It looks at these international instruments as a basis against which the South African legal framework governing emergency medical treatment should be measured. In considering what this right means, this chapter first considers what the status of such a right is under international law and comparative constitutional law and in which ways it is recognised. It looks at whether this right is recognised expressly or implicitly under international law and whether it is recognised in a broader sense or more narrowly under specific terms. In considering comparative constitutional law, this chapter looks at how such a right is recognised under the constitutions of every other state that recognises emergency medical treatment as a constitutional right and weighs up the negative and positive aspects of these provisions in an attempt to determine which is the best way to recognise this right. The nature of the obligations of states in terms of this right will also be considered along with the obligations of non-state actors.

### II. THE STATUS OF EMERGENCY MEDICAL TREATMENT AS A RECOGNISED RIGHT UNDER INTERNATIONAL LAW

In the ordinary sense of the words, healthcare is a broad term under which emergency medical treatment falls. Healthcare is defined as ‘the maintaining and restoration of health by the treatment and prevention of disease especially by trained and licensed professionals’.<sup>80</sup> Emergency medicine, on the other hand, ‘is the medical specialty dedicated to the diagnosis and treatment of unforeseen illness or injury’.<sup>81</sup> Emergency medical treatment thus forms a part of emergency medicine as a specialised discipline, which in turn falls under the broader field of healthcare in general. Before considering the constitutional right to not be refused emergency medical treatment in South Africa, it is worth assessing whether international law recognises such a right. If emergency medical treatment is recognised as a right under international law, the discussion to follow seeks to determine how such a right is recognised. Is it recognised in the broader sense, or more specific terms?

Safeguarding individual human rights against states is one of the main purposes of international law.<sup>82</sup> Article 55 of the Charter of the United Nations (UN Charter)

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<sup>80</sup> Merriam-Webster ‘Health care’ available at <https://www.merriam-webster.com/dictionary/health%20care#medicalDictionary>, accessed on 6 February 2021.

<sup>81</sup> American College of Emergency Physicians ‘Definition of emergency medicine’ January 2021, available at <https://www.acep.org/globalassets/new-pdfs/policy-statements/definition-of-emergency-medicine.pdf>, accessed 6 February 2021.

<sup>82</sup> J Dugard *International law: a South African perspective* (2016) 4<sup>th</sup> edition 320.

places an obligation on the United Nations to, intending to respect ‘equal rights’,<sup>83</sup> promote ‘higher standards of living’<sup>84</sup> and ‘universal respect for, and observance of human rights and fundamental freedoms for all without distinction as to race, sex, language or religion’.<sup>85</sup> Article 56 binds all member states to unite to ensure that the purposes as laid out in Article 55 are achieved.<sup>86</sup> The Preamble of the Constitution of the World Health Organisation (WHO) refers to the UN Charter in declaring several principles on behalf of the states that are a party to it.<sup>87</sup> The Preamble binds the contracting party states in establishing the WHO ‘as a specialised agency in terms of Article 57’ of the UN Charter.<sup>88</sup> The Preamble defines health as a ‘state of complete physical, mental and social well-being’.<sup>89</sup> It also recognises the broader right to the ‘highest attainable standard of health’ as a vital human right for the enjoyment of every single person, despite factors such as age, race or gender.<sup>90</sup> Article 1 of the WHO Constitution articulates the objective of the WHO; the fulfilment of the ‘highest possible level of health’ for all people.<sup>91</sup> The Preamble also states that ‘governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures’.<sup>92</sup>

The Universal Declaration of Human Rights (UDHR) lays out the essential conditions needed to promote ‘optimal health and well-being’.<sup>93</sup> Although there is no express provision relating to the provision of emergency medical treatment, Article 25 of the UDHR provides a broader provision that ‘everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including ... medical care and necessary social services...’.<sup>94</sup> The UDHR does not legally bind states as it is not a treaty, but the standards set out therein have influenced many later human rights treaties and conventions.<sup>95</sup> Various domestic bills of rights have been modelled after the UDHR, the conduct of states has been measured against it and many courts, even in South Africa, have used it as a tool for interpretation.<sup>96</sup> The United Nations Office of the High Commissioner for Human Rights has described the UDHR as a benchmark against which respect for and compliance with international human rights standards must be measured.<sup>97</sup> Crucially, the UDHR has been strengthened and given legal force through the adoption of the International Covenant on Economic,

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<sup>83</sup> Art. 55 Charter of the United Nations, June 26, 1945, 59 Stat. 1031, T.S. 993, 3 Bevens 1153 (hereafter UN Charter).

<sup>84</sup> Art. 55(a) UN Charter.

<sup>85</sup> Art. 55(c) UN Charter.

<sup>86</sup> Art. 56 UN Charter.

<sup>87</sup> World Health Organisation ‘Constitution of the World Health Organisation’ available at [https://www.who.int/governance/eb/who\\_constitution\\_en.pdf](https://www.who.int/governance/eb/who_constitution_en.pdf), accessed on 13 May 2019 (hereafter Constitution of the WHO).

<sup>88</sup> As above.

<sup>89</sup> As above.

<sup>90</sup> As above.

<sup>91</sup> Art. 1 Preamble of the Constitution of the WHO.

<sup>92</sup> Preamble of the Constitution of the WHO.

<sup>93</sup> As above.

<sup>94</sup> Art. 25 UDHR.

<sup>95</sup> Dugard (n 82 above) 325.

<sup>96</sup> Dugard (n 82 above) 326.

<sup>97</sup> Office of the United Nations High Commissioner for Human Rights ‘Fact Sheet No.2 (Rev.1), The International Bill of Human Rights’ 4 available at <https://www.ohchr.org/Documents/Publications/FactSheet2Rev.1en.pdf>, accessed on 18 November 2020.

Social and Cultural Rights (ICESCR),<sup>98</sup> and the International Covenant on Civil and Political Rights (ICCPR).<sup>99</sup> These two covenants include the implementation measures that are necessary to protect the rights and freedoms encompassed in the UDHR.<sup>100</sup> The UDHR, ICESCR and ICCPR, together with its two Optional Protocols,<sup>101</sup> are known as the 'International Bill of Rights'.<sup>102</sup> Neither the ICCPR, nor its two Optional Protocols, have any express provisions on health rights, or emergency medical treatment. Article 6 of the ICCPR, however, does recognise the inherent right to life.<sup>103</sup> It can be argued that this right includes the provision of emergency medical treatment since emergency treatment is often life-saving.

The Preamble to the ICESCR recognises the rights contained therein as deriving from the 'inherent dignity' of human beings.<sup>104</sup> Article 2 of the ICESCR places a duty on each state party to take strides towards realising the rights contained in the covenant,<sup>105</sup> within the available resources and such rights should be exercised without discrimination.<sup>106</sup> The ICESCR differs from the ICCPR as it focuses on economic, social and cultural rights and expressly recognises certain health rights. Article 12 of the ICESCR places an obligation on states to 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.<sup>107</sup> More specific to the actual provision of healthcare, Article 12(2)(d) places a duty on states to create 'conditions which would assure to all medical service and medical attention in the event of sickness'.<sup>108</sup> While the ICESCR does not expressly mention emergency medical treatment, it could be argued that emergency medical treatment is encompassed under the broader notions of 'all medical service and medical attention' under Article 12 (2)(d). The right to not be refused emergency medical treatment under international law is implied in this instance.

While Article 12 of the ICESCR provides for the right to the highest attainable standard of health and the obligations of states in relation thereto, this provision is quite broad. The concept of physical and mental health are fairly broad terms, which may include many different conditions. The terms 'medical service and medical attention' provided for under Article 12(2)(d) are also multi-faceted, as the medical field is relatively broad and multi-dimensional with different role-players and specialities within different fields. While not legally binding on states, General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR) is a helpful tool for interpretation in that it assesses the normative content of the right in

<sup>98</sup> International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3 (hereafter ICESCR).

<sup>99</sup> International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (hereafter ICCPR).

<sup>100</sup> Office of the United Nations High Commissioner for Human Rights (n 97 above) 4.

<sup>101</sup> Optional Protocol to the International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 59, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 302 and Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty, G.A. res. 44/128, annex, 44 U.N. GAOR Supp. (No. 49) at 207, U.N. Doc. A/44/49 (1989).

<sup>102</sup> Office of the United Nations High Commissioner for Human Rights (n 97 above) 1.

<sup>103</sup> Art. 6 ICCPR.

<sup>104</sup> Preamble ICESCR.

<sup>105</sup> Art. 2(1) ICESCR.

<sup>106</sup> Art. 2(2) ICESCR.

<sup>107</sup> Art. 12(1) ICESCR.

<sup>108</sup> Art. 12(2)(d) ICESCR.

terms of Article 12 of the ICESCR and provides further insight where the provision is not so clear or specific.<sup>109</sup> It notes that while Article 12(1) defines the right to health, a non-exhaustive list of state duties is provided for in Article 12(2).<sup>110</sup> In considering this definition, it is emphasised that the right to health is not the same as the right to being healthy.<sup>111</sup> Holders of this right are entitled to ‘a system of health protection which provides equal opportunity for people to enjoy the highest attainable level of health’.<sup>112</sup> When contemplating the highest attainable health standard of a person, General Comment 14 stresses that a person's biological disposition, as well as their socio-economic circumstances, need to be considered, along with the 'available resources' of the state.<sup>113</sup> In saying this, the state cannot bear the sole responsibility for an individual's health, particularly where certain individuals are prone to developing different health risks or conditions based either on genetics or lifestyle factors.<sup>114</sup> The right to health therefore relates particularly to the facilities, goods and services that must be provided to ensure the highest attainable health standard.<sup>115</sup> General Comment 14 does not specifically focus on emergency medical treatment, but it does confirm that the right to health under Article 12 includes 'timely and appropriate health care'.<sup>116</sup> Under this premise, emergency medical treatment should arguably fall under the goods and services that need to be provided.

There are four ‘essential elements’ to the general right to health as described by the CESCR.<sup>117</sup> These elements are interrelated and are applicable and vital to emergency healthcare systems to ensure their proper functioning and protection and fulfilment of the right to health.<sup>118</sup> These essential elements are:

*a) Availability*

Depending on the country's development level, sufficient functioning goods and services and healthcare facilities and programmes need to be made available by the state.<sup>119</sup> The availability of resources and the notion of progressive realisation must be borne in mind when considering these four elements.<sup>120</sup> The reason for this is that in more developed countries with more available resources, the state is obligated to make sure that the right to health is fully realised, whereas, in less developed countries with severe resource constraints, states are expected to progressively realise the right over time and states are to fulfil their obligations as quickly and as fully as possible, within the available resources.<sup>121</sup>

<sup>109</sup> Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000) (hereafter General Comment 14).

<sup>110</sup> General Comment 14 (n 109 above) par 7.

<sup>111</sup> General Comment 14 (n 109 above) par 8.

<sup>112</sup> As above.

<sup>113</sup> General Comment 14 (n 109 above) par 9.

<sup>114</sup> As above.

<sup>115</sup> As above.

<sup>116</sup> General Comment 14 (n 109 above) par 11.

<sup>117</sup> General Comment 14 (n 109 above) par 12.

<sup>118</sup> TW Burkholder, K Hill & EJ Calvello Hynes ‘Developing emergency care systems: a human rights-based approach (2019) 97 *Bull World Health Organ* 612 at 614.

<sup>119</sup> General Comment 14 (n 109 above) par 12(a).

<sup>120</sup> Burkholder, Hill & Calvello Hynes (n 118 above) 614.

<sup>121</sup> As above.

*b) Accessibility*

Healthcare amenities, including emergency medical facilities, must be accessible to all people.<sup>122</sup> Accessibility is a multi-dimensional concept when it comes to healthcare, including emergency medical treatment.<sup>123</sup> Accessibility includes non-discrimination in access, physical access, affordability to allow economic access, and access to information regarding health and health services.<sup>124</sup>

*c) Acceptability*

This means that in the provision of medical goods and services, medical ethics must be upheld and different cultures and genders must be respected.<sup>125</sup>

*d) Quality*

This essential element encompasses the need for scientifically approved and medically appropriate provision of healthcare services and staff must be adequately medically trained.<sup>126</sup>

Bearing these four essential elements in mind, General Comment 14 looks at the guidelines on the steps that states need to take following Article 12(2) of the ICESCR.<sup>127</sup> For the discussion on emergency medical treatment, of significance is the interpretation of Article 12(2)(a) which provides for the right to maternal, child and reproductive health. The CESCR has further expanded on this right and has stated that it includes 'emergency obstetric services'.<sup>128</sup> In reference to Article 12(2)(c) providing for the right to the prevention, treatment and control of diseases, the CESCR comments in General Comment 14 that this right includes 'the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations'.<sup>129</sup> In interpreting Article 12(2)(d) on the right to health facilities goods and services, the CESCR extends this right to include 'timely access to basic preventative and curative, rehabilitative health services' for the treatment of a wide range of healthcare conditions, including diseases and injuries.<sup>130</sup> In light of these interpretations, although Article 12 of the ICESCR does not explicitly mention emergency medical treatment, under the interpretations of the CESCR in General Comment 14, it can arguably be deduced that emergency medical treatment is intended to be encompassed under the wider proviso of Article 12.

In 1978, the Declaration of Alma-Ata came into existence as a result of the International Conference on Primary Healthcare that took place in what was Alma-Ata, Kazakhstan.<sup>131</sup> This Declaration makes an urgent call for 'action by all governments, all health and development workers, and the world community to protect

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<sup>122</sup> General Comment 14 (n 109 above) par 12(b).

<sup>123</sup> As above.

<sup>124</sup> As above.

<sup>125</sup> General Comment 14 (n 109 above) par 12(c).

<sup>126</sup> General Comment 14 (n 109 above) par 12(d).

<sup>127</sup> General Comment 14 (n 109 above) par 13.

<sup>128</sup> General Comment 14 (n 109 above) par 14.

<sup>129</sup> General Comment 14 (n 109 above) par 16.

<sup>130</sup> General Comment 14 (n 109 above) par 17.

<sup>131</sup> World Health Organization, Declaration of Alma-Ata in *International Conference on Primary Health Care Alma-Ata*, USSR, 6-12 September 1978 (hereafter Declaration of Alma-Ata).

and promote health of all people of the world'.<sup>132</sup> It reiterates that health is an essential human right and does not support the inequities in 'health status of people' between 'developed and developing countries'.<sup>133</sup> The Declaration of Alma-Ata places a duty on governments to ensure that adequate 'health and social measures' are put into place to safeguard the health of their peoples.<sup>134</sup> Although this declaration does not expressly mention emergency medical treatment, it does focus on primary healthcare in general, which in the broader sense, includes emergency medical services. The Declaration of Ouagadougou has reaffirmed the importance of the provisions of the Declaration of Alma Ata insofar as it recognises health as a fundamental human right.<sup>135</sup> The Declaration of Ouagadougou goes further to urge member states, particularly in the African context, to update their health policies on several health issues, including trauma,<sup>136</sup> but no further mention is made of emergency medical treatment.

An especially relevant treaty in the African context is the African Charter on Human and Peoples Rights (ACHPR).<sup>137</sup> Article 2 stipulates that the rights and freedoms contained in the ACHPR should be afforded to individuals without discrimination.<sup>138</sup> Article 4 of the ACHPR is remarkable in its description of human beings being 'inviolable'.<sup>139</sup> This provision is vital when regarding the right to health, and more importantly in this conversation, the right to emergency medical treatment, in that it provides that every person is to have their life respected and to have 'integrity of his person'.<sup>140</sup> A broad negative duty is placed on 'everyone', under the Preamble of the ACHPR, to not unjustifiably deprive anyone of this right.<sup>141</sup> With the sentiments of Article 4 in mind, Article 16 of the ACHPR again reiterates what is stated in the above-mentioned treaties in mentioning that everyone should have the right to optimal states of health on a physical and mental level.<sup>142</sup> This is a broad right. A positive obligation is placed on member states to take the required steps to ensure the protection of the health of their citizens and to see to it that they 'receive medical attention when they are sick'.<sup>143</sup> A recurring notion that has proven evident in the treaties and conventions that have been assessed so far, is that where there is a provision for the protection of health and well-being, these rights appear to be more concerned with the prevention and treatment of illness and 'sickness' with very little mention of medical attention in the form of the treatment of trauma or injury. So far in this international law discussion, there has been no express provision for emergency medical treatment

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<sup>132</sup> As above.

<sup>133</sup> Art. II Declaration of Alma Ata.

<sup>134</sup> Art. V Declaration of Alma-Ata.

<sup>135</sup> World Health Organisation Regional Office for Africa 'Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new Millennium' 30 April 2008 at 3, available at [https://www.afro.who.int/sites/default/files/2017-06/decouagadougou\\_declaration\\_eng.pdf](https://www.afro.who.int/sites/default/files/2017-06/decouagadougou_declaration_eng.pdf), accessed on 7 November 2020 (hereafter Declaration of Ouagadougou).

<sup>136</sup> Declaration of Ouagadougou (n 135 above) 5.

<sup>137</sup> African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), (hereafter ACHPR). The ACHPR was adopted in Nairobi in 1981 and came into force in 1986. South Africa signed and ratified the ACHPR in 1996.

<sup>138</sup> Art. 2 ACHPR.

<sup>139</sup> Art. 4 ACHPR.

<sup>140</sup> As above.

<sup>141</sup> As above.

<sup>142</sup> Art. 16(1) ACHPR.

<sup>143</sup> Art. 16(2) ACHPR.

being included in a right on its own. Instead, it can be deduced that emergency medical treatment is included in these broader terms.

The idea that the protection of health in international law is focused mainly on combatting illness is evident again in Article 24 of the Convention on the Rights of the Child (CRC).<sup>144</sup> Article 24(1) binds member states in recognising the rights of children in experiencing the 'highest attainable standard of health' and the emphasis is made on ensuring that no child is deprived of access to facilities to treat illnesses and restore health.<sup>145</sup> Article 24(2) places a positive obligation on member states to safeguard this right and to reduce mortality in children,<sup>146</sup> as well as to provide 'necessary medical assistance and health care' to children.<sup>147</sup> What constitutes 'necessary medical assistance' is not clarified. Perhaps it could be interpreted to include emergency medical treatment in the case of injury, trauma or other medical emergencies, although the specific emphasis is put on the improvement of 'primary healthcare'.<sup>148</sup> In the ordinary sense of the words, one would assume that emergency medical treatment would fall under the broader idea of necessary medical assistance. While the CRC does not expressly state that states must provide emergency medical treatment, Article 6 does recognise the right to life and places an obligation on member states to 'ensure to the maximum extent possible the survival and development of the child',<sup>149</sup> which arguably should include emergency medical treatment in life or death situations.

What has been made evident above is that, although the International Bill of Rights and the treaties and conventions that have followed recognise health as a general right to some extent, emergency medical treatment is not expressly provided for and access to emergency medical treatment is not specifically protected as a right in itself under major international treaties and conventions. Rather, it is implied under the broader premise of the international right to the highest attainable standard of health. Emergency medical treatment is arguably recognised in international law under the broader concept of healthcare and the protection of the right to the highest attainable standard of health. This is not ideal as provisions such as Article 12 of the ICESCR are broad and open for interpretation (or misinterpretation) without specific guarantee of protection of a right to medical treatment in emergencies. While emergency medical treatment arguably exists as a right that is recognised in international law by drawing inference from several international instruments and treaties, several versions of this right may exist under several treaties and conventions recognising it in the broader sense. However broad the recognition of the right may be, by being a signatory to these international instruments, South Africa should also recognise the right of its people to the highest attainable standard of health, and by implication of the discussion above, the right to emergency medical treatment. The discussion to follow assesses whether emergency medical treatment is recognised as a right on its own under comparative constitutional law and whether individual constitutions of states provide more express protection for the right to not be refused emergency medical treatment.

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<sup>144</sup> Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989) (hereafter CRC).

<sup>145</sup> Art. 24(1) CRC.

<sup>146</sup> Art. 24(2)(a) CRC.

<sup>147</sup> Art. 24(2)(b) CRC.

<sup>148</sup> Art. 24(2)(b) CRC.

<sup>149</sup> Art. 6(2) CRC.

### III. EMERGENCY MEDICAL TREATMENT AS A RIGHT UNDER COMPARATIVE CONSTITUTIONAL LAW

While the constitutions of many countries around the world recognise the right to health or medical care in some way, there are a select few which explicitly mention emergency medical treatment as Section 27(3) of the South African Constitution does. There are several countries, including South Africa, which recognise such rights in a narrower sense, compared to the broader, general right to health under international law. These are recognised as more limited rights, often in addition to, or supplementary to the general right to health care. In this study, consideration has been given to the constitutional provisions of every state that mentions emergency medical treatment, or a similar variation of the words, in their constitutions.

Several states explicitly recognise emergency medical treatment, or emergency healthcare, as a claimable entitlement. The wording used to entrench such rights differs between states. In South Africa, the right is that nobody may be refused emergency medical treatment.<sup>150</sup> Other constitutions have used this phrase or similar phrases. The constitutional provisions of Kenya and Fiji relating to emergency medical treatment are almost identical to the South African provision. Section 43(2) of the Kenyan Constitution provides that ‘a person shall not be denied emergency medical treatment’.<sup>151</sup> A slight difference between the Kenyan and Fijian provisions, and the South African provision, is that the beneficiaries of the right in the Kenyan and Fijian provisions are ‘a person’ while in the South African provision the beneficiary is ‘no one’. ‘No one’ is a universal phrase that is understood to encompass ‘everyone’, in the same sense that ‘a person’ would seemingly mean any person and these rights thus apply to every person or everyone.<sup>152</sup>

Section 35 of the Constitution of Nepal is more specific as to who the right protects in stating that ‘every citizen shall have the right to seek basic health care services from the state and no citizen shall be deprived of emergency health care’.<sup>153</sup> This right clearly states that it is citizens of Nepal that may not be deprived of emergency health care, but subsection 3 of the same section is slightly broader in stating that ‘each person shall have equal access to health care’. Although the Nepalese provision is broader in that it provides for the more general term ‘emergency health care’ as opposed to emergency medical treatment, the provision is more restrictive in who it protects, as only Nepal’s citizens are afforded constitutional protection of not being denied emergency health care. Constitutional provisions that use universal terms such as ‘no one’ or ‘a person’, which are found in the Constitutions of South Africa,

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<sup>150</sup> S 27(3) Constitution.

<sup>151</sup> S 43(2) of the Constitution of Kenya, 2010 (hereafter Kenyan Constitution).  
S 28(2) of the Constitution of the Republic of Fiji, 2013 (hereafter Fijian Constitution) is very similar in that it provides that ‘a person must not be denied emergency medical treatment’. The word ‘denied’ is used instead of ‘refuse’, which is used in the South African provision, but these words are synonymous.

<sup>152</sup> I Currie & J De Waal *Bill of rights handbook* 6<sup>th</sup> edition (2013) 35.

<sup>153</sup> S 35(1) of the Constitution of Nepal, 2015 (hereafter Nepalese Constitution).

Kenya, and Fiji,<sup>154</sup> are preferable as they protect all people under their jurisdiction, whether they are citizens of the country or not.<sup>155</sup>

The term ‘no one’ appears in the Somalian constitutional provision, just as it does in the South African provision, but the Somalian provision provides somewhat more protection for the poor in stating that ‘no one may be denied emergency healthcare for any reason, including lack of economic capability’.<sup>156</sup> This provision is more inclusive and ensures the protection of the interests of vulnerable people. In countries where poverty is prevalent, such as South Africa, a clause such as this which explicitly states that inability to pay for emergency medical treatment does not allow for refusal of such treatment, would ensure further protection of the rights of the poor and vulnerable. This would protect persons who are unable to pay for (often costly) medical treatment from being denied such treatment in medical emergencies. The Somalian provision also differs slightly from the South African provision in that, as opposed to emergency medical treatment, it refers to ‘emergency healthcare’, which is arguably a broader term that, from the definition of healthcare discussed above, would include emergency medical treatment in addition to other healthcare aspects.

The majority of constitutional provisions relating to emergency medical treatment or emergency healthcare prohibit the refusal or denial of such treatment. While Article 18 of the Constitution of Egypt is similar in this sense to the provisions discussed above, it differs from the constitution of any other country in that it expressly criminalises the refusal of medical treatment in emergencies and protects all human beings in stating that ‘denying any form of medical treatment to any human in emergency or life-threatening situations is a crime’.<sup>157</sup> This contrasts with the South African right, as Section 27(3) of the South African Constitution itself does not expressly state what the consequences of refusal are. The Egyptian provision, on the other hand, directly states that should somebody deny a person who requires medical attention in an emergency, that person is guilty of a crime.<sup>158</sup> The advantage of adding such a clause to this constitutional provision is that it could possibly act as a deterrent. The threat of punishment or obtaining a criminal record as a consequence of refusing emergency medical treatment may be more effective in preventing such refusal, as opposed to merely stating that nobody may be denied such treatment. On the other hand, the effect may just be that the words in this provision may carry a heavier weight to its readers, but it does not necessarily negate the enforceability of provisions that do not provide for such an express consequence. In South African law, for example, in terms of Section 38 of the Constitution, should a constitutional right be infringed or threatened, the courts may be approached to grant appropriate relief.<sup>159</sup> So if somebody’s right in terms of Section 27(3) was violated, that person could approach the courts to obtain relief.

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<sup>154</sup> Other states which also apply universal terms in their constitutional provisions for such a right include Egypt, Zimbabwe and Somalia.

<sup>155</sup> Article 18 of the Art.18 of the Constitution of the Arab Republic of Egypt, 2014 (hereafter Egyptian Constitution) is unique in that it prohibits the denying of emergency medical treatment to ‘any human’.

<sup>156</sup> S 27 of the Provisional Constitution of the Federal Republic of Somalia, 2012 (hereafter Somalian Constitution).

<sup>157</sup> Art. 18 Egyptian Constitution.

<sup>158</sup> As above.

<sup>159</sup> S 38 Constitution.

Section 76 of the Constitution of Zimbabwe, South Africa's neighbouring country, stipulates that 'no person may be refused emergency medical treatment in any health-care institution'.<sup>160</sup> This is comparable to the South African provision, but it is more restrictive as it mentions that the emergency treatment may not be refused in a healthcare facility and does not account for instances where it may be required in a public space, road or at an individual's work or home. The South African right is broader in that it does not specify any particular place where the refusal of emergency medical treatment is not allowed. While the constitutional provisions discussed thus far are all phrased in the negative sense in that refusal of emergency medical treatment is not allowed, if one looks at the Constitution of Zimbabwe, refusal is prohibited but a positive obligation is still created. Section 29 of the Zimbabwean Constitution places an active duty on the state to 'take appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution' and places an active obligation on the state to ensure that the protection afforded by Section 76 of the Zimbabwean Constitution is realised.<sup>161</sup>

The Constitutions of Sudan and South Sudan also place an active duty on their respective states to ensure the provision of emergency medical services. Section 31 of the Transitional Constitution of South Sudan differs from the Constitution of South Africa and the other states mentioned above as there is no express prohibition on the refusal of emergency medical treatment.<sup>162</sup> Instead, this section actively provides that all levels of government must 'provide free primary health care and emergency services for all citizens'.<sup>163</sup> This is the broader right to be provided with emergency services in a healthcare context, as opposed to the right to not be refused such treatment as we have in the South African Constitution. Likewise, Section 65 of the Constitution of Sudan provides that 'the state undertakes to provide primary health care and emergency services free of charge for all citizens, to develop public health, and establish, develop and rehabilitate health and basic diagnostic institutions'.<sup>164</sup>

These provisions also differ from the South African right as Section 27(3) does not provide that the emergency medical treatment is free of charge. The constitutional provisions of Sudan and South Sudan, are however unambiguous in stating that the state must provide emergency medical services free of charge to their citizens.<sup>165</sup> Like the constitutional provision of Nepal, the Sudanese and South Sudanese provisions are restrictive in that protection is only afforded to the citizens of each respective country. This is not ideal as non-citizens finding themselves within these jurisdictions for various reasons, such as refugees or asylum seekers, are essentially not covered by the protection of these provisions, should they experience a medical emergency. Section 65 of Sudan's Constitution also only states that the state must provide these services. It does not account for the actions of private services. In this sense, the other provisions which have a broader prohibition on the refusal or denial of such services are better, as neither state nor private services or facilities may deny such emergency treatment. In the Constitution of Sudan, such instances are not accounted for and there is less accountability for private actors in medical emergencies. While on the face of it, the

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<sup>160</sup> S 76(3) of the Constitution of Zimbabwe, 2013 (hereafter Zimbabwean Constitution).

<sup>161</sup> S 29(1) Zimbabwean Constitution.

<sup>162</sup> S 31 of the Transitional Constitution of the Republic of South Sudan, 2011 (hereafter South Sudanese Constitution).

<sup>163</sup> As above.

<sup>164</sup> S 65 of the Constitution of Sudan, 2019 (hereafter Sudanese Constitution).

<sup>165</sup> As above.

provision that such services provided by the state must be free of charge may seem admirable, this provision is arguably not as strong as that of Somalia, which also provides protection for those who can't afford emergency healthcare but extends further to prohibit the denial thereof based on this, or any other reason. The effect of this prohibition of refusal is that such services must legally be administered or provided to those in need.

While the nine constitutional provisions above expressly protect either the right to be provided emergency medical treatment or the right to not be denied such treatment, none of them provide any further scope or detail regarding what constitutes emergency medical treatment, emergency health care or what a medical emergency entails. Although Nepal's Constitution includes the right to not be deprived of emergency health care, Section 35 of the Nepalese Constitution does not provide for any further scope of what would fall under this term.<sup>166</sup> Nepal's Public Service Health Act, 2075 (2018) does, however, go into more detail in defining what 'emergency health service' entails.<sup>167</sup> According to Section 2 of this Act, it is the 'initial and immediate service to be provided as it is necessary to free the lives of the persons from risk, save the lives or organs from being lost, whose lives are in the risky condition upon falling into unexpected incident or emergency condition'.<sup>168</sup> This legislative provision provides slightly more scope as to what constitutes emergency health services under the constitutional provision, however, it still leaves the question as to what would fall under an 'emergency condition'.

Section 43(2) of the Kenyan Constitution also does not detail the scope of emergency medical treatment, but Kenya's Health Act 21 of 2017 does provide further detail as to what would fall under 'emergency treatment'.<sup>169</sup> Section 2 of the Health Act defines 'emergency treatment' as 'necessary immediate health care that must be administered to prevent death or worsening of a medical situation'.<sup>170</sup> It separately defines a medical emergency as 'an acute situation of injury or illness that poses an immediate risk to life or health of a person or has potential for deterioration in the health of a person or if not managed timely would lead to adverse consequences in the well-being'.<sup>171</sup> This definition encompasses both injury and illness and speaks to the urgency of medical emergencies. Section 7 of the same Act deals specifically with emergency treatment and clarifies under Section 7(2) that the scope of emergency medical treatment extends to 'pre-hospital care',<sup>172</sup> stabilising patients or,<sup>173</sup> if the healthcare provider assisting the individual does not have the appropriate facilities or capability to stabilise the person, the referral to the next appropriate facility must be arranged.<sup>174</sup>

Although the words may differ, the constitutional protection of emergency medical treatment or emergency health care as a right is expressly stated in the constitutional provisions of the aforementioned states. The protection of emergency medical treatment as a right is not as explicit in other constitutions but is rather implied

<sup>166</sup> S 35(1) Nepalese Constitution.

<sup>167</sup> The Public Health Service Act 11, 2075 (2018) (hereafter Public Service Health Act).

<sup>168</sup> S 2 Public Service Health Act.

<sup>169</sup> The Health Act 21, 2017 (Hereafter 'Health Act').

<sup>170</sup> S 2 Health Act.

<sup>171</sup> As above.

<sup>172</sup> S 7(2)(a) Health Act.

<sup>173</sup> S 7(2)(b) Health Act.

<sup>174</sup> S 7(2)(c) Health Act.

through other provisions. An example of this is Article 34 of the Constitution of Romania.<sup>175</sup> It does not expressly protect the right to emergency medical treatment, but it does guarantee the right to health,<sup>176</sup> and states that the state is to ensure public health.<sup>177</sup> It then states that

the organization of the medical care and social insurance systems in case of illness, accidents, childbirth, and recovery, the supervision of the exercise of the medical professions and of paramedical activities, as well as other measures for the protection of the individual's physical and mental health are established by law.<sup>178</sup>

By including 'paramedical activities' and the organisation of medical care in the case of illness, accidents and childbirth under the measures which are to protect the health of individuals, it is arguably implied that the subsections of Article 34 of the Romanian Constitution protect the right to be provided medical care or treatment in emergencies.

The Constitution of Finland also does not expressly mention emergency medical treatment, but it does make provision in Section 19 that the 'public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population'.<sup>179</sup> Although, as with the Constitution of Romania, Section 19 of the Constitution of Finland does not expressly mention emergency medical treatment, an active duty is placed on the Finnish public authorities to guarantee the right to medical services, which, by broader implication should include emergency medical services and treatment.<sup>180</sup> By not being included therein, emergency medical treatment is not defined in the Constitution of Finland, nor the country's Health Care Act 1326 of 2010, but Section 40 of this Act does detail the scope of emergency medical services.<sup>181</sup> Under this section,

emergency medical services include

Urgent treatment of patients who have suffered an injury or a sudden onset of an illness primarily outside of health care treatment facilities... and transport of patients to the treatment unit with the most appropriate medical services;<sup>182</sup>

This provision speaks to the urgency element of medical emergencies and includes both injury and illness in its scope, as opposed to what we have seen above in international law where much of the focus is on illness as opposed to injuries.

*a) The implicit recognition of the right to not be refused emergency medical treatment under the right to life*

The Constitution of India does not explicitly recognise the right to not be refused emergency medical treatment.<sup>183</sup> It does, like many countries including South Africa,<sup>184</sup> recognise the right to life.<sup>185</sup> Article 21 of the Indian Constitution provides that no person may be deprived of their life. In the landmark decision of *Paschim*

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<sup>175</sup> Art. 34 of the Constitution of Romania, 1991 (hereafter Romanian Constitution).

<sup>176</sup> Art. 34(1) Romanian Constitution.

<sup>177</sup> Art. 34(2) Romanian Constitution.

<sup>178</sup> Art. 34(3) Romanian Constitution.

<sup>179</sup> S 19 of the Constitution of Finland, 1999.

<sup>180</sup> As above.

<sup>181</sup> S 40 Health Care Act 1326 of 2010 (hereafter Health Care Act).

<sup>182</sup> S 40(1) Health Care Act.

<sup>183</sup> The Constitution of India, 1950 (hereafter Indian Constitution).

<sup>184</sup> S 11 Constitution.

<sup>185</sup> Art. 21 Indian Constitution.

*Banga Khet Mazdoor Samity and others v State of West Bengal and another* (1996) AIR SC 2426, the Supreme Court of India construed that, included in the right to life under Article 21 of the Indian Constitution, is the duty to provide emergency medical treatment to safeguard human life.<sup>186</sup>

In this case, Mr Hakim Seikh had fallen off a train, causing him to suffer severe injury to his head, including a brain haemorrhage.<sup>187</sup> He immediately needed medical attention and was taken to a primary healthcare facility, which did not have the ‘necessary facilities’ to treat his condition and he was referred to a hospital by the medical officer on duty.<sup>188</sup> He was taken to a state hospital a few hours later and after x-rays were taken of his skull, it was recommended that he be admitted to hospital to be treated immediately.<sup>189</sup> The hospital he had been taken to, however, did not have any beds available and he was transferred to another hospital in the early hours of the next morning.<sup>190</sup> This hospital also did not have any beds available, and he was again transferred to another state health facility.<sup>191</sup> Mr Seikh was refused again based on unavailability of beds and after being moved around to various facilities, despite a CT scan showing that this was a medical emergency, he was eventually attended to at a private hospital, which resulted in him incurring significant medical bills.<sup>192</sup>

The court was faced with the legal question of whether the fact that Mr Seikh was not treated for his severe injuries by the state health facilities, due to lack of resources and capacity, constituted a violation of his right to not be deprived of life in terms of Article 21 of the Constitution of India.<sup>193</sup> In coming to its decision, the court remarked that ‘providing adequate medical facilities of the people is an essential part of the obligations undertaken by the government in a welfare state’.<sup>194</sup> The court held that

Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the Medical Officers employed therein are duty-bound to extend medical assistance for preserving human life. Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21. In the present case there was breach of the said right of Hakim Seikh guaranteed under Article 21 when he was denied treatment at the various Government hospitals which were approached even though his condition was very serious at that time and he was in need of immediate medical attention.<sup>195</sup>

The court emphasised the importance of preserving human life and the duty of state hospitals and their employees to provide medical treatment to do so.<sup>196</sup> This is the basis upon which the court concluded that the failure by the state healthcare facilities to provide Mr Seikh with timely treatment, despite his emergent condition, constituted a

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<sup>186</sup> *Paschim Banga Khet Mazdoor Samity and others v State of West Bengal and another* (1996)

AIR SC 2426 (*Paschim Banga*) par 9.

<sup>187</sup> *Paschim Banga* (n 186 above) par 2.

<sup>188</sup> As above.

<sup>189</sup> As above.

<sup>190</sup> As above.

<sup>191</sup> As above.

<sup>192</sup> As above.

<sup>193</sup> *Paschim Banga* (n 186 above) par 4.

<sup>194</sup> *Paschim Banga* (n 186 above) par 9.

<sup>195</sup> As above.

<sup>196</sup> As above.

violation of his right to life.<sup>197</sup> By coming to this decision, the Supreme Court had derived the right to not be refused medical treatment in an emergency from the right to life under the Indian Constitution, arguing that this right includes the duty to preserve life, which often requires emergency medical treatment.<sup>198</sup> Although the Supreme Court did not use the words ‘emergency medical treatment’, the emphasis on providing ‘timely medical treatment’ and ‘immediate medical attention’ to somebody in need thereof, can easily be construed to indicate that the court implied that emergency medical treatment should be provided in these instances to preserve human life. Failure to provide such emergency medical treatment, which is at times needed to preserve human life, would be tantamount to a violation of the right to life in terms of Article 21 of the Indian Constitution. The right to not be refused emergency medical treatment is therefore implied in the right to life under Indian constitutional law.

While some states implicitly recognise the right to receive or not be refused emergency medical treatment, having an express constitutional provision unequivocally protecting such rights is preferable. This creates clear, claimable entitlements and provides a stronger safety net, protecting the interests of those who require medical treatment in emergencies. Some constitutional provisions expressly state that emergency medical treatment should be provided by the state, whilst the majority of constitutional provisions protect the right in the sense that such treatment may not be denied or refused. The latter is arguably the better way to recognise such a right as it can extend the duty to not refuse such treatment to both state and private entities, whereas the provisions which provide that the state must provide such treatment only apply to the state. Although these rights are phrased in the negative, the effect is that positive obligations are still placed on both state and private entities to not refuse emergency medical treatment to anyone.

#### **IV. OBLIGATIONS OF STATES AND NON-STATE ACTORS**

This chapter has established that there is an international right to the highest attainable standard of health from which the right to emergency medical treatment can be derived. It has also shown that various states explicitly recognise emergency healthcare or emergency medical treatment as a claimable right under constitutional law. In some instances, this right is framed in such a way that emergency medical treatment should actively be provided, whereas the majority of these constitutional provisions have stated that such treatment may not be refused to those in need. For these rights to be realised, certain obligations need to be fulfilled by various parties. In terms of the international law and comparative constitutional law provisions which have been highlighted, the question now, is what is the nature of the obligations created by these provisions, and who is ultimately bound by them?

##### *a) Emergency medical treatment and the obligations of states*

While emergency medical treatment is not specifically mentioned in the International Bill of Rights, Article 12 of the ICESCR is still significant in protecting the right to the highest standard of health, placing a duty on states to ensure the provision of

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<sup>197</sup> As above.

<sup>198</sup> As above.

medical treatment for those who require it.<sup>199</sup> Emergency medical treatment is arguably included in its scope. General Comment 3 of the CESCR discusses the nature of the obligations of state parties to the ICESCR with particular reference to Article 2, which focuses specifically on the obligations of states.<sup>200</sup> In response to the question of whether states bear any obligations under international law in terms of the right to health and more specifically emergency medical treatment, in short, the answer would be yes.

In discussing the nature of state obligations, Article 2(1) of the ICESCR specifically provides that states who are parties to the covenant undertake to take active steps towards the realisation of the socio-economic rights contained in the ICESCR, which includes the right to the highest standard of health, and ultimately the provision of emergency medical treatment.<sup>201</sup> Included in these 'steps' that have to be taken, is the adoption of legislation, which General Comment 3 regards as especially important, particularly in relating to the adoption of legislation surrounding health.<sup>202</sup> The CESCR does, however, also state that although legislative measures can be adopted, this 'is by no means exhaustive of the obligations of state parties'.<sup>203</sup> An emphasis is made on the fact that states should still take other 'appropriate' measures to realise these rights, but states should determine what is appropriate under the circumstances of each state.<sup>204</sup> Included in these appropriate measures, according to General Comment 3, is having judicial remedies for the rights contained in the ICESCR and state parties are obligated to have judicial remedies available if these rights are violated.<sup>205</sup> In the context of Article 12 and the healthcare rights contained therein, this would mean that states must have judicial remedies in place when these health rights are violated. Following the discussion on emergency medical treatment, the consequence of this would then be that in a case where the right to emergency medical treatment is violated, a judicial remedy should be available to the person whose rights were violated.

Every state party is mandated by a core obligation to at least satisfy the basic elements of the rights contained in the ICESCR.<sup>206</sup> The example is used that if many people in a specific country are deprived of primary healthcare, then that state party has failed to 'discharge its obligations under the covenant'.<sup>207</sup> Having said this, it is further emphasised that resource constraints of particular states need to be taken into account, but states need to show that they made 'every effort' to discharge their obligations by using all their available resources to meet their obligations.<sup>208</sup> Even in states where resources are severely constrained, the vulnerable members of society have to be accounted for and protected.<sup>209</sup> General Comment 3 provides that 'low-cost

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<sup>199</sup> Art. 12 ICESCR.

<sup>200</sup> Committee on Economic, Social and Cultural Rights, General Comment 3, The nature of States parties' obligations (Fifth session, 1990), U.N. Doc. E/1991/23, annex III at 86 (1991) (hereafter General Comment 3).

<sup>201</sup> Art. 2(1) ICESCR.

<sup>202</sup> General Comment 3 (n 200 above) par 3.

<sup>203</sup> General Comment 3 (n 200 above) par 4.

<sup>204</sup> As above.

<sup>205</sup> General Comment 3 (n 200 above) par 5.

<sup>206</sup> General Comment 3 (n 200 above) par 10.

<sup>207</sup> As above.

<sup>208</sup> As above.

<sup>209</sup> General Comment 3 (n 200 above) par 12.

targeted programmes' must be adopted to ensure the protection of the vulnerable groups in society.

While Article 12 of the ICESCR expands on the right to the highest attainable standard of health, this provision does not give much direction on what states need to do to ensure the fulfilment and protection of the right.<sup>210</sup> To address this, General Comment 14 elaborates on the normative content of the right as well as state obligations in terms of this right.<sup>211</sup> Of particular relevance to this dissertation, is that General Comment 14 emphasises the need for equality in the provision of healthcare. It expressly states that states must provide healthcare services to those who cannot afford it and states have to prevent any forms of discrimination in the provision of these services.

General Comment 14 explains that human rights, including the right to health (and thus also the right to not be refused emergency medical treatment), places three kinds of obligations onto states.<sup>212</sup> These obligations are namely to 'respect, protect and fulfil' the rights.<sup>213</sup> In this instance, it would mean that under the obligation to respect the right to health under Article 12, states themselves must not interfere, whether directly or indirectly, with any person's enjoyment of this right.<sup>214</sup> The state's obligation to protect the right means that the state has to 'take measures that prevent third parties from interfering' with the guarantees under the right to health.<sup>215</sup> The state's obligation to fulfil the right entails that state parties have to 'adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health'.<sup>216</sup> What we see here, is that state obligations are multifaceted when it comes to the right to health and the right to emergency medical treatment. Although states have a negative obligation to respect the rights, by not interfering with the enjoyment of rights, they have a positive obligation to ensure the protection of such rights from third parties and to take certain action steps to ensure that these rights are fulfilled.

With these obligations in mind, General Comment 14 specifies that states are obligated to respect the right to health under Article 12 by 'refraining from denying or limiting equal access for all persons' and further, that states may not enforce discriminatory actions or policies relating to the provision of health services.<sup>217</sup> Looking at the constitutional provisions of South Africa, Somalia, Fiji, Kenya and other states that provide that nobody may be refused or denied emergency medical treatment, these provisions tie in here with the state's obligation to respect the right by not interfering with the enjoyment of the right by not denying or refusing this treatment. The protection of these rights under the various constitutional and domestic law provisions of states also ties in with the fact that states are obligated to protect the right to health by adopting legislation and taking 'other measures ensuring equal access to health care and health-related services provided by third parties'.<sup>218</sup> States are further urged to make sure that the privatisation of basic services, such as

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<sup>210</sup> Burkholder, Hill & Calvillo Hynes (n 118 above) 613.

<sup>211</sup> General Comment 14 (n 109 above).

<sup>212</sup> General Comment 14 (n 109 above) par 33.

<sup>213</sup> As above.

<sup>214</sup> As above.

<sup>215</sup> As above.

<sup>216</sup> As above.

<sup>217</sup> General Comment 14 (n 109 above) par 34.

<sup>218</sup> General Comment 14 (n 109 above) par 35.

emergency medical services, does not hinder the ‘availability, accessibility, acceptability and quality’ of these services.<sup>219</sup> Regarding the obligation to fulfil the right to health, states have to adequately recognise the right to health in national legislation and policy and plan for the realisation of the right must be included.<sup>220</sup> States also have to make sure that there are enough healthcare facilities with trained staff.<sup>221</sup> States must also actively ensure the right to health is enjoyed by all individuals and communities, with a particular emphasis on the duty to ensure that measures are in place to attend to the specific needs of vulnerable groups of people.<sup>222</sup>

According to General Comment 14, read with General Comment 3 and the Declaration of Alma Ata, there are six core obligations that states have to meet at the bare minimum level.<sup>223</sup> These obligations are non-derogable and while the obligations to provide essential food and ensure access to shelter are important, it is the remaining four core obligations that apply to this discussion on emergency medical treatment.<sup>224</sup> States have the core obligation ‘to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalised groups’<sup>225</sup> In addition to this, states have the core obligations to ‘provide essential drugs’<sup>226</sup> and make sure that all health amenities and goods are equitably distributed.<sup>227</sup> A ‘national public health strategy and plan of action’ which tackles the specific health-related issues of that country must be adopted and implemented by states and should include national health standards that have to be met.<sup>228</sup> This needs to be continually reviewed and the public should be consulted and invited to participate in this process. This health strategy must pay particular attention to the needs of the vulnerable and marginalised members of society.<sup>229</sup> Where states have failed or omitted to take the necessary measures to fulfil their obligations in terms of the right to health under Article 12, they can be found guilty of violating this right.<sup>230</sup>

Under comparative constitutional law and the respective constitutional and legislative provisions of the aforementioned states, we have seen at times that these provisions place an active duty on the state to ensure the provision of emergency medical treatment or emergency healthcare.<sup>231</sup> In the majority of constitutional provisions speaking to emergency medical treatment, however, a negative duty is created in that such treatment may not be denied or refused to anyone. The state is included in this and state healthcare services and facilities may not refuse emergency medical treatment to anyone in these instances. The duty to respect the right thus places a negative obligation on the part of states to refrain from denying access to such treatment.<sup>232</sup> Although these rights have been framed in this negative fashion, it still

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<sup>219</sup> DM Chirwa ‘Socio-economic rights and privatization of basic services in South Africa: a theoretical framework’ (2003) 4(4) *ESR Review* 4 at 7.

<sup>220</sup> General Comment 14 (n 109 above) par 36.

<sup>221</sup> As above.

<sup>222</sup> General Comment 14 (n 109 above) par 37.

<sup>223</sup> General Comment 14 (n 109 above) par 43.

<sup>224</sup> Burkholder, Hill & Calvello Hynes (n 118 above) 614.

<sup>225</sup> General Comment 14 (n 109 above) par 43(a).

<sup>226</sup> General Comment 14 (n 109 above) par 43 (d).

<sup>227</sup> General Comment 14 (n 109 above) par 43 (e).

<sup>228</sup> General Comment 14 (n 109 above) par 43 (f).

<sup>229</sup> As above.

<sup>230</sup> General Comment 14 (n 109 above) par 49.

<sup>231</sup> Seen in the Constitutions of Sudan, South Sudan, Zimbabwe, Romania.

<sup>232</sup> General Comment 14 (n 109 above) par 34.

also places a positive obligation onto states as certain steps must be taken by the state to ensure that these rights are enjoyed.

The World Health Assembly (WHA) is that part of the WHO that makes decisions and creates policies.<sup>233</sup> While international law has mainly focused on the right to health in a more general sense, the WHA has adopted several resolutions in recent years that specifically speak to emergency medical treatment. Although the WHA resolutions are considered soft law and are not necessarily legally binding on states, these resolutions are helpful tools for interpretation and provide further insight into the international standards expected of states.<sup>234</sup> As emergency medical treatment has only recently begun to emerge as a right under international and comparative constitutional law, the WHA has in recent years adopted several resolutions to set out what is expected of states in terms of the provision of emergency medical treatment.

In 2004, the WHA adopted Resolution WHA57.10 on Road Safety and Health, which recognised the horrific mortality rate associated with 'road traffic crashes'.<sup>235</sup> Emphasis was put on the high mortality rate associated with middle and low-income countries.<sup>236</sup> Road traffic injuries are highlighted as a significant public health concern with grave implications on social and economic costs.<sup>237</sup> In saying this, the WHA has recognised that this aspect of public health is neglected and without 'urgent action', the dire consequences and implications on the rate of mortality will only get worse.<sup>238</sup> This resolution places an onus on both states and private individuals, as part of civil society, to provide prehospital and trauma care for those injured in road traffic incidents.<sup>239</sup> Governments are urged in this resolution to assign 'focal points' in public health sectors that focus on the prevention and treatment of injuries caused by road crashes.<sup>240</sup>

The Sixtieth WHA adopted Resolution WHA60.22 in 2007, named '*Health systems: emergency-care systems*'.<sup>241</sup> It has been described as a 'landmark health care policy tool to improve emergency care access and availability globally'.<sup>242</sup> In this resolution, the WHA acknowledges that on a global scale over 100 million people are injured annually and over five million of these incidents result in fatalities as a result of violence and injury.<sup>243</sup> It reports that 90 per cent of these fatalities take place in

<sup>233</sup> World Health Organisation 'Seventy-Second World Health Assembly' available at <https://www.who.int/about/governance/world-health-assembly/seventy-second-world-health-assembly>, accessed on 30 May 2019).

<sup>234</sup> LO Gostin & D Sridhar & D Hougenobler 'The normative authority of the World Health Organisation' (2015) 129 (7) *Public Health* 854 at 855.

<sup>235</sup> World Health Organisation, Fifty-Seventh World Health Assembly Resolution WHA57.10 'Road Safety and Health' 22 May 2004, available at [https://apps.who.int/gb/ebwha/pdf\\_files/WHA57/A57\\_R10-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R10-en.pdf), accessed on 5 December 2020 (hereafter WHA 57.10).

<sup>236</sup> As above.

<sup>237</sup> As above.

<sup>238</sup> As above.

<sup>239</sup> WHA 57.10 (n 235 above) Art. 1.

<sup>240</sup> WHA 57.10 (n 235 above) Art. 2.

<sup>241</sup> World Health Organisation, Sixtieth World Health Assembly Resolution WHA60.22 'Health systems: emergency-care systems' 23 May 2007 available at [https://apps.who.int/iris/bitstream/handle/10665/22596/A60\\_R22-en.pdf?sequence=1&isAllowed=y](https://apps.who.int/iris/bitstream/handle/10665/22596/A60_R22-en.pdf?sequence=1&isAllowed=y), accessed on 16 November 2020 (hereafter WHA60.22).

<sup>242</sup> C Stein *et al* 'Access to out-of-hospital emergency care in Africa: consensus conference recommendations' (2016) 6 *African Journal of Emergency Medicine* 158.

<sup>243</sup> WHA 60.22 (n 241 above).

‘low- and middle-income countries’.<sup>244</sup> The WHA has stressed the necessity of ‘primary prevention’ in decreasing the encumbrance of injuries.<sup>245</sup> The WHA also notes that

improved organization and planning for provision of trauma and emergency care is an essential part of integrated health-care delivery, plays an important role in preparedness for, and response to, mass-casualty incidents, and can lower mortality, reduce disability and prevent other adverse health outcomes arising from the burden of everyday injuries.<sup>246</sup>

In saying this, the WHA envisages that further measures should be taken on a global scale to fortify the facilitation of emergency health care.<sup>247</sup> Special consideration is made for the fact that improvements need to be made on a global scale when it comes to emergency medical care and the treatment of trauma, particularly in the timely and effective provision of such assistance to those in need.<sup>248</sup> This resolution urges states to investigate and pinpoint any unmet needs in the provision of prehospital and emergency care.<sup>249</sup> Member states are called to task ministries of health in assessing and supporting trauma and emergency care provision.<sup>250</sup> The resolution also urges member states to launch ‘formal and integrated trauma and emergency-care systems and to draw on informal systems and community resources in order to establish pre-hospital care capacity in areas where formal, prehospital, emergency medical-care systems are impractical’.<sup>251</sup> Where formal emergency care systems are in place, member states are advised to implement supervision to ensure compliance with minimum core standards with regards to training, equipment and infrastructure.<sup>252</sup> This resolution strongly advises member states to implement a telephone number that is universally accessible and is common knowledge.<sup>253</sup> The emergency number to call for an ambulance in South Africa is 10177.<sup>254</sup>

An important provision of this resolution is in Article 2(6) where member states are urged to ‘identify a core set of trauma and emergency-care services, and to develop methods for assuring and documenting that such services are provided appropriately to all who need them’.<sup>255</sup> The resolution takes into account the human resources involved in the provision of trauma and emergency healthcare in that it provides that states should ensure that proper training and working conditions are provided.<sup>256</sup> Member states are also pleaded to adopt measures for appropriate education systems in emergency healthcare,<sup>257</sup> and to ensure that proper records are taken to evaluate and strengthen emergency and trauma care provision where need

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<sup>244</sup> As above.

<sup>245</sup> As above.

<sup>246</sup> As above.

<sup>247</sup> As above.

<sup>248</sup> WHA 60.22 (n 241 above) Art. 1.

<sup>249</sup> WHA 60.22 (n 241 above) Art. 2(1).

<sup>250</sup> WHA 60.22 (n 241 above) Art. 2(2).

<sup>251</sup> WHA 60.22 (n 241 above) Art. 2(3).

<sup>252</sup> WHA 60.22 (n 241 above) Art. 2(4).

<sup>253</sup> WHA 60.22 (n 241 above) Art. 2(5).

<sup>254</sup> Western Cape Government ‘Calling for help in an emergency’ 9 April 2020, available at <https://www.westerncape.gov.za/service/calling-help-emergency>, accessed on 30 November 2020.

<sup>255</sup> WHA 60.22 (n 241 above) Art. 2(6).

<sup>256</sup> WHA 60.22 (n 241 above) Art. 7.

<sup>257</sup> WHA 60.22 (n 241 above) Art. 8.

be.<sup>258</sup> One of the most significant provisions in this resolution is where member states are called upon ‘to review and update current legislation, including where necessary financial mechanisms and management aspects, so as to ensure that a core set of trauma and emergency-care services are accessible to people who need them’.<sup>259</sup> Whether these standards have been sufficiently met by the state in South Africa will be investigated in the chapters that follow. Morris has argued that states worldwide have a chance and, in fact, a duty to ensure that emergency medical care is made a priority by way of changes to policy as well as education and awareness.<sup>260</sup>

*b) Emergency medical treatment and the obligations of non-state entities*

International health law has been critiqued as a fairly underdeveloped sphere of international law.<sup>261</sup> Toebes contends that health inequities or injustices are not considered as strongly as other public international law aspects, such as international trade or even humanitarian law.<sup>1</sup> Based on the discussion above, one can only agree and can go even further to say that emergency medical treatment in particular is a significantly underdeveloped aspect of international health law. International health law is particularly underdeveloped insofar as emergency medical treatment and the duty bearers under this right are concerned. The discussion above showed that the obligations of states in terms of this right can be derived from the general obligations of states under the ICESCR and the general international right to health. The obligations of private actors in terms of the right to emergency medical treatment are even less straightforward under international law.

It is worth considering where the private healthcare sector and business entities fit into the grand scheme of duty bearing in emergency medical treatment under international law. Although only states can be a party to the ICESCR, all members of society including individuals, private entities, non-profit organisations and health professionals hold responsibilities in ensuring the realisation of the right to the highest attainable standard of health.<sup>262</sup> States do, however, have to create a setting where these other actors may fulfil their responsibilities.<sup>263</sup> This ties in with the state’s obligation to protect, which includes the responsibility to take measures to ensure that private entities do not pose a threat to health rights and access to healthcare.<sup>264</sup>

General Comment 24 was recently adopted by the CESCR at its sixty-first session in 2017.<sup>265</sup> Businesses and the private sector play a big part when it comes to realising socio-economic rights.<sup>266</sup> General Comment 24 points out that, amongst other things, businesses create jobs and ‘private investment’ contributes significantly towards the improvement of their respective sectors.<sup>267</sup> Health is one of the covenant

<sup>258</sup> WHA 60.22 (n 241 above) Art. 9.

<sup>259</sup> WHA 60.22 (n 241 above) Art. 10.

<sup>260</sup> S C Morris ‘Emergency medicine and global health policy: history and next steps’ (2016) 6 (2) *Journal of Global Health* 1.

<sup>261</sup> B Toebes ‘International health law: an emerging field of public international law’ (2015) 55(3) *Indian Journal of International Law* 300.

<sup>262</sup> General Comment 14 (n 109 above) par 42.

<sup>263</sup> As above.

<sup>264</sup> General Comment 14 (n 109 above) par 35.

<sup>265</sup> General Comment 24 (n 61 above).

<sup>266</sup> General Comment 24 (n 61 above) par 1.

<sup>267</sup> As above.

rights affected by business activities pointed out in General Comment 24.<sup>268</sup> General Comment 24 highlights that the CESCR often faces instances where the activities of corporate bodies and private entities have had adverse effects on socio-economic rights as a result of states not properly regulating these entities and their impact on human rights.<sup>269</sup> These ‘business activities’ relate to actions taken by businesses, on both a small and large scale, regardless if they are by transnational companies or on a domestic level and regardless of who owns the business - whether the businesses are fully private companies or owned by the State.<sup>270</sup> General Comment 24 recognises that in several countries, individuals have a right of recourse against businesses in instances where rights are or may be violated.<sup>271</sup> This right of recourse allows for the individual to impose either positive or negative obligations on these entities to ensure that their rights are protected.<sup>272</sup>

International standards dictate that ‘business entities are expected to respect covenant rights regardless of whether domestic laws are fully enforced in practice’.<sup>273</sup> Private entities are thus also obligated to respect the international right to health, and consequentially, the right to emergency medical treatment. This means that businesses may not interfere, directly or indirectly, with the enjoyment of these health rights. Following General Comment 24, states must safeguard against discrimination in the exercise of socio-economic rights, even insofar as it relates to private entities.<sup>274</sup> States must prohibit private entities from exercising any form of discrimination when it comes to these rights.<sup>275</sup> This would entail that states have a duty to prohibit both public and private healthcare providers from discriminating against any person in the provision of emergency medical treatment. Section 27 of the Somalian Constitution hits the nail on the head here as it is open-ended in terms of who it applies to, meaning that both the state and private entities may not deny emergency healthcare to somebody in need. It further provides that this treatment may not be denied for any reason, not even ‘lack of economic capability’.<sup>276</sup> This prohibits private entities from refusing emergency treatment to somebody in need, even if they cannot afford to pay for the treatment. This prohibits discrimination in the provision of emergency healthcare, with emphasis being placed on discrimination based on economic standing. General Comment 24 makes explicit provision that

state parties may be held directly responsible for the action or inaction of business entities:  
(a) if the entity concerned is in fact acting on that state party’s instructions or is under its control or direction in carrying out the particular conduct at issue.<sup>277</sup>

This could be construed to mean that if a private business entity, such as a private healthcare facility, did not respect, protect and fulfil social, economic or cultural rights – the state could potentially be held directly accountable. As a consequence of breach, or non-compliance with international standards, General Comment 24 suggests that states should impose ‘criminal or administrative sanctions and penalties’ where private

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<sup>268</sup> General Comment 24 (n 61 above) par 2.

<sup>269</sup> General Comment 24 (n 61 above) par 1.

<sup>270</sup> General Comment 24 (n 61 above) par 3.

<sup>271</sup> General Comment 24 (n 61 above) 4.

<sup>272</sup> As above.

<sup>273</sup> General Comment 24 (n 61 above) par 5.

<sup>274</sup> As above.

<sup>275</sup> As above.

<sup>276</sup> S 27 Somalian Constitution.

<sup>277</sup> General Comment 24 (n 61 above) par 11.

entities violate covenant rights.<sup>278</sup> We have seen this happen, for example, in the Egyptian Constitution, where denying somebody emergency medical treatment is a crime.<sup>279</sup>

General Comment 24 also provides that states should facilitate civil suits and remedies for these infringements and take action, such as revoking business licenses, should business entities not act accordingly.<sup>280</sup> The obligation of states to protect also includes the duty to formulate and impose a legal framework that would protect health rights and prevent businesses and other private entities from infringing these rights.<sup>281</sup>

General Comment 24 takes the increase in privatisation of essential services into account and this is relevant to the provision of healthcare – especially emergency medical services.<sup>282</sup> It states that private healthcare entities should not prevent access to affordable, quality healthcare services.<sup>283</sup> Although General Comment 24 does not state that private healthcare providers must provide their services free of charge, it does reinforce the notion that one's inability to pay should not affect one's enjoyment of essential healthcare services.<sup>284</sup>

States thus retain at all times the obligation to regulate private actors to ensure that the services they provide are accessible to all, are adequate, are regularly assessed in order to meet the changing needs of the public and are adapted to these needs. Since privatisation of the delivery of good or services essential to the enjoyment of Covenant rights may result in a lack of accountability, measures should be adopted to ensure the right of individuals to participate in assessing the adequacy of provision of such goods and services.<sup>285</sup>

In the context of emergency medical treatment, this means that private medical providers such as hospitals, or private ambulance services need to be regulated by the state to prevent discrimination and to ensure that they provide emergency medical treatment to anyone in need thereof.

Many of the constitutional provisions prohibiting the denial of emergency medical treatment discussed above do not apply to the state only. In the majority of these provisions, it merely states that denial or refusal of this treatment is not allowed, or in the case of Egypt, such action would be a crime. Many of these provisions do not state specifically that it is only the state which may not refuse such treatment. These provisions do not specify who the duty bearers are per se, or who it is that may not deny emergency medical treatment. By virtue of this, it can arguably be deduced that nobody may refuse anybody such treatment. This means that even private entities or individuals in those specific countries may not refuse emergency medical treatment to somebody in need. This is a negative obligation to refrain from refusing emergency medical treatment, and if somebody presents with a medical emergency this places an active obligation to provide such treatment and not refuse it.

What happens if somebody without medical insurance or the ability to immediately pay for healthcare presents to a private healthcare facility in a medical

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<sup>278</sup> General Comment 24 (n 61 above) par 15.

<sup>279</sup> Art 18 Egyptian Constitution.

<sup>280</sup> General Comment 24 (n 61 above) par 15.

<sup>281</sup> General Comment 24 (n 61 above) par 16.

<sup>282</sup> General Comment 24 (n 61 above) par 21.

<sup>283</sup> As above

<sup>284</sup> General Comment 24 (n 61 above) par 22.

<sup>285</sup> As above.

emergency? International law provides little guidance on this exact scenario and the duties of private service providers towards patients. As we've seen, international health law is quite state-centred and does not always account for other role-players, such as private companies, non-governmental organisations or even public-private partnerships.<sup>286</sup> As private healthcare providers generally run first and foremost as businesses, when considering international health law, one has to take into account the 'balance of interests' of trade and commercial interests of businesses against the needs of those who require healthcare and emergency medical treatment under the international right to health.<sup>287</sup>

Though they may operate as businesses, private healthcare providers still hold certain responsibilities in terms of the right to health because they essentially perform a state function by providing health care.<sup>288</sup> Public health systems generally run on large scales as they are publicly funded as a result of tax and national budgets, but one can reasonably deduce that private institutions run differently with varying capacities, budgets and resources. The dynamics of private healthcare providers and their services are complex and there are competing interests and 'tensions' at play.<sup>289</sup> While private healthcare providers may in certain instances allow for more efficient provision of healthcare, particularly in that there may be more resources available in addition to state resources in the case of a medical emergency, by virtue of these providers running as businesses, this may pose a threat to the affordability of emergency medical services, which affects accessibility.<sup>290</sup>

One has to take into account that, while in an ideal world nobody would ever be refused healthcare, especially not in a medical emergency, private healthcare providers do not operate how the state does and do not receive funding in the same manner. One cannot reasonably expect businesses to always, at their own cost, provide free services to every person that presents themselves at these private healthcare facilities. The right to health and the right to emergency medical treatment are inarguably essential human rights to have for all human beings. The very nature of medical emergencies means that in some instances, individuals may have to rely on private healthcare providers to receive emergency medical treatment. International law itself does not provide much guidance on the obligations of private entities towards persons who do not have health insurance, or the financial means to pay for private healthcare. Some states have legislation in place to prevent instances of 'patient dumping', where indigent persons are refused emergency medical treatment in private facilities based on their inability to pay.<sup>291</sup>

In the United States, Section 1395dd of the Emergency Medical Treatment and Labour Act (EMTALA),<sup>292</sup> provides that regardless of an individual's financial circumstances or eligibility for certain benefits under the Act, there are two core obligations that all emergency departments have to fulfil.<sup>293</sup> First, if a person presents

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<sup>286</sup> Toebes (n 261 above) 301.

<sup>287</sup> As above.

<sup>288</sup> General Comment 24 (n 61 above) par 42.

<sup>289</sup> Toebes (n 261 above) 319.

<sup>290</sup> As above.

<sup>291</sup> S Rosenbaum 'The enduring role of the Emergency Medical Treatment and Active Labour Act' (2013) 32 (12) *Health Affairs* 2075 at 2077.

<sup>292</sup> The Emergency Medical Treatment and Labor Act, 1986 enacted under the Consolidated Omnibus Budget Reconciliation Act, 1985 42 USC S 1395 dd (EMTALA).

<sup>293</sup> Rosenbaum (n 291 above) 2077.

to a hospital's emergency department, that hospital must, within their capability, conduct an 'appropriate medical screening examination' to determine if the person has an emergency medical condition.<sup>294</sup> Further, if it is determined that an emergency medical condition is in fact present, that hospital must, within their available resources, either provide emergency medical treatment to stabilise the patient, or transfer the patient to another appropriate medical facility.<sup>295</sup> If it is deemed an emergency medical condition, the hospital may not transfer the patient if they have not been stabilised, except under exceptional circumstances.<sup>296</sup> The effect of these provisions is, that if an indigent person approached a private hospital's emergency department for assistance, they would have to be screened to determine if they had an emergency medical condition, and if so, such condition would have to be stabilised or the patient would have to be transferred to the next appropriate facility. The Act provides further protection for indigent patients under subsection (h) as the hospital may not delay the screening or stabilisation of a patient to 'to inquire about the individual's method of payment or insurance status'. The relevant treatment required for screening and stabilisation must be provided and if the hospital does not have the capability, the patient must be transferred to the next appropriate healthcare facility.

Kenya's Health Act emphasises that every person has the constitutional right to emergency medical treatment.<sup>297</sup> The Act goes into further detail as to what falls under emergency medical treatment and differs to EMTALA of the United States in that 'pre-hospital care' is included under this scope, whereas EMTALA only applies where a patient arrives at an emergency department of a hospital.<sup>298</sup> Section 7(2) of the Health Act similarly states that emergency medical treatment includes the stabilisation of the person presenting with a medical emergency, or where the healthcare provider does not have the facilities or capability to stabilise the person, that the person is referred somewhere that does have the facilities needed for stabilisation. Section 12 of this Act clarifies that it is both public and private healthcare providers that are obligated to provide such emergency medical treatment. This means that private healthcare providers in Kenya are obligated to provide pre-hospital care, provide emergency medical treatment to stabilise patients or transfer them to the next appropriate facility should they not have the relevant facilities or capacity where somebody requires emergency medical treatment. Section 91(b) of the Health Act protects the interests of those who do not have medical aid or who can't afford these services by providing that even in the case of private healthcare providers, they are bound by the Act to 'provide emergency services in their field of expertise required or requested either by individuals, population groups or institutions, without regard to the prospect or otherwise of direct financial reimbursement'. This does not mean that the private healthcare provider may not be entitled to compensation for the services provided, however.<sup>299</sup> Section 92 of the Health Act makes provision for public-private partnerships where the state can enter into agreements with the private healthcare sector so that their facilities may be used to serve the better needs of the health of the

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<sup>294</sup> S 1395 dd (a) EMTALA.

<sup>295</sup> S 1395 dd (b) EMTALA.

<sup>296</sup> S 1395 dd (c) EMTALA. These circumstances include where a patient has requested in writing to be transferred, where the medical benefits of transferring the patient to another facility outweigh those if the patient is treated at the first hospital, or where it is deemed medically appropriate.

<sup>297</sup> S 7(1) Health Act.

<sup>298</sup> S 7(2) Health Act.

<sup>299</sup> S 91(2) Health Act.

population. This can arguably be read to include situations where a private healthcare provider is better equipped to provide emergency medical treatment, should the occasion arise.

Kenya's Health Act and EMTALA of the United States are good examples of states fulfilling their obligation to protect the right to emergency medical treatment by enacting legislation that regulates private healthcare providers in medical emergencies. The interests of all patients, regardless of their ability to pay, are protected in these provisions as both state and private healthcare providers have to, at the very least, provide emergency medical treatment to stabilise an individual with an emergency medical condition. Should the provider not have the capacity or capability to do so, they must at least transfer them to the next appropriate facility so that emergency medical treatment can be provided.

Although private entities have to fall in line with international standards and laws concerning covenant rights and emergency healthcare rights, states still carry a heavy burden to protect and fulfil these rights. Several obligations still rest on states to not only fulfil and protect the right to healthcare services within public entities but also to regulate private entities to ensure that their business activities stay in line with international human rights and do not infringe these rights or hinder their fulfilment.<sup>300</sup> While international law does not compel the private health sector to provide their services free of charge, General Comment 24 emphasises that part of regulating private healthcare services, means that these services should be affordable to ensure that one's enjoyment of covenant health rights does not depend on one's ability to pay.<sup>301</sup> This is especially important to avoid 'socioeconomic segregation' in the enjoyment of these rights.<sup>302</sup>

The notion of affordability is emphasised in General Comment 14 – particularly insofar as the essential element of accessibility is concerned. Economic accessibility concerns both state and non-state healthcare providers in that

Health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.<sup>303</sup>

Hence, although General Comments 14 and 24 do not state that private providers have to provide their services free of charge, General Comment 14 does state that part of the state's obligation to protect the right to health includes making sure that 'privatisation of the health sector' does not compromise the accessibility of healthcare.<sup>304</sup> While private healthcare providers typically charge a fee for their services, they have to ensure that these services are affordable. If not, the State is obligated to step in as part of its obligation to protect, to ensure that the third party (the private provider) does not interfere with the enjoyment of the right to health.<sup>305</sup>

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<sup>300</sup> General Comment 24 (n 61 above) par 58.

<sup>301</sup> General Comment 24 (n 61 above) par 21.

<sup>302</sup> General Comment 24 (n 61 above) par 22.

<sup>303</sup> General Comment 14 (n 109 above) par 12(b).

<sup>304</sup> General Comment 14 (n 109 above) par 35.

<sup>305</sup> As above.

According to General Comment 24, the state's obligation to fulfil requires states 'to take necessary steps, to the maximum of their available resources, to facilitate and promote the enjoyment of covenant rights, and, in certain cases, to directly provide goods and services essential to such enjoyment'. As part of this obligation, General Comment 24 recognises that this may require the state to mobilise resources and in some instances, this requires cooperation with businesses to best fulfil these rights.<sup>306</sup> The CESCR welcomes the development of action plans between businesses and human rights, particularly in that private actors are now also being assigned certain responsibilities and obligations in terms of these rights.<sup>307</sup> In this context, this would mean that under the right to emergency medical treatment, the development of action plans to regulate private actors and their obligations towards individuals and communities would be a welcomed development, especially given the fact that international law neglects to specifically address the obligations of private entities in terms of emergency medical treatment, leaving these duties open to interpretation, unless specific states have enacted legislation to address the issue within their own jurisdictions.

Though private entities do bear some obligations in terms of the provision of emergency medical treatment, States still hold many responsibilities in terms of keeping these private entities in check. It can therefore be construed that, under international law, the duty to realise the right to emergency medical treatment thus ultimately rests with the state whether it be directly or indirectly.

## V. CONCLUSION

This chapter has shown that neither the International Bill of Rights nor any of the treaties and conventions that South Africa is a signatory to explicitly mention a right to emergency medical treatment. This right is, however, implicitly recognised through the broader right to the highest attainable standard of health under Article 12 of the ICESCR,<sup>308</sup> as well as the provisions of other international instruments that South Africa is signatory to, such as Article 16 of the ACHPR and Article 24 of the CRC.

Emergency medical treatment as a right has been recognised in more specific terms in the constitutions of numerous states. Some states, such as South Africa, Kenya and Fiji, have recognised the right in a negative sense in prohibiting the refusal of emergency medical treatment. Other states, like Sudan and South Sudan, have explicitly provided that the state has to provide such treatment to its citizens. The constitutional provision which provides arguably the most protection for more people is Section 27 of the Somalian Constitution. It applies to all people and binds both to the state and private entities in providing that 'no one may be denied emergency healthcare for any reason, including lack of economic capability'.<sup>309</sup> A provision such as this is necessary especially in countries where many people live in poverty and cannot afford to pay for basic healthcare, let alone for emergency medical treatment.

This chapter has also shown that in India, although the Constitution does not have an express right to emergency medical treatment, the courts have implied this

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<sup>306</sup> General Comment 24 (n 61 above) par 23.

<sup>307</sup> General Comment 24 (n 61 above) par 59.

<sup>308</sup> This was affirmed in General Comment 14. See p 13-14 above.

<sup>309</sup> S 27 Somalian Constitution.

right in the right to life.<sup>310</sup> The argument is made that an express constitutional provision protecting either the right to not be refused emergency medical treatment, or at least to be provided this treatment, is preferable as it creates a clearer, claimable entitlement and negates any possibility of misinterpretation of whether such a right exists in law or not. The most ideal way to recognise this right is to expressly provide that emergency medical treatment may not be refused to anyone, for any reason, including inability to pay for such treatment.

Although the majority of the constitutional provisions recognise this right in the negative sense in that such treatment may not be refused, a positive obligation is still placed on both states and non-state entities to provide emergency medical treatment if somebody requires it. States are bound under international law to respect, protect and fulfil covenant rights. In this sense, the state must ensure the right to the highest attainable standard of health, which arguably sometimes includes the right to emergency medical treatment. Emergency medical treatment is an emerging right under international law, and several resolutions of the WHA have been adopted in recent years with recommendations of steps that states should take to better emergency medical systems and to ensure that this treatment is adequately provided.

This chapter has highlighted that international law is underdeveloped insofar as the duties of states and non-state entities in the provision of emergency medical treatment is concerned. Private entities do not escape responsibility when it comes to emergency medical treatment. This chapter has shown that non-state actors are also duty-bound to provide emergency medical treatment when somebody requires it, and such treatment may not be refused, even if the person cannot afford to pay for it.

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See *Paschim Banga* and S 21 Indian Constitution discussed on p 23-24.

## CHAPTER 3

### A HISTORICAL OVERVIEW OF EMERGENCY MEDICAL TREATMENT IN SOUTH AFRICA

#### I. INTRODUCTION

‘Health inequalities’ is a term used to describe the ‘differences in health status between groups within a country’.<sup>311</sup> South Africa is a country with a history that is riddled with tales of discrimination. It, therefore, comes as no surprise that the healthcare system of the country has its own history of segregation and injustices which have had long-lasting effects which have been embedded into our healthcare system as it is today.

This chapter discusses the history of emergency medical treatment in South Africa and the inequities and human rights violations that were persistent before the implementation of the 1996 Constitution and the Bill of Rights. It will address the question of whether before 1994 much regard was given to the notion of emergency medical treatment, and if so, in what way this was done. It will assess whether emergency medical treatment was protected by law or policies in the country before the right existed in the current Bill of Rights. In looking at the history of the healthcare sector in South Africa, one of the main questions this chapter aims to answer is how the South African healthcare sector has evolved and how accessible it was before 1994, with particular attention being paid to the evolution and accessibility of emergency medical treatment.

#### II. BEFORE APARTHEID: A COLONIAL STATE OF AFFAIRS

1652 is pinpointed as a significant year in South Africa’s history as it marks the time around which the white population of the country established its presence in southern Africa by means of the European colonisers arriving at and inhabiting the Cape of Good Hope.<sup>312</sup> Upon their arrival, they first encountered the indigenous African persons who lived on the southern African land.<sup>313</sup>

Prior to the arrival of the European colonisers, there were no clear cut ‘states’ in Africa as there are today.<sup>314</sup> The indigenous people in southern Africa, known as the ‘KhoiKhoi’ and ‘San Tribes’,<sup>315</sup> lived in kingdoms and factions of people connected through kinship and smaller groups of people.<sup>316</sup> They had been living on the land for thousands of years before the settlers arrived,<sup>317</sup> with their own methodology concerning medicine and healthcare.<sup>318</sup> In southern Africa, public healthcare became a growing concern as a result of the occupation of the land by the colonisers,<sup>319</sup> which came about through the formation of a formal authoritative

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<sup>311</sup> McIntyre & Ataguba (n 24 above) 2.

<sup>312</sup> Coovadia *et al* (n 4 above) 818.

<sup>313</sup> As above.

<sup>314</sup> Chirwa (n 3 above) 22.

<sup>315</sup> Coovadia *et al* (n 4 above) 818.

<sup>316</sup> Chirwa (n 3 above) 23.

<sup>317</sup> Coovadia *et al* (n 4 above) 818.

<sup>318</sup> Chirwa (n 3 above) 23.

<sup>319</sup> As above.

government which forced the indigenous persons away from their land-dwellings or forced them to work as labourers on farms established by the settlers.<sup>320</sup>

Around 1654, the settlers started importing slaves from other countries such as Indonesia, Mozambique and India as farmworkers.<sup>321</sup> The very first healthcare practitioners for the settlers were military workers who were employed by the Dutch East India Company, while the indigenous people and the slaves had their separate healers, who were part of an assembly of healthcare providers in the Cape.<sup>322</sup> The early nineteenth century saw a prevalence in Christian missionaries arriving in Africa to spread Western culture throughout Africa using Western education and medicine.<sup>323</sup> At this point in time, slavery was still prominent in Africa and one of the most significant manifestations that occurred as a result of the arrival of the missionaries was their determination to put a stop to slavery in Africa.<sup>324</sup> Chirwa notes that ‘slave trade was not just a gross human rights violation, it was also a major health disaster’.<sup>325</sup> Many families were displaced due to the slave trade, and those taken as slaves were imperilled with awful living conditions, notwithstanding the terrible socio-economic and psychological damage inflicted on those who were left behind.<sup>326</sup> The missionaries founded schools as well as healthcare centres, which at first reportedly ‘differed little in outcome from that of traditional healers’.<sup>327</sup> These centres were available to the missionaries themselves and also to those African persons who converted to Christianity.<sup>328</sup> This provision of healthcare and education thus came with conditions, with the missionary medical centres being established with the end-goal of replacing traditional African medicinal practices with those of Western, ‘scientific’, healthcare practices.<sup>329</sup> This, in turn, showed an element of dominance as those persons who wanted to access the healthcare provided by the missionaries had to desert their own traditional African belief system for Christianity to receive medical treatment – thus already demonstrating the marginalisation of indigenous persons.<sup>330</sup>

Once the colonisers founded a national governmental authority, the legal systems of their European countries of origin were imported into the region, which in turn marginalised African medicinal customs further by banning African medicine, labelling it as witchcraft.<sup>331</sup> The colonial government was not as concerned with the poor or the marginalised as the missionaries were and the colonial healthcare system was established to cater for colonialists and their relatives, colonial soldiers and other Westerners that found themselves within the colonies.<sup>332</sup> This is the epitome within which a discriminatory healthcare system in southern Africa, and particularly South Africa, was formed.<sup>333</sup> The healthcare policies that were put into place ensured that a much higher quality of medical attention would be provided to white colonials as opposed to the sub-standard healthcare offered to persons of African descent.<sup>334</sup> The

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<sup>320</sup> Coovadia *et al* (n 4 above) 818.

<sup>321</sup> Coovadia *et al* (n 4 above) 829.

<sup>322</sup> Coovadia *et al* (n 4 above) 818.

<sup>323</sup> Chirwa (n 3 above) 25.

<sup>324</sup> As above.

<sup>325</sup> As above.

<sup>326</sup> As above.

<sup>327</sup> Coovadia *et al* (n 4 above) 829.

<sup>328</sup> Chirwa (n 3 above) 26.

<sup>329</sup> As above.

<sup>330</sup> As above.

<sup>331</sup> Chirwa (n 3 above) 28.

<sup>332</sup> As above.

<sup>333</sup> As above.

<sup>334</sup> As above.

discrimination proved to be prominent in that healthcare centres were geographically positioned so that they were mainly in urban areas, which were difficult to access for non-white persons and these medical institutions were divided based on race.<sup>335</sup>

The Dutch East India Company reigned over the Cape until 1806 when the British came into rule in South Africa.<sup>336</sup> During this time the indigenous African peoples were either forced off the land, where the only options left, were to live in absolute poverty in the rural areas, or they were reduced to working as ‘wage-labourers’.<sup>337</sup> The discovery of gold and diamonds in the late nineteenth century triggered a shift in focus of the nation from agriculture to industrial practices such as mining.<sup>338</sup> The growth of the wealth emanating from the mining industry induced an emergent demand for cheap labour in the form of black men, and cheap migrant labour is held to be the foundation of ‘social, economic and political developments’ and subsequently played a major factor in the formation of patterns of disease<sup>339</sup>.

Segregation in the medical field in the region traces back as early as 1755, which is when the first public hospitals were built in the Cape.<sup>340</sup> Two hospitals were erected after the second outbreak of smallpox – one for white individuals and another for the non-white population.<sup>341</sup> The first recognised doctors were of European descent whereas it was not until 1910 that a grand total of 3 non-white doctors were enlisted.<sup>342</sup> This signifies how discrimination prevailed even in the training of medical professionals and the mechanisms of service provision.<sup>343</sup> Not only were non-whites not allowed to access whites-only medical centres, but the medical resources they were allowed to access were incredibly limited as the colonial government scarcely made provision for the training of black doctors and if they did, it was for the purpose of assistance to European doctors.<sup>344</sup>

The promulgation of the Public Health Amendment Act 23 of 1897 officially established segregation specifically in the South African healthcare system as remedial and precautionary medical services were provided by race.<sup>345</sup> In terms of private healthcare, all private medical services were paid by ‘out-of-pocket payments’ until 1889.<sup>346</sup> The first form of medical insurance schemes came about in 1889, aimed at caring for the medical essentials of white miners and only white people were allowed to belong to these schemes for almost a century.<sup>347</sup>

The Union of South Africa was founded in 1910, which allowed healthcare amenities to be split between the four provinces that were in place at the time;<sup>348</sup> namely the Cape Province, Natal, Orange Free State and Transvaal.<sup>349</sup> The South

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<sup>335</sup> As above.

<sup>336</sup> Coovadia *et al* (n 4 above) 818.

<sup>337</sup> As above.

<sup>338</sup> Coovadia *et al* (n 4 above) 819.

<sup>339</sup> As above.

<sup>340</sup> Coovadia *et al* (n 4 above) 829.

<sup>341</sup> As above.

<sup>342</sup> As above.

<sup>343</sup> Chirwa (n 3 above) 28.

<sup>344</sup> Chirwa (n 3 above) 29.

<sup>345</sup> A Gray *et al*, World Health Organisation, Improving health system efficiency, ‘South Africa: Implementation of reforms under the National Drug Policy’ 2015 at 4, available at [https://www.who.int/health\\_financing/documents/Efficiency\\_health\\_systems\\_South\\_Africa/en](https://www.who.int/health_financing/documents/Efficiency_health_systems_South_Africa/en) / accessed 5 December 2018.

<sup>346</sup> Coovadia *et al* (n 4 above) 826.

<sup>347</sup> As above.

<sup>348</sup> Coovadia *et al* (n 4 above) 820.

<sup>349</sup> Gray *et al* (n 345 above) 4.

Africa Act of 1909, which was the equivalent of the Constitution of South Africa in place at the time, did not make any mention of any form of healthcare rights.<sup>350</sup> The Public Health Act 36 of 1919 introduced South Africa's first Department of Public Health.<sup>351</sup> This Act also empowered the local authorities to take responsibility for 'preventative and promotive health care'<sup>352</sup> in their respective jurisdictions,<sup>353</sup> and hospital care was to be governed by the four provinces.<sup>354</sup>

In 1945, Dr Henry Gluckman became the first Jewish person to hold the position of Minister in South Africa when he was appointed Minister of Health.<sup>355</sup> Gluckman was responsible for the Gluckman Commission, which endeavoured to transform the South African healthcare structure to include a series of 'community health centres' which could be seen as the pioneers to community-based primary healthcare facilities.<sup>356</sup> Unfortunately, shortly after Gluckman became the Minister of Health, the Nationalist Party came into authority in 1948 – at the beginning of apartheid. At this stage, Gluckman's endorsements were not yet in force and the new government in place overruled his policies, which were then not materialised.<sup>357</sup>

### III. THE APARTHEID-ERA: SEGREGATION IN THE HEALTHCARE SYSTEM

It is no secret that segregation was the epitome of the apartheid era in South Africa. In true apartheid fashion, the healthcare sector was just as segregated as separate public healthcare facilities were established during this time to cater to the separate racial groups.<sup>358</sup> People were classified by race either as White, Black Africans, Coloured or Asian and received differential treatment according to their respective racial category.<sup>359</sup> This separated healthcare system was further divided at the formation of the homelands, or 'Bantustans', which were geographical areas specifically assigned to black African people in South Africa.<sup>360</sup> Each of these areas had their own health department which operated independently from each other, meaning that upon the dissolution of the apartheid regime, there were 14 distinct healthcare departments within the country – all operating differently to one another.<sup>361</sup> The result of this was that because there was so much focus on hospitals, the primary healthcare sector in South Africa was left in an infantile state, far behind where it should have been in terms of development.<sup>362</sup> This evidently has left a long-lasting effect on our healthcare system as it is today.

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<sup>350</sup> The South Africa Act, 1909.

<sup>351</sup> S 2 Public Health Act 36 of 1919.

<sup>352</sup> Coovadia *et al* (n 4 above) 825.

<sup>353</sup> S 7 Public Health Act 36 of 1919.

<sup>354</sup> Coovadia *et al* (n 4 above) 825.

<sup>355</sup> Jewish Telegraphic Agency 'Jewish doctor named Minister of Health in South Africa: first Jew in cabinet' 13 November 1945 available at <https://www.jta.org/1945/11/13/archive/jewish-doctor-named-minister-of-health-in-south-africa-first-jew-in-cabinet> accessed 5 December 2018.

<sup>356</sup> Coovadia *et al* (n 4 above) 825.

<sup>357</sup> As above.

<sup>358</sup> Gray *et al* (n 345 above) 4.

<sup>359</sup> As above.

<sup>360</sup> As above.

<sup>361</sup> Coovadia *et al* (n 4 above) 825.

<sup>362</sup> As above.

The apartheid-era saw ‘disproportionate resource allocation policies by the state at a systemic level’, which led to the low quality of healthcare and other services being made available to black African people.<sup>363</sup> Examples of this are the delays in treatment, shortages of medicines and hospital beds, black patients being refused bed sheets and having to sleep on the floor, inferior food being provided to black people and black women being told to leave the hospitals as soon as they had given birth.<sup>364</sup> Dhai comments that the state did, in fact, have sufficient resources but, due to the racist policies of apartheid, this inferior care is what black South Africans were left with.<sup>365</sup>

Regarding human resources during apartheid, the mentality of the government at the time was that black persons should only be ‘educated to a level appropriate for a menial position in society’.<sup>366</sup> Where the first medical school in South Africa was opened in Cape Town in 1920 for training whites only, the first medical school for black people was only established over 30 years later in the form of the University of Natal Medical School.<sup>367</sup> From 1968 up until 1977, black doctors comprised of a mere 3 per cent of all medical graduates.<sup>368</sup> By the 1970s, the ‘doctor to population ratio’ in the designated homelands was 1:15 000 – which is much lower than the 1:1 700 ratio for the remainder of South Africa.<sup>369</sup> Black nurses were no stranger to discrimination either. Although they were regarded as ‘part of the educated elite’ amongst the black populations, before the 1970s, they were not allowed to tend to white patients and they were not allowed to have white juniors in their working environments.<sup>370</sup> Unsurprisingly, until 1986 black nurses were remunerated at a much lower pay scale than white nurses.<sup>371</sup> This shows that it was not only patients but also the medical staff who experienced discrimination in the healthcare sector.

Although the public healthcare sector was ‘desegregated’ in 1988, the 1994 government was left to govern a fragmented healthcare system due to black-designated healthcare facilities being severely underfunded during apartheid.<sup>372</sup> This is evident in that during the 1986/1987 financial year, the ‘average per capita healthcare expenditure’ in the areas previously known as the ‘homelands’ was R 55 – compared to the R 172 average being spent on the rest of the country.<sup>373</sup> The systematic underfunding of the Bantustan healthcare facilities had a severely negative impact on how medicines could be accessed and funded by each healthcare department and a very limited range of medicines was therefore made available to these areas.<sup>374</sup> Access to healthcare and access to medicines in the apartheid era was problematic – particularly for marginalised populations.

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<sup>363</sup> A Dhai ‘A health system that violates patients’ rights to access health care’ (2012) 5 (1) *South African Journal of Bioethics and Law* 2.

<sup>364</sup> Dhai (n 363 above) 2.

<sup>365</sup> As above.

<sup>366</sup> Coovadia *et al* (n 4 above) 823.

<sup>367</sup> Coovadia *et al* (n 4 above) 829.

<sup>368</sup> As above.

<sup>369</sup> Coovadia *et al* (n 4 above) 820.

<sup>370</sup> Coovadia *et al* (n 4 above) 829.

<sup>371</sup> As above.

<sup>372</sup> McIntyre & Ataguba (n 24 above) 2.

<sup>373</sup> As above.

<sup>374</sup> As above.

#### IV. AMBULANCE APARTHEID: EMERGENCY HEALTHCARE UNDER APARTHEID RULE

Neither the Constitution of 1961,<sup>375</sup> nor of 1983 that were in place in South Africa during apartheid made any reference to health rights nor emergency medical treatment as a human right.<sup>376</sup> Racist apartheid policies and regulations were prevalent during this time, even in those areas of the medical field which are most dire.<sup>377</sup> Even blood transfusions, which are often vital in medical emergencies, were affected, such that white and non-white donors could not donate blood or ‘bleed’ in the same room and had to be facilitated in separate areas.<sup>378</sup> The blood was labelled and separated by race and white people were prohibited from being recipients of ‘black’ blood.<sup>379</sup>

Perhaps most indicative of how fundamentally racist the policies and legislation regulating the medical profession and provision of healthcare were, was the segregation of ambulances by racial classification.<sup>380</sup> Under absolutely no circumstances, even if it were a medical emergency, was a white ambulance allowed to transport a black person.<sup>381</sup> Ambulances intended for white patients were superior in quality and there were far more available than ambulances designated to attend to black patients.<sup>382</sup> This policy alone resulted in a much lower standard of care and many deaths which should and could have been prevented.<sup>383</sup> Many new-born black babies in critical condition lost their lives due to these discriminatory policies.<sup>384</sup> Ambulances carrying these infants would have to go past the white hospitals, which would have been equipped with the necessary medical facilities, to go to the sub-par black facilities and in many cases, this resulted in unnecessary deaths which could have been prevented entirely.<sup>385</sup>

This ‘ambulance apartheid’, as described by Mr Hesham Neamatollah Effendi in his testimony to the TRC, was so inherently flawed that it even resulted in occasional instances where white people, the intended beneficiaries of apartheid, were prevented from receiving emergency medical treatment.<sup>386</sup> In his testimony, Effendi, a coloured man, recalls an incident from 1973 that he describes as a ‘gross human violation’. One of his neighbours, a white man, was stabbed by his wife and urgently needed to be taken to hospital by ambulance.<sup>387</sup> The ambulance was taking long to arrive and the neighbours wanted Effendi to take him to the hospital in his car as the situation was dire.<sup>388</sup> When Effendi got to the house, the ambulance had just arrived and the police were on scene but the ambulance that was dispatched was a ‘coloured’ ambulance and was not allowed to transport a white patient. A non-white designated ambulance was dispatched because the call was for a patient who was stabbed and because of racial prejudice, it was just assumed that this must have happened to a coloured person and

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<sup>375</sup> Republic of South Africa Constitution Act 32 of 1961.

<sup>376</sup> Republic of South Africa Constitution Act 110 of 1983.

<sup>377</sup> Baldwin-Ragaven et al (n 33 above) 42.

<sup>378</sup> As above.

<sup>379</sup> As above.

<sup>380</sup> As above.

<sup>381</sup> As above.

<sup>382</sup> As above.

<sup>383</sup> As above.

<sup>384</sup> As above.

<sup>385</sup> As above.

<sup>386</sup> Baldwin-Ragaven et al (n 33 above) 43.

<sup>387</sup> Baldwin-Ragaven et al (n 33 above) 42.

<sup>388</sup> As above.

not a white person.<sup>389</sup> Even though Effendi pleaded with them to take the victim to a hospital as he was losing large amounts of blood, they refused because it was against the law.<sup>390</sup> Effendi then tried to take the man to the hospital in his car but the police barred him from doing so and threatened to arrest him because he was a coloured man. Eventually, Effendi got the man to a hospital but unfortunately, he succumbed to his injuries.<sup>391</sup> The doctor that attended to him confirmed that as a direct result of the long unnecessary delays (due to the inherent racism at hand), that man died when he could have received life-saving treatment.<sup>392</sup> It is because of policies such as these that many South Africans did not receive emergency medical treatment.

## V. POST-APARTHEID: THE NEW CONSTITUTIONAL DISPENSATION

The fragmented nature of South Africa's healthcare system is deeply rooted in our country's history of exclusion and discrimination as shown above. A beacon of hope for marginalised South Africans emerged in 1994 when the new constitutional dispensation came into effect, which introduced socio-economic rights for every person in the country.<sup>393</sup>

Section 27(1) of the Constitution specifies that everyone has the right to access to healthcare services. Subsection (2) of this constitutional provision obligates the state to 'take reasonable legislative and other measures within the resources available to achieve the progressive realisation of each of these rights'.<sup>394</sup> The most notable provision in the South African legal framework providing for emergency medical treatment lies in Section 27(3) of the Constitution, which states that 'nobody may be refused emergency medical treatment'. This is an unconditional, inflexible right.<sup>395</sup> This provision is more inclusive in protecting the interests of all people who require emergency medical assistance, a welcomed change from the racist apartheid laws mentioned above.

Since 1994, a variety of health-related legislation and policies have been adopted.<sup>396</sup> The NHA, as amended by the National Health Amendment Act 12 of 2013, was adopted as framework legislation governing the entirety of the healthcare system in South Africa.<sup>397</sup> Several pieces of legislation have since been adopted to regulate different healthcare professionals.<sup>398</sup> There has also been legislation regulating the medical insurance industry such as the Medical Schemes Act 131 of 1998, the Council for Medical Schemes Levies Act 58 of 2000 and the Medical Schemes Amendment Bill 58 of 2008.<sup>399</sup>

In line with Section 27(3) of the Constitution, Section 5 of the NHA provides that medical establishments and healthcare workers may not refuse any person from

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<sup>389</sup> Baldwin-Ragaven et al (n 33 above) 43.

<sup>390</sup> As above.

<sup>391</sup> As above.

<sup>392</sup> As above.

<sup>393</sup> Dhai (n 363 above) 2.

<sup>394</sup> S 27(2) Constitution.

<sup>395</sup> Dhai (n 363 above) 2.

<sup>396</sup> McIntyre & Ataguba (n 24 above) 3.

<sup>397</sup> McIntyre & Ataguba (n 24 above) 57.

<sup>398</sup> McIntyre & Ataguba (n 24 above) 3.

<sup>399</sup> McIntyre & Ataguba (n 24 above) 58.

receiving emergency medical treatment.<sup>400</sup> Section 25(2)(m) of the NHA provides that the head of a provincial department is responsible for ensuring that emergency medical services are coordinated and provided.<sup>401</sup>

On 1 December 2017, the Minister of Health at the time, Aaron Motsoaledi, promulgated the Emergency Medical Services Regulations (EMS Regulations) in accordance with Section 43(1) of the NHA read together with Section 90(1)(m).<sup>402</sup> Section 90(1)(m) empowers the Minister, after consulting the National Health Council, to make regulations concerning ‘emergency medical services and emergency medical treatment, both within and outside of health establishments’.<sup>403</sup>

Section 1 of the EMS Regulations contains definitions of the various terms used in emergency medicine.<sup>404</sup> These regulations govern how emergency services should run and operate and the standards that need to be met, such as what equipment should be used and what ambulances and response vehicles should be stocked with to be fully operational.<sup>405</sup> Section 26 of the EMS Regulations is particularly relevant to this discourse as it relates to the management of emergency medical services.<sup>406</sup> In terms of Section 26(3)(b), emergency service managers must make sure that the provision of emergency medical care is done in a way that is safe and that quality care is provided.<sup>407</sup> Section 26(3)(e) further places a duty on emergency services managers to safeguard that patients are not ‘refused emergency medical treatment by the Emergency Medical Service because of the patient’s inability to pay, or on any other grounds’.<sup>408</sup> This provision is particularly significant as we discuss patient refusal on the inability to pay for expensive medical treatment in the next few chapters.

In July 2019, the Minister of Health introduced the anticipated NHI Bill in the National Assembly.<sup>409</sup> The introduction of a National Health Insurance has been a point of contention in South Africa for a long time which now, by virtue of this Bill, appears to be materialising. The NHI Bill, and its possible implications, will be discussed later in this study. Of significance at this point in the discussion, is that the Preamble of the NHI Bill explicitly recognises ‘the socio-economic injustices, imbalances and inequities of the past’,<sup>410</sup> and it purports to redress these historical divisions in looking forward to establishing a nation founded on ‘democratic values, social justice and fundamental human rights’.<sup>411</sup>

## VI. CONCLUSION

South Africa has a history of inequities in the quality of healthcare accessible to different people, which stems from superior healthcare being provided to white people of European descent, as opposed lesser quality healthcare to persons of African

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400 S 5 NHA.  
 401 S 25(2)(m) NHA.  
 402 EMS Regulations.  
 403 S 90(1)(m) NHA  
 404 Reg 1 EMS Regulations.  
 405 Reg 11 of Annexure A EMS Regulations.  
 406 Reg 26 EMS Regulations.  
 407 Reg 26(3)(b) EMS Regulations.  
 408 Reg 26(3)(e) EMS Regulations.  
 409 NHI Bill.  
 410 As above.  
 411 As above.

descent. To look forward to finding solutions to the challenges our healthcare system currently faces, it is important to consider the reasons why our healthcare system is the way it is today and recognise the ‘inequities of the past’ described in the Preamble of the NHI Bill. It is apt to have made an inquiry into the history of the South African healthcare system in itself.

This chapter has shown that the southern African region, including South Africa itself, has a history of discrimination and racial segregation since the arrival of the colonisers and throughout apartheid in South Africa. These discriminatory systems that were put in place directly affected the provision of healthcare. Access to healthcare facilities was segregated based on race and those who were discriminated against often did not receive quality healthcare. Many people often did not receive very necessary medical assistance based on the areas within which they were restricted to live because of the segregation laws in place at the time. The geographical positioning of certain groups of people has historically affected their access to quality healthcare, and as will be shown in chapter 6, this has had a lasting effect in the country as certain areas have remained underdeveloped.

Prior to 1994, there was no constitutionally entrenched right to healthcare in South Africa and very little regard was given to emergency medical treatment as a basic human right.<sup>412</sup> Instead of protecting the right to not be refused emergency medical treatment, the apartheid laws and policies in place at the time did the exact opposite. As shown by the testimony of Mr Effendi and many others during the TRC Health Hearings, many people were refused emergency medical treatment based on their race as even ambulances providing emergency medical treatment were legally racially segregated.

The healthcare system in South Africa has evolved since the new democratic dispensation and the implementation of the latest Constitution and the Bill of Rights. On paper, the South African health system has evolved from a system of discrimination and segregation to being more accessible for people of different races. For the first time in the country’s history, the right to healthcare is constitutionally entrenched and these laws are more inclusive, as Section 27(3) states that ‘no one may be refused emergency medical treatment’. A range of healthcare legislation has since come into effect, with more focus on specific health issues, such as the EMS Regulations.

With the problematic history of the South African healthcare system in mind, as well as the various international law standards set out in the previous chapter, the chapters to follow seek to determine whether significant progress has been made to develop the current legal framework governing the South African healthcare sector at present. Particular focus will be given to whether the right to not be refused emergency medical treatment is properly protected and realised for all South Africans. The provisions of Section 27(3) will be analysed in greater detail in the next chapter along with various interpretations of the right to not be refused emergency medical treatment and the implications thereof.

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<sup>412</sup> See the South Africa Act, 1909; Republic of South Africa Constitution Act 32 of 1961 and Republic of South Africa Constitution Act 110 of 1983.

## CHAPTER 4

### THE MEANING OF THE RIGHT TO NOT BE REFUSED EMERGENCY MEDICAL TREATMENT IN SOUTH AFRICA

#### I. INTRODUCTION

This chapter unpacks the South African right under Section 27(3) of the Constitution that ‘no one may be refused emergency medical treatment’. The first question it asks is who the beneficiaries of this right are, and what is meant by the term ‘no one’. The second main question is what is meant by the term ‘emergency medical treatment’. This discussion assesses how the right is defined in the Constitution, and how this constitutional provision has been interpreted by the Constitutional Court. The assessment of what emergency medical treatment means also considers the position of this right in light of international law and comparative constitutional law. The analysis will look at how the right is recognised in South African law and whether this is done broadly or in a narrower sense and how it fares against international law and comparative constitutional law. The third main question concerns the nature of the obligations of both state and non-state actors related to emergency medical treatment in South Africa. In answering this question, consideration will be given to whether this is a positive right or a negative right, what is meant by the term ‘refusal’ and to the international law standards discussed in chapter 2.

#### II. ‘NO ONE’: BENEFICIARIES OF THE RIGHT

The first important point to consider when analysing Section 27(3) is who this particular section applies to and aims to protect – i.e. the beneficiaries of this right. Who is it that may not be refused emergency medical treatment? The section does not mention any specific category or class of persons who is or is not protected by this right. It simply refers to ‘no one’.

When determining the beneficiaries of this right, cognisance should be given to Section 7(1) of the Constitution, particularly in that the Bill of Rights enshrines ‘rights of *all people* in our country’. As mentioned in chapter 2, in the ordinary sense of the words ‘no one’ is accepted to encompass ‘everyone’ and in terms of who the beneficiaries of rights are, these terms are regarded as synonymous.<sup>413</sup> In the same way that the right to life under Section 11 of the Constitution,<sup>414</sup> or the general right to health care under Section 27(1) applies to ‘everyone’,<sup>415</sup> by using the term ‘no one’ in Section 27(3), it is accepted that this right applies to ‘all natural persons within the territory of the Republic’.<sup>416</sup>

It is important to remember that Section 39(1) of the Constitution provides specific guidelines for interpreting the Bill of Rights in that:

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<sup>413</sup> See chap 2 p 18 above.

<sup>414</sup> S 11 of the Constitution provides that ‘everyone has the right to life’.

<sup>415</sup> S 27(1)(a) of the Constitution provides that ‘everyone has the right to have access to health care services’.

<sup>416</sup> I Currie & J De Waal (n 152 above) 36.

when interpreting the Bill of Rights, a court, tribunal or forum –

- (a) must promote the values which underlie an open and democratic society based on human dignity, equality and freedom;
- (b) must consider international law; and
- (c) may consider foreign law.<sup>417</sup>

In looking at subsection (b) above, consideration should be given to whether the beneficiaries aspect of Section 27(3) falls in line with the international standards which were discussed previously. As we know from chapter 2, Article 55 of the UN Charter provides that all people should have their fundamental human rights and freedoms observed, regardless of their ‘race, sex, language, or religion’.<sup>418</sup> The interpretation that ‘no one’ means ‘everyone’ meets this standard when considering the beneficiaries of Section 27(3). This interpretation also falls in line with the broader international standards set in Article 12 of the ICESCR which provides that ‘everyone’ has the right to the ‘highest attainable standard of physical and mental health’.<sup>419</sup> Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination also obligates states to guarantee the right to public health and medical care for ‘everyone’<sup>420</sup> irrespective of their ‘race, colour, or national or ethnic origin, to equality before the law’.<sup>421</sup>

Section 9 of the Constitution contains the equality clause.<sup>422</sup> Subsection (1) states that ‘everyone is equal before the law and has the right to equal protection and benefit of the law’.<sup>423</sup> Emphasis should again be placed on the word ‘everyone’. Subsection (2) expands on this and states that ‘equality includes the full and equal enjoyment of all rights and freedoms’.<sup>424</sup> Subsections (3) and (4) prohibit the state or any other person from discriminating against another person on several grounds.<sup>425</sup> Read together with Section 27(3), these provisions mean that the right to not be refused emergency medical treatment protects all people, regardless of their age, race, gender, social status or citizenship.

### III. THE MEANING OF ‘EMERGENCY MEDICAL TREATMENT’ IN SOUTH AFRICA

Chapter 2 above established that the right to emergency medical treatment is implicitly recognised in international law under the broader right to the highest attainable standard of health.<sup>426</sup> In line with the international standards previously discussed, Section 27(1) of the Constitution recognises the general right of everyone to have access to health care services. In addition to this broader right, Section 27(3) makes explicit provision that ‘no one may be refused emergency medical treatment’. This section is more specific and narrower than the international law provisions discussed,

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<sup>417</sup> S 39(1) Constitution.

<sup>418</sup> Art. 55 UN Charter.

<sup>419</sup> Art. 12 ICESCR.

<sup>420</sup> Art 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination, G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195 (ICERD).

<sup>421</sup> Art 5 ICERD.

<sup>422</sup> S 9 Constitution.

<sup>423</sup> S 9(1) Constitution.

<sup>424</sup> S 9(2) Constitution.

<sup>425</sup> S 9(3) and (4) Constitution.

<sup>426</sup> See chap 2 p 13 above.

as it makes express provision for emergency medical treatment, which is a more specific subset of the wider provision of health care in general. While Section 27(1) is the more general right to health care, Section 27(3) is particularly focused on emergency medical treatment. On the face of it, it is not clear what exactly is meant by ‘emergency medical treatment’ under this provision.

Shortly after the current Constitution and the Bill of Rights came into effect, the Constitutional Court in *Soobramoney* undertook to interpret Section 27(3).<sup>427</sup> Thiagraj Soobramoney, the applicant in the matter, was a diabetic man with ischaemic heart disease, cerebrovascular disease and had suffered a stroke.<sup>428</sup> His kidneys had failed to the point where he had no chance of a full recovery and he had reached the ‘final stages of chronic renal failure’.<sup>429</sup> He, therefore, required regular dialysis to prolong his lifespan.<sup>430</sup> Although he had made arrangements to receive this treatment from private healthcare facilities, at some stage he could no longer afford to pay for the treatment.<sup>431</sup> He subsequently approached Addington State Hospital in KwaZulu-Natal, which had 20 dialysis machines – although many of the machines were in a state of despair.<sup>432</sup> The hospital was unable to provide this ongoing treatment to Soobramoney because of the restricted number of dialysis machines available.<sup>433</sup> Due to severe resource constraints, the state hospital had a specific policy on who qualified for dialysis treatment.<sup>434</sup> ‘Only patients who suffer from acute renal failure, which can be treated and remedied by renal dialysis’ would automatically qualify for such treatment.<sup>435</sup> As his condition was chronic and irreversible, Soobramoney did not automatically qualify for the renal dialysis programme which resulted in him approaching the court for an interdict to prevent the hospital from refusing him from receiving dialysis.<sup>436</sup> His application was dismissed,<sup>437</sup> and he subsequently applied for leave to appeal, which was granted on an urgent basis.<sup>438</sup>

In his application for leave to appeal, instead of relying on the general right to healthcare under Section 27(1) of the Constitution, Soobramoney based his argument on Section 27(3) coupled with Section 11 of the Constitution - the right to life.<sup>439</sup> As we know from *Paschim Banga* discussed in chapter 2, the Supreme Court in India held that the right to not be refused emergency medical treatment was to be read into the right to life under Article 21 of the Indian Constitution.<sup>440</sup> The court in that case held that the right to life includes the duty to preserve life, which often requires emergency medical treatment.<sup>441</sup> The applicant in *Soobramoney* relied on the *Paschim Banga* case to substantiate his argument that the right to life under Section 11 of the Constitution applied in this instance.<sup>442</sup> Although Section 39(1)(c) of the Constitution does provide

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<sup>427</sup> *Soobramoney* (n 58 above).

<sup>428</sup> *Soobramoney* (n 58 above) par 1.

<sup>429</sup> As above.

<sup>430</sup> As above

<sup>431</sup> *Soobramoney* (n 58 above) par 5.

<sup>432</sup> *Soobramoney* (n 58 above) par 1.

<sup>433</sup> As above.

<sup>434</sup> *Soobramoney* (n 58 above) par 3.

<sup>435</sup> As above.

<sup>436</sup> As above.

<sup>437</sup> As above

<sup>438</sup> *Soobramoney* (n 58 above) par 6.

<sup>439</sup> *Soobramoney* (n 58 above) par 7.

<sup>440</sup> See chap 2 p 23-24 above.

<sup>441</sup> As above.

<sup>442</sup> *Soobramoney* (n 58 above) par 18.

that when the Bill of Rights is interpreted, foreign law may be considered, Chaskalson P felt it necessary to highlight that the facts in *Paschim Banga* were 'materially different' to those in *Soobramoney*.<sup>443</sup> The man in *Paschim Banga* had fallen off a train and had suffered severe injuries to his head which needed to be treated immediately, in contrast to Mr Soobramoney who had a chronic condition where his kidneys had failed. The court in *Soobramoney* considered the patient in *Paschim Banga* and indicated that

this is precisely the sort of case which would fall within section 27(3). It is one in which emergency treatment was clearly necessary. The occurrence was sudden, the patient had no opportunity of making arrangements in advance for the treatment that was required, and there was urgency in securing the treatment in order to stabilise his condition. The treatment was available but denied.<sup>444</sup>

In saying this, the South African Constitutional Court uses the patient in *Paschim Banga* as an example of an instance where the application of Section 27(3) would be justified. The court emphasises the urgent need for treatment that was required to stabilise the patient and the fact that the incident that caused the injury was a sudden occurrence and this was not a situation where it could be foreseen that medical treatment would be required.

Additionally, the Constitutional Court points out that 'the right to medical treatment does not have to be inferred from the nature of the state established by the Constitution, or the right to life which it guarantees. It is dealt with directly in section 27'.<sup>445</sup> One should circle back to the discussion in chapter 2 on comparative constitutional law and how there is no express right to emergency medical treatment under Indian constitutional law, and how it has rather been held by the court in *Paschim Banga* that emergency medical treatment is impliedly included in the right to life. In that instance, the court had to interpret the right to life to include emergency medical treatment. The Constitutional Court in *Soobramoney* is correct in saying that there is no need to infer the right to medical treatment from the right to life here, as this right is already provided for under Section 27.<sup>446</sup> The argument made in *Paschim Banga* should not have been applied here in *Soobramoney* as the material facts of the two cases were too different, with one patient having a chronic condition and the other having a sudden head injury which required immediate attention, along with that fact that the two legal systems and constitutions are vastly different in the express rights contained therein.

What makes *Soobramoney* a landmark decision is the Constitutional Court's analysis of Section 27(3) and what is meant by the right to not be refused emergency medical treatment. Chaskalson P held that

the purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate medical attention, such as the injured person in *Paschim Banga Khet Mazdoor Samity v State of West Bengal*, should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the

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<sup>443</sup> As above.

<sup>444</sup> As above.

<sup>445</sup> *Soobramoney* (n 58 above) par 19.

<sup>446</sup> As above.

necessary treatment. What the section requires is that remedial treatment that is necessary and available be given immediately to avert harm.<sup>447</sup>

Looking at this interpretation, one can only agree with the court that Soobramoney did not suffer a ‘sudden catastrophe’. Although tragic and requiring medical attention, his condition was chronic and irreversible. As the court emphasised, his condition was an ‘ongoing state of affairs’ as his body was deteriorating and Section 27(3) was therefore not applicable.<sup>448</sup> As the various Constitutional Court judges attempted to interpret the meaning behind ‘emergency medical treatment’ in Section 27(3), there are certain recurring elements and keywords that stand out in this judgement. In the quote above, reference is made to a ‘sudden catastrophe’ that has occurred.

This element of ‘suddenness’ is also highlighted by Madala J who agrees with Chaskalson P in stating that ‘Section 27(3) envisages a dramatic, sudden situation or even which is of a passing nature in terms of time. There is some suddenness and at times even an element of unexpectedness in the concept “emergency medical treatment”’.<sup>449</sup> This emphasis on ‘suddenness’ and ‘unexpectedness’ concurs with what Chaskalson P had pointed out about the patient in *Paschim Banga* and how he could not have had an opportunity to arrange for treatment before his accident –<sup>450</sup> because how could he have known he would need it? Evidently, two of the key elements of emergency medical treatment are that it is required suddenly and unexpectedly, in that it cannot be foreseen before the time that it will be needed. Hence prior arrangements for such treatment cannot be made. These unexpected and sudden elements are again reiterated by Sachs J who also states that those who should rely on Section 27(3) are people ‘who fall victim to sudden and unexpected collapse. It provides reassurance to all members of society that accident and emergency departments will be available to deal with the unforeseeable catastrophes which could befall any person, anywhere and at any time’.<sup>451</sup> The emergency medical treatment provided by accident and emergency departments paints this picture of urgency and incidents that have happened by accident – which is quite different to Soobramoney's chronic condition wherein over time his body had deteriorated and he now required dialysis. Although this treatment was necessary for him to prolong his life, if we look at how the court has emphasised the unexpectedness of medical emergencies, and how arrangements for treatment could not be made beforehand when faced with such an emergency, one can understand how the court came to its decision that Section 27(3) did not apply in the *Soobramoney* case.<sup>452</sup> Mr Soobramoney knew that he required ongoing dialysis to prolong his life and it was a known fact that this treatment was needed for the foreseeable future.

In an attempt to define what is meant by emergency medical treatment under Section 27(3), the key elements highlighted by the court that need to apply are as follows. Firstly, there must have been a sudden incident.<sup>453</sup> Secondly, such incident must have been unexpected – meaning that the need for emergency medical treatment would have been unforeseen and it would not have been possible to have made prior

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<sup>447</sup> *Soobramoney* (n 58 above) par 20.

<sup>448</sup> *Soobramoney* (n 58 above) par 21.

<sup>449</sup> *Soobramoney* (n 58 above) par 38.

<sup>450</sup> *Soobramoney* (n 58 above) par 18.

<sup>451</sup> *Soobramoney* (n 58 above) par 51.

<sup>452</sup> *Soobramoney* (n 58 above) par 21.

<sup>453</sup> *Soobramoney* (n 58 above) par 5, 18, 20 and 38.

arrangements for treatment seeing that the incident had been unforeseen.<sup>454</sup> Thirdly, urgent or immediate treatment would be needed.<sup>455</sup> Lastly, this treatment would be needed to avert harm or stabilise the patient.<sup>456</sup> Taking these four elements into account, although Soobramoney needed dialysis to avert further damage, his case does not meet the first few elements – particularly in that a sudden event had not occurred and his need for treatment was not unforeseen. The court was correct in stating that Section 27(3) did not apply and that this was not an instance of emergency medical treatment.

The court did not deny the fact that Soobramoney required treatment, but rather emphasised that he relied on the incorrect provision and Section 27(3) was not applicable. He could have instead relied on the more general provisions of Section 27(1) and Section 27(2) of the Constitution where it is provided that everyone should have access to state healthcare facilities to the extent that there are sufficient available resources.<sup>457</sup> While the hospital could not provide Soobramoney with the treatment he required due to resource constraints, Sachs J has an interesting interpretation of the right to life in the context with which it was relied on in this case.<sup>458</sup> He states that the right to life does not extend mean ‘the right indefinitely to evade death’.<sup>459</sup> As Soobramoney’s condition was irreversible, it is dubious whether his need for constant or regular use of dialysis machines could be regarded as an emergency. Although it would be necessary to prolong his life, if his use of this equipment is enforced through Section 27(3) specifically, this would entail that he would always be in a state of emergency. Instead, use of the dialysis machines would be to purely prolong his life, not to immediately stabilise him to avert harm. His condition was not going to get any better, the treatment would be solely to prolong his life and slow down the deterioration process. This is not emergency medical treatment, but rather necessary medical treatment in the general sense.

Not all authors agree with the court’s interpretation of what constitutes emergency medical treatment. Kramer is critical of the court, particularly of Madala J’s judgement, which concurred with the majority.<sup>460</sup> He takes issue with the court’s emphasis on suddenness and unexpectedness. He argues that this redefinition of a medical emergency would be problematic if one were to swap Soobramoney’s failing kidneys with a condition that obstructs a patient’s airways.<sup>461</sup> The example of an asthmatic person is used in that somebody who has an existing asthmatic condition could experience breathing complications possibly having a connection to the pre-existence of asthma. Such a person may have consulted a doctor and had medicine prescribed to them, which they could use to treat their condition at home. If the breathing complications do not get better but the person (as many people tend to do in South Africa) does not approach an emergency division in a medical facility for a few days due to financial barriers or transport issues or any other personal problems – their breathing constriction may rapidly get worse to the extent that they need to approach a medical facility as soon as possible. ‘This asthma attack may be an allergic-type

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<sup>454</sup> *Soobramoney* (n 58 above) par 18, 38 and 51.

<sup>455</sup> *Soobramoney* (n 58 above) par 18 and 20.

<sup>456</sup> As above.

<sup>457</sup> *Soobramoney* (n 58 above) par 22.

<sup>458</sup> *Soobramoney* (n 58 above) par 57.

<sup>459</sup> As above.

<sup>460</sup> As above.

<sup>461</sup> Kramer (n 42 above) 53.

incident that may be seasonally anticipated, but which may henceforth constitutionally *NOT* be defined as a medical emergency, because of the lack of a dramatic, sudden event that was unexpected'.<sup>462</sup> The point is raised then that countless 'life-threatening medical emergencies' come about as complications from chronic and pre-existing conditions.<sup>463</sup> According to Kramer's argument, the Constitutional Court's precedent would consequently result in these events not being regarded as medical emergencies in terms of Section 27(3) due to a lack of suddenness and unexpectedness.<sup>464</sup>

While Kramer makes a valid point to some extent, he misses the point that the pre-existing condition and the medical emergency itself (such as an asthma attack) should be separated. An asthma attack (or any similar sudden change in a person's medical condition) would still be an unexpected (or at least sudden) event that requires urgent medical treatment to avert harm or to stabilise the patient. Although an asthmatic person may know that they are prone to asthma attacks, they may not know exactly when they will have an attack or what the severity thereof will be, and this does not negate the urgency of such an attack which may occur suddenly and may require immediate medical treatment to stabilise the patient. If somebody who is deprived of oxygen does not receive it immediately, they could die in a very short amount of time – in comparison to somebody whose condition gradually deteriorates and such deterioration could be slowed down by certain medical treatments (such as dialysis). The former would require emergency medical treatment while the latter would require general (non-emergent) medical treatment. While both forms of treatment may very well be necessary, they should be distinguished.

Where Kramer is correct, is that the decision in *Soobramoney* has had a lasting effect. Since *Soobramoney*, the courts have been reluctant to redefine medical emergencies, as evidenced in *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape 2016 (1) SA 325 (CC) (Oppelt)* where the court recognised that there is no definition of medical emergencies in the Constitution, but went further to say that it would not attempt to define the phrase as it would not be helpful in the matter.<sup>465</sup> Almost two decades after *Soobramoney*, the Gauteng Local Division of the High Court was faced with a similar set of facts in the *Ereselo* matter.<sup>466</sup> The applicant in the matter sought an order against the Minister of Health and the Director-General of the Department of Health whilst attempting to challenge the constitutionality of the provisions of the policy that prevents asylum seekers or refugees in South Africa from being eligible for certain medical procedures, such as kidney and renal transplants and dialysis.<sup>467</sup> In dismissing her application, the court relied heavily on the judgment handed down in *Soobramoney*.<sup>468</sup> The applicant in this matter also had 'irreversible end stage kidney failure' and required chronic dialysis until she could receive an organ transplant, but she did not qualify for the transplant as she is not a South African citizen.<sup>469</sup> The question of whether or not the applicant received emergency treatment is addressed in the testimony of Dr Davies, who states that Ereselo was placed on temporary haemodialysis to ensure that she was in a stable

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<sup>462</sup> As above.

<sup>463</sup> As above.

<sup>464</sup> As above.

<sup>465</sup> *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape 2016 (1) SA 325 (CC)* (hereafter *Oppelt*) par 58.

<sup>466</sup> *Ereselo* (n 60 above).

<sup>467</sup> As above.

<sup>468</sup> *Ereselo* (n 60 above) par 27.

<sup>469</sup> *Ereselo* (n 60 above) par 9.

enough condition so that could be taken to the next appropriate facility.<sup>470</sup> In doing so, the applicant and her family were ‘given a letter to take to the Ethiopian Embassy with the view to assist her with repatriation to Ethiopia’.<sup>471</sup> This ultimately led to the court concluding that she was not refused emergency treatment and that appropriate steps were taken to ensure that she was in a stable enough condition to be transported back to her country of origin to receive permanent treatment there.<sup>472</sup> This case again confirms what was decided in *Soobramoney*, in that although she required medical treatment after she was stabilised, there was no sudden, unexpected event that followed which needed to be immediately treated to avert harm. While there are patients who have irreversible conditions and require chronic dialysis to prevent their deaths, such medical treatment is in our law not regarded as emergency medical treatment and should be distinguished therefrom.

Although the definition of emergency medical treatment is not clear from Section 27(3) of the Constitution itself, the Constitutional Court has provided some clarity with its analysis of the right. As we now know, the court has indicated that emergency medical treatment is required where there has been a sudden, unexpected incident that requires urgent or immediate medical treatment to avert harm or stabilise the patient. As there is no express provision for emergency medical treatment as a right in itself under international law, there is subsequently also no definition thereof under international law to compare the Constitutional Court’s definition to. We also know from chapter 2, that although certain other states also recognise emergency medical treatment as a right, none of these constitutional provisions provides a definition thereof, which means that the court’s definition cannot be compared to this either.<sup>473</sup>

We did, however, see a definition of ‘emergency health service’ under Section 2 of Nepal’s Public Service Health Act.<sup>474</sup> Although the wording may differ, the definition under this provision and the definition provided by the Constitutional Court both touch on the fact that there is an unexpected incident that requires immediate intervention to avert harm. The Constitutional Court’s definition is also similar to the provision under Section 40 of Finland’s Health Care Act discussed previously. Section 40 also speaks to a ‘sudden onset’ and ‘urgent treatment’ but if one looks at how the elements of emergency medical treatment are set out by the Constitutional Court, the definition of emergency medical treatment that follows covers more basis and is more precise and clear than both the Nepalese and Finnish provisions as both of these had elements missing, which the Constitutional Court had touched on. Although these provisions are similar to the Constitutional Court’s interpretation of emergency medical treatment, the Constitutional Court’s interpretation is preferable and provides more clarity as it covers more elements.

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<sup>470</sup> *Ereselo* (n 60 above) par 29.

<sup>471</sup> As above.

<sup>472</sup> *Ereselo* (n 60 above) par 34.

<sup>473</sup> See chap 2 p 21 above.

<sup>474</sup> ‘Emergency health service’ under this section means the ‘initial and immediate service to be provided as it is necessary to free the lives of the persons from risk, save the lives or organs from being lost, whose lives are in the risky condition upon falling into unexpected incident or emergency condition’.

#### IV. THE NATURE OF THE OBLIGATIONS CREATED BY THE RIGHT TO NOT BE REFUSED EMERGENCY MEDICAL TREATMENT

##### a) State obligations

Rights have duties attached to them.<sup>475</sup> As a rule of thumb in the South African legal system, nobody has a ‘legal duty to act unless the law imposes a duty to do so’.<sup>476</sup> A positive duty exists where one has an obligation to actively do something.<sup>477</sup> A negative duty, on the other hand, entails the opposite, i.e. the duty to refrain from doing something – such as refraining from refusing somebody access to emergency medical treatment.<sup>478</sup> As we have seen above, Section 27(3) of the Constitution states that no one may be refused emergency medical treatment. The wording used to describe this right is phrased negatively. This raises the question of whether this right entails only the obligation to refrain from refusing emergency medical treatment, or whether the obligation created therein is actually to actively provide emergency medical treatment.

States hold both positive and negative obligations when it comes to socio-economic rights.<sup>479</sup> Chapter 2 discussed how with health rights, particularly the right to not be refused emergency medical treatment, General Comment 14 lays out that states have three kinds of obligations.<sup>480</sup> The obligations are to respect, protect and fulfil these rights. In the South African context, this has been confirmed by the Constitutional Court in *Government of the Republic of South Africa & Others v Grootboom & Others* 2000 (11) BCLR 1169 (CC) (*Grootboom*). The Constitutional Court in *Grootboom* held that ‘socio-economic rights are expressly included in the Bill of Rights; they cannot be said to exist on paper only’.<sup>481</sup> In saying this, the court highlights that according to Section 7(2) of the Constitution ‘the state must respect, protect, promote and fulfil the rights in the Bill of Rights’.<sup>482</sup> This mirrors the international law standards set by Article 2(1) of the ICESCR and General Comment 14.<sup>483</sup>

In considering the state’s negative obligation, this discussion first looks at the obligation to respect. Under international law, it has been established that the obligation to respect ‘requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health’.<sup>484</sup> Considering the South African right to not be refused emergency medical treatment, this would mean that the state has the duty to respect the right by refraining from interfering with the enjoyment of this right. Under General Comment 14 this means that the state must refrain from denying equal access to emergency medical treatment and that the state may not have discriminatory

<sup>475</sup> C McConnachie *et al* ‘The Constitution and the right to basic education’ in C McConnachie *et al* *Basic Education Rights Handbook – Education Rights in South Africa* 15. Available at [section27.org.za/wp-content/uploads/2017/02/Chapter-1.pdf](http://section27.org.za/wp-content/uploads/2017/02/Chapter-1.pdf) (accessed 24 January 2019).

<sup>476</sup> D J McQuoid-Mason ‘When are doctors legally obliged to stop and render assistance to injured persons at road accidents?’ (2016) 106(6) *Medicine and the Law* 575.

<sup>477</sup> C McConnachie *et al* (n 475 above) 15.

<sup>478</sup> As above.

<sup>479</sup> M Dafele ‘The negative obligation of the housing right: an analysis of the duties to respect and protect’ (2013) 29 *SAHRJ* 594.

<sup>480</sup> See chap 2 p 26 above.

<sup>481</sup> *Government of the Republic of South Africa & Others v Grootboom & Others* 2000 (11) BCLR 1169 (CC) (*Grootboom*) par 20.

<sup>482</sup> As above.

<sup>483</sup> General Comment 14 considers the obligation to promote to be included under the obligation to fulfil. General Comment 14 (n 109 above) fn 23.

<sup>484</sup> General Comment 14 (n 109 above) par 33.

policies in their provision of emergency medical treatment which would prevent somebody from receiving this treatment.<sup>485</sup>

The South African Constitutional Court has described this duty to respect as a negative obligation requiring the state to ‘refrain from interfering with social and economic rights’, which is relevant to this discussion on the right to not be refused emergency medical treatment.<sup>486</sup> In other words, the state has a duty to not do something that might infringe somebody’s right to not be refused emergency medical treatment. The state must thus not do anything that would be tantamount to the refusal of emergency medical treatment to anyone who requires it.

The court in *Soobramoney* confirms that ‘Section 27(3) itself is couched in negative terms – it is a right to not be refused emergency medical treatment’.<sup>487</sup> According to the court, the state should not have bureaucratic or other discriminatory requirements in place which would prevent somebody from receiving emergency medical treatment if they so required. Further, state ambulances, emergency services or hospitals should not turn anyone away if they need emergency medical treatment.<sup>488</sup> Following the court’s interpretation in *Soobramoney*, this means that emergency medical treatment must be administered to the person who presents with a medical emergency. Referencing *Soobramoney*, the court in *Oppelt* states that the right to emergency medical treatment ‘provides reassurance to all members of society that emergency departments will be available to deal with unforeseeable catastrophes that could befall any person, anywhere and at any time’.<sup>489</sup> By providing that nobody may be refused emergency medical treatment, this provision is in place to assure that, should somebody present to a state hospital with a medical emergency, that such treatment would be provided to stabilise a patient and to avert harm. If one reflects on what it would mean to refrain from refusing emergency medical treatment, logically this would mean that such treatment should be provided if it is asked for or required. The state may not discriminate in their provision of emergency medical treatment, particularly since the beneficiaries of this right are ‘everyone’ in the country, meaning that even if somebody cannot afford to pay for state-provided emergency medical treatment, the state still has to provide such treatment. Refusal of such treatment by the state based on the patient’s inability to pay is arguably a discriminatory practice and under Section 27(3), the state may not refuse anybody emergency medical treatment – even if they are unable to pay for it.

The state does not provide healthcare and emergency medical treatment free of charge to all persons. Instead, to determine who will receive these services for free, the state uses a means test.<sup>490</sup> Depending on the degree to which a person can afford to pay for state healthcare, the state will subsidise the necessary medical treatment either fully or in part, depending on that person’s income and financial position.<sup>491</sup> The consequence of this is that for those who absolutely cannot afford it, the state is

<sup>485</sup> See chap 2 p 26 above.

<sup>486</sup> *Mazibuko & Others v City of Johannesburg* 2010 (4) SA 1 (CC) par 47.

<sup>487</sup> *Soobramoney* (n 58 above) par 20.

<sup>488</sup> As above.

<sup>489</sup> *Oppelt* (n 465 above) par 56.

<sup>490</sup> South African Human Rights Commission ‘Access to health care’ available at <https://www.sahrc.org.za/home/21/files/FINAL%20Access%20to%20Health%20Care%20Educational%20Booklet.pdf>, accessed on 9 October 2021.

<sup>491</sup> Western Cape Government ‘Subsidised patients’ available at [https://www.westerncape.gov.za/general-publication/western-cape-government-hospital-tariffs-overview?toc\\_page=3](https://www.westerncape.gov.za/general-publication/western-cape-government-hospital-tariffs-overview?toc_page=3), accessed on 9 October 2021.

obligated to provide emergency medical treatment for free. Those who can afford to pay will have to pay for these services and the amount that has to be paid will depend on which income bracket the patient falls under.<sup>492</sup> While the state may not refuse emergency medical treatment to anyone, some people will have to foot the bill after the provision of such treatment, while those who cannot afford such treatment will be categorised as 'subsidised patients' and will either receive this treatment for free or at a lower fee based on their income bracket. The question of who exactly is entitled to free healthcare and free emergency medical treatment provided by the state under the NHA is discussed in more detail later in chapter 5.

Consideration should be given to the fact that the state's negative obligation in terms of Section 27(3) does not only mean that the state must not do anything that might constitute refusal of emergency medical treatment. The Constitutional Court has explained that, when it comes to socio-economic rights, a breach of the negative obligation 'occurs directly when there is a failure to respect the right, or indirectly when there is a failure to prevent the direct infringement of the right by another or a failure to respect the existing protection of the right by taking measures that diminish that protection'.<sup>493</sup> In other words, while the obligation to respect requires the state itself to not do anything that might infringe the right under Section 27(3), the state also has the obligation to protect the right from being infringed by third parties, as well as the obligation not to do anything to diminish any existing protection mechanisms currently in place to protect the right. Emphasis should be placed on General Comment 14's assertion that the obligation to protect, particularly in terms of health rights, includes taking measures to prevent anyone from interfering with the guarantees under the international right to health.<sup>494</sup> Under South African law, Section 7(2) of the Constitution specifically requires the state to protect the rights in the Bill of Rights, which includes the right under Section 27(3). The state, therefore, must protect the right to not be refused emergency medical treatment against any interference of the enjoyment of this right by third parties.

As with many rights in the Constitution, some challenges may arise in the enjoyment of the right under Section 27(3). It is well-known that South Africa has infrastructure challenges and the healthcare sector has resource constraints. This is a significant factor that has to be taken into account, even if somebody presents to public healthcare facility with a medical emergency. Though, in terms of Section 27(3), the hospital must not refuse emergency medical treatment and has to provide such treatment, as Madala J points out, 'the guarantees of the Constitution are not absolute but may be limited in one way or another'.<sup>495</sup> In saying this, the court recognises that purely having words in the Constitution guaranteeing rights will not stop the issues that South Africa faces.<sup>496</sup> One of the biggest hurdles standing in the way of the enjoyment of these rights is resource constraints. Though state healthcare providers may have a duty to not refuse emergency medical treatment, one needs to take into account that in some instances somebody may require certain treatment but the healthcare provider may not have the necessary equipment, qualified staff or capacity to provide such treatment. We have seen this in cases such as *Soobramoney* where

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<sup>492</sup> As above.

<sup>493</sup> *Governing Body of the Juma Masjid Primary School v Essay NO 2011 (8) BCLR 761 (CC)* (*Juma Masjid*) par 58.

<sup>494</sup> General Comment 14 (n 109 above) par 33.

<sup>495</sup> *Soobramoney* (n 58 above) par 43.

<sup>496</sup> As above.

state hospitals simply do not have the resources to provide certain medical treatments to absolutely everybody.<sup>497</sup>

Chapter 2 showed that some constitutions of states around the world have a positive formulation of the right to emergency medical treatment.<sup>498</sup> It also showed that the majority of constitutions that have a provision relating to emergency medical treatment are phrased in the negative, usually with a provision that such treatment may not be refused or denied.<sup>499</sup> Although these provisions are phrased in the negative, it does not mean that a positive obligation is not created. While the wording of Section 27(3) of the Constitution is negative, there are still certain active steps that the state needs to take to ensure that this right can be enjoyed. In determining the nature of the state's obligations in terms of this right, reference should be made to the international law obligations discussed in chapter 2. We know from that discussion, that Article 2(1) of the ICESCR provides that a state must take steps 'to the maximum of its available resources, with a view to achieving progressively the full realization of the rights' contained in the covenant, which includes the right to the highest attainable standard of health, and ultimately emergency medical treatment.<sup>500</sup> This is significant when considering the state's obligation to fulfil the right under section 27(3). The importance of Article 2(1) and the notion of the progressive realisation of rights was highlighted in *Grootboom*.<sup>501</sup> While this case dealt primarily with state obligations in terms of the right to housing under Section 26 of the Constitution, the Constitutional Court did refer to Section 27 of the Constitution and stated that

Socio-economic rights must all be read together in the setting of the Constitution as a whole. The state is obliged to take positive action to meet the needs of those living in extreme conditions of poverty, homelessness or intolerable housing. Their interconnectedness needs to be taken into account in interpreting the socio-economic rights, and, in particular, in determining whether the state has met its obligations in terms of them.<sup>502</sup>

In following this approach to reading socio-economic rights in the Constitution together, it is important to read Section 27(3) within the context of Section 27(2). Section 27(2) of the Constitution mirrors the sentiments behind Article 2(1) of the ICESCR in providing that, in terms of the healthcare rights provided for under Section 27, 'the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights'.

To determine what would be regarded as 'reasonable measures' that the state would have to take to realise the right to not be refused emergency medical treatment, reference should be made to *Grootboom*. Although the court was interpreting the provisions of Section 26(2), which is to be read in the context of the right to housing, the wording of this section is identical to Section 27(2) and the interpretation is thus relevant for this discussion on the health rights under Section 27. The state needs to ensure 'that laws, policies, programmes and strategies' are satisfactory to fulfil the

<sup>497</sup> *Soobramoney* (n 58 above) par 2.

<sup>498</sup> See S 31 South Sudanese Constitution and S 65 Sudanese Constitution (previously discussed in chap 2 p 20) where it is expressly stated that the state undertakes to provide citizens with primary healthcare and free emergency services.

<sup>499</sup> We have seen this not only in the Constitution of South Africa but also in the constitutions of Fiji, Nepal, Kenya, Somalia, Egypt and also Zimbabwe.

<sup>500</sup> Chap 2 p 25 above.

<sup>501</sup> *Grootboom* (n 481 above) par 27.

<sup>502</sup> *Grootboom* (n 481 above) par 24.

obligations under Section 27.<sup>503</sup> The court held that the state must design a 'national framework' to fulfil its obligations.<sup>504</sup> It was further highlighted that 'the state is required to take reasonable legislative and other measures' and that the adoption of legislation on its own is not enough.<sup>505</sup> The state needs to implement policies and programmes to give effect to legislation, and it was held that this implementation must be reasonable.<sup>506</sup> The court explains that

in determining whether a set of measures is reasonable, it will be necessary to consider housing problems in their social, economic and historical context and to consider the capacity of institutions responsible for implementing the programme. The programme must be balanced and flexible and make appropriate provision for attention to housing crises and to short, medium and long term needs. A programme that excludes a significant segment of society cannot be said to be reasonable. Conditions do not remain static and therefore the programme will require continuous review.<sup>507</sup>

If we apply the court's reasoning to Section 27(2) and Section 27(3), this would mean that to determine if the state has taken reasonable measures to realise the right to not be refused emergency medical treatment, any problems in the provision of such treatment would have to be viewed in light of the social, economic and historical context and the capacity of emergency medical service facilities and providers should be taken into consideration. The country's problematic history in the healthcare sector and provision of emergency medical treatment was discussed in the previous chapter. Issues such as race, geographical positioning and social-economic standing have a long-standing significance in the provision of, and access to emergency medical treatment. While problems with access to emergency medical treatment in today's age will be discussed in the chapters to follow, these factors must be borne in mind when determining whether state measures are reasonable.

A society must seek to ensure that the basic necessities of life are provided to all if it is to be a society based on human dignity, freedom and equality. To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right.<sup>508</sup>

In saying this, the court emphasises that the measures that the state takes to realise the right should take the needs and circumstances of our society's most vulnerable groups into account. Sufficient measures should be taken to protect the people that require the protection of these rights the most. If measures taken do not tend to the needs of these people, they cannot be regarded as reasonable.<sup>509</sup>

Although Section 27(3) is phrased in the negative, Section 27(2) expressly provides that the state must actively take certain steps to progressively realise this right. The court in *Grootboom* highlights that 'the term "progressive realisation" shows that it was contemplated that the right could not be realised immediately' – but states have to take certain steps over time to attain this goal.<sup>510</sup> The South African healthcare

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<sup>503</sup> *Grootboom* (n 481 above) par 40.

<sup>504</sup> As above

<sup>505</sup> *Grootboom* (n 481 above) par 42.

<sup>506</sup> As above.

<sup>507</sup> *Grootboom* (n 481 above) par 43.

<sup>508</sup> *Grootboom* (n 481 above) par 44.

<sup>509</sup> As above.

<sup>510</sup> *Grootboom* (n 481 above) par 45.

system is crippled by resource constraints which can sometimes lead to certain healthcare demands not being met.<sup>511</sup> With these obstacles in mind, the notion of progressive realisation envisions that considering the available resources, the state takes certain steps to achieve the goal of realising these rights over time. In the context of emergency medical treatment, this would mean that the state should take measures to address any issues which would prevent the right to not be refused emergency medical treatment from being realised, within the bounds of the resources available to it, to ensure that over time that these obstacles are removed to ensure the realisation of the right. This again also ties in with the obligation to protect in that any obstacles preventing the realisation of the right to not be refused emergency medical treatment need to be addressed.

So, would a lack of capacity or resources be a defence if a state healthcare provider is unable to provide emergency medical treatment? Yacoob J in *Grootboom* expresses that ‘Section 26 does not expect more of the state than is achievable within its available resources’.<sup>512</sup> The same can arguably be said for Section 27(2) read with Section 27(3) in this case. The court in *Grootboom* again relies on the judgment in *Soobramoney* in emphasising that with a lack of resources, an absolute fulfilment of these obligations cannot always take place.<sup>513</sup> As the court says, ‘there is a balance between goals and means. The measures must be calculated to attain the goal expeditiously and effectively but the availability of resources is an important factor in determining what is reasonable’.<sup>514</sup> It is important to bear in mind the impossibility of state healthcare facilities to provide emergency medical treatment to people when they simply cannot do so because of resource constraints and capacity issues. According to the HPCSA, if a health care practitioner is

unable to provide a service, they should refer the patient to another health care practitioner or to a health care facility where the required service can be obtained, provided that in an emergency situation practitioners shall be obliged to provide care in order to stabilize the patient and then to arrange for an appropriate referral to another practitioner or facility.<sup>515</sup>

This means that state healthcare providers cannot rely on a lack of capacity alone if they are unable to provide emergency medical treatment. As the court in *Soobramoney* says, Section 27(3) envisages that where emergency medical treatment is required and it is available, it must be provided without delay to avert harm.<sup>516</sup> If it is not available, the health care provider must refer the patient to another provider where such treatment will be available.

In assessing the active steps that states are obliged by international instruments to take,<sup>517</sup> the court in *Grootboom* refers to the provision in General Comment 3 that the state has a ‘minimum core obligation’ to at least meet the essential elements of covenant rights.<sup>518</sup> The court held that ‘a state party must demonstrate that every effort

<sup>511</sup> *Soobramoney* (n 58 above) par 11.

<sup>512</sup> *Grootboom* (n 481 above) par 46.

<sup>513</sup> As above.

<sup>514</sup> As above.

<sup>515</sup> Health Professions Council of South Africa ‘Ethical guidelines for good practice in the health care professions’ at 9 available at [https://www.hpcsa.co.za/Uploads/Professional\\_Practice/Ethics\\_Booklet.pdf](https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf), accessed on 10 October 2021.

<sup>516</sup> *Soobramoney* (n 58 above) par 20.

<sup>517</sup> Such as Art.2(1) ICESCR.

<sup>518</sup> *Grootboom* (n 481 above) par 29.

has been made to use all of the resources at its disposal to satisfy the minimum core of the right. However, it is to be noted that the general comment does not specify precisely what that minimum core is'.<sup>519</sup> While the court has indicated that General Comment 3 does not explain what the minimum core of reach right is, General Comment 14 does set out the four essential elements to the general right to the highest attainable standard of health.<sup>520</sup> It was established in chapter 2 that these four elements also apply to emergency medical treatment.<sup>521</sup> These essential elements were found to be imperative for emergency medical systems, as a subset of healthcare systems to function properly. To make sure that nobody is refused emergency medical treatment, the state must ensure that these facilities are available, accessible, acceptable and meet the required quality standards. These essential elements were discussed in sufficient detail in chapter 2 above.

What is evident here, is that although Section 27(3) is phrased negatively, it places both negative and positive obligations on the state. While the state and state healthcare providers have a negative duty to refrain from refusing emergency medical treatment to anybody, the state still has to take active steps to ensure the fulfilment of this right by taking 'reasonable measures' to ensure the progressive realisation of this right within its available resources.<sup>522</sup>

*b) Emergency medical treatment and the obligations of non-state entities*

Section 8 of the Constitution deals with the application of the Bill of Rights and is relevant to the discussion of who is bound by these rights. While Section 8(1) binds the state, Section 8(2) states that 'a provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right'. The wording in Section 27(3) is open-ended in that it states that no one may be refused emergency medical treatment. It does not state that the state alone may not refuse emergency medical treatment to somebody. By virtue of Section 8(2), taking the nature of the right to not be refused emergency medical treatment into account, and the open-ended obligation it creates to refrain from refusing emergency medical treatment to somebody who needs it, private entities are arguably also bound by Section 27(3).

In analysing Section 8(2), Chirwa points out that although by virtue of this section, a private entity may be bound by a right, this does not mean that they would hold all the same responsibilities that the state would in terms of the same right.<sup>523</sup> To determine if a private entity has been bound by the right and has possibly violated the right, it is contended consideration should be given to whether the private entity was exercising a function that would typically belong to the state.<sup>524</sup> In the context of emergency medical treatment, the state bears both negative and positive obligations. This then raises the question: if a private entity, such as a private hospital or ambulance service delivers emergency medical treatment, would they be bound by the same

<sup>519</sup> *Grootboom* (n 481 above) par 30.

<sup>520</sup> General Comment 14 (n 109 above) par 11.

<sup>521</sup> See chap 2 p 14 above.

<sup>522</sup> S 27(2) Constitution.

<sup>523</sup> DM Chirwa 'Non-state actors' responsibility for socio-economic rights: the nature of their obligations under the South African Constitution' (2002) 3(3) *ESR Review* 6.

<sup>524</sup> As above.

obligations as the state, given that this function is also performed by state hospitals and state-run emergency medical services. If so, to what extent are they bound?

Dafel has described non-state actors as ‘limited duty bearers’ in the context of socio-economic rights.<sup>525</sup> It has been ascertained that under international law, businesses and private entities are ‘expected to respect covenant rights’, which includes health rights.<sup>526</sup> A non-state actor’s duty to respect socio-economic rights has been confirmed by the Constitutional Court when it stated that ‘the purpose of section 8(2) of the Constitution is not to obstruct private autonomy or to impose on a private party the duties of the state in protecting the Bill of Rights. It is rather to require private parties not to interfere with or diminish the enjoyment of a right’.<sup>527</sup> This affirms that non-state entities also have a negative obligation to respect the right to not be refused emergency medical treatment. They too have a duty to refrain from interfering with the enjoyment of this right and must desist from refusing anybody emergency medical treatment if it is needed.

While private actors are bound by the duty to respect, this concept that they are ‘limited duty bearers’ must be borne in mind as private entities do not bear all the same obligations of the state and not to the same extent. Section 27(2) of the Constitution, for example, specifically binds the state to take measures towards the progressive realisation of the rights, and this section does not apply to private actors. It is clear, however, that at the very least, non-state healthcare providers are bound by the duty to respect the right to not be refused emergency medical treatment and must refrain from standing in the way of this right being realised. The implication being that, should somebody approach a private healthcare provider for emergency medical treatment, they must provide such treatment and may not refuse it. As with state healthcare providers, if emergency medical treatment is available at a private healthcare facility and is needed, it must be provided to the patient without delay to prevent harm.<sup>528</sup> If they do not have the available facilities, the patient must be stabilised and then referred to a facility that can provide the necessary treatment.<sup>529</sup>

What if somebody who does not have medical aid cover, or who cannot afford to pay for private healthcare needs to receive emergency medical treatment from a private healthcare provider? Section 27(3) is clear that ‘nobody may be refused emergency medical treatment’. Private healthcare providers may not refuse anybody emergency medical treatment because they are unable to pay for it.

This does not mean that non-state actors must provide emergency medical treatment for free. While with state healthcare providers, if somebody cannot afford treatment, this is subsidised by the state either fully or in part, private healthcare providers operate differently. Just as international law does not dictate that private healthcare providers must provide their services free of charge, neither does the South African Constitution.<sup>530</sup> While General Comment 14 does urge that private healthcare services must be affordable to ensure accessibility to these services, in a country such

<sup>525</sup> Dafel (n 479 above) 591.

<sup>526</sup> See chap 2 p 31 above.

<sup>527</sup> *Juma Musjid* (n 493 above) par 58.

<sup>528</sup> *Soobramoney* (n 58 above) par 20.

<sup>529</sup> Health Professions Council of South Africa ‘Ethical guidelines for good practice in the health care professions’ at 9 available at [https://www.hpcs.co.za/Uploads/Professional\\_Practice/Ethics\\_Booklet.pdf](https://www.hpcs.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf), accessed on 10 October 2021.

<sup>530</sup> See chap 2 p 35 above.

as South Africa, there are so many people who still cannot afford to pay for healthcare.<sup>531</sup> If somebody without medical aid cover or the financial ability to pay for private healthcare needs emergency medical treatment, private hospitals may not refuse to treat the patient.<sup>532</sup> If the situation requires pre-hospital care and ambulance services, the private ambulance must transport the patient to the closest appropriate hospital.<sup>533</sup> As we saw in the discussion above on Kenya and the USA,<sup>534</sup> the private hospital needs to first stabilise the person experiencing a medical emergency before they can request any payment for the treatment and the patient may be transferred to a state facility once stabilised if they do not have medical aid cover.<sup>535</sup> While the state has to provide free emergency medical treatment to those who cannot afford it, private entities are not bound in the same way.

Where somebody cannot afford to pay for emergency medical treatment from a private healthcare provider, there are competing interests at hand. Firstly, the patient's right to not be refused emergency medical treatment, against the private healthcare provider's pecuniary interests. As non-state healthcare facilities may not refuse anybody emergency medical treatment, what happens if a facility charges the patient, who is then unable to, or simply does not pay for their treatment and the private provider sues the patient for the outstanding fees? To answer this, the landmark decision of *Jaftha v Schoeman; Van Rooyen v Stoltz* 2005 (2) SA 140 (CC) (*Jaftha*) must be mentioned.

This case raised the question of whether the sale in execution of somebody's home is allowed if they have not paid their debt.<sup>536</sup> This case concerned two women with similar circumstances. Mrs Jaftha was not in good health and she was poor and unemployed and had borrowed an amount of R250 from somebody.<sup>537</sup> She was repaying the debt in instalments but the matter was referred to the magistrate's court as she had not paid the debt in full.<sup>538</sup> She tried to make further payments to the attorneys representing the creditor, but after returning home after being hospitalised, she found out that her house had been attached to be sold in execution to pay off this amount.<sup>539</sup> She made further payments to the attorneys, which exceeded the original debt, but she ended up being dispossessed of her home as the attorneys requested her to pay R7000 to prevent the sale in execution, an amount she was not able to afford.<sup>540</sup> Similarly, Mrs Van Rooyen, an uneducated and poor woman with three children, bought vegetables on credit to the value of R190.<sup>541</sup> She was also unable to pay her debt and the same attorneys approached the magistrate's court and her home was also sold in execution for R1000.<sup>542</sup> Both women had state housing and were disqualified

<sup>531</sup> As above.

<sup>532</sup> South African Human Rights Commission 'Access to health care' available at <https://www.sahrc.org.za/home/21/files/FINAL%20Access%20to%20Health%20Care%20Educational%20Booklet.pdf>, accessed on 9 October 2021.

<sup>533</sup> As above.

<sup>534</sup> See chap 2 p 34-35 above.

<sup>535</sup> South African Human Rights Commission 'Access to health care' available at <https://www.sahrc.org.za/home/21/files/FINAL%20Access%20to%20Health%20Care%20Educational%20Booklet.pdf>, accessed on 9 October 2021.

<sup>536</sup> *Jaftha v Schoeman, Van Rooyen v Stoltz* 2005 (2) SA 140 (CC) (*Jaftha*) par 1.

<sup>537</sup> *Jaftha* (n 536 above) pars 3-4.

<sup>538</sup> *Jaftha* (n 536 above) par 4.

<sup>539</sup> as above.

<sup>540</sup> As above.

<sup>541</sup> *Jaftha* (n 536 above) par 5.

<sup>542</sup> As above.

from obtaining other state housing.<sup>543</sup> The court felt the need to emphasise that, as in this case, there was an increase of state-provided houses being sold in execution in the area for amounts far below what they were worth.<sup>544</sup>

The court highlighted that ‘any claim based on socio-economic rights must necessarily engage the right to dignity. The lack of adequate food, housing and health care is the unfortunate lot of too many people in this country and is a blight to their dignity’.<sup>545</sup> While this case is more centred around the right to housing and the Constitutionality of Sections 66 and 67 of the Magistrates Court Act concerning sales in execution, what is relevant for this discussion is the courts approach towards socio-economic rights and the dignity of those whose rights are affected. The court emphasised that ‘the underlying problem raised by the facts of this case is not greed, wickedness or carelessness, but poverty’.<sup>546</sup> In saying this, the court confirms that this is a welfare problem where the inability to pay can have severe consequences which throw people back into poverty, which is not easy to overcome.<sup>547</sup>

In this case, the applicants had argued that their rights to housing under Section 26 had been violated and that there is a negative obligation, which applies to both the state and private persons, to desist from preventing or impairing ‘existing access’ to adequate housing.<sup>548</sup> The court agreed with this by saying that ‘at the very least, any measure which permits a person to be deprived of existing access to adequate housing, limits the rights protected in Section 26(1). Such a measure may, however, be justified under Section 36 of the Constitution’.<sup>549</sup> Under Section 36(1),

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

- (a) The nature of the right;
- (b) The importance of the purpose of the limitation;
- (c) The nature and extent of the limitation;
- (d) The relation between the limitation and its purpose; and
- (e) Less restrictive means to achieve the purpose.

The court relied on this section in emphasising that ‘the nature of the right and the nature and extent of the limitation are of great importance when weighted against the importance of the purpose of the limitation’.<sup>550</sup> While this case deals with housing as a socio-economic right, it is still significant to socio-economic rights in general, and for the purposes of this discussion, the right to not be refused emergency medical treatment, particularly insofar as private healthcare providers who run as businesses are concerned. In considering private providers running as businesses, reference should be made to the court in *Jaftha* which held that a creditor’s interests should not just be disregarded.<sup>551</sup> In some instances, even if there is a menial amount of money owed by a debtor, sometimes the advantage to the creditor would be bigger than the

<sup>543</sup> *Jaftha* (n 536 above) par 12.

<sup>544</sup> As above.

<sup>545</sup> *Jaftha* (n 536 above) par 21.

<sup>546</sup> *Jaftha* (n 536 above) par 30.

<sup>547</sup> as above.

<sup>548</sup> *Jaftha* (n 536 above) par 31.

<sup>549</sup> *Jaftha* (n 536 above) par 34.

<sup>550</sup> *Jaftha* (n 536 above) par 36.

<sup>551</sup> *Jaftha* (n 536 above) par 42.

harm caused to the debtor, should the debt be executed.<sup>552</sup> In these cases, the court holds that execution may be justifiable.<sup>553</sup> Important for this discussion of private healthcare providers and indigent patients, is the court's assertion that this is a balancing process.<sup>554</sup> In some circumstances, execution will not be justifiable because of the severe hardship it would cause to an indigent debtor.<sup>555</sup> The court does recognise that in certain circumstances, a debtor may ask to pay off the debt in instalments.<sup>556</sup> The applicants in *Jaftha* tried to argue that homes under a certain value bracket should be protected from ever being sold in execution,<sup>557</sup> but the court held that we cannot have a blanket prohibition as the interests of creditors also need to be taken into account.<sup>558</sup>

What makes this particularly relevant to this discourse on the payment of private healthcare fees by indigent patients when emergency medical treatment has been provided, is that the circumstances of each case need to be taken into account.<sup>559</sup> For example, in some instances, the amount owed might be 'trifling' to the creditor, such as a big multi-million-Rand hospital group, in which case it might not be justifiable for an indigent person to lose their house over if they could not afford to pay for emergency medical treatment.<sup>560</sup> The court does not say that creditors must just write off the debts, but rather that there should be a balance of interests and that first there must be an attempt to come up with some or other payment plan to pay off the debt.<sup>561</sup> If somebody incurred a debt with a private healthcare provider because they could not afford to pay for their services, the court would take several factors into account, including the circumstances under which the debt arose, what efforts the debtor has made to pay off the debt, the economic standing of both the debtor and the private healthcare provider, whether the debtor has any income to pay off the debt and 'any other relevant' factors before the court.<sup>562</sup>

What this case shows that there is not a 'one-size-fits-all' answer to these circumstances. In some cases, it may well be that somebody makes use of a private hospital and does not pay their bill and the hospital sues them, leading to the sale and execution of their property. In other instances, this would be unjustifiable as the interests of the indigent debtor in their enjoyment of basic socio-economic rights would outweigh the interests of a rich creditor. While private healthcare providers are not obligated to provide emergency medical treatment to somebody free of charge, the way in which they are compensated for the services rendered to somebody who is not financially able to pay upfront, or who does not have medical aid cover, will depend on the circumstances of each case. In some instances, this may not be in the best interests of the hospital as a business. Nevertheless, no private healthcare provider may refuse to provide anybody emergency medical treatment if they cannot pay for it. If they do, they will be liable for violating that person's right under Section 27(3).

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<sup>552</sup> As above.

<sup>553</sup> As above.

<sup>554</sup> As above.

<sup>555</sup> *Jaftha* (n 536 above) par 43.

<sup>556</sup> *Jaftha* (n 536 above) par 49.

<sup>557</sup> *Jaftha* (n 536 above) par 50.

<sup>558</sup> *Jaftha* (n 536 above) par 51.

<sup>559</sup> *Jaftha* (n 536 above) par 57.

<sup>560</sup> As above.

<sup>561</sup> *Jaftha* (n 536 above) par 59.

<sup>562</sup> *Jaftha* (n 536 above) par 60.

As the private healthcare provider is essentially performing a state function, they hold certain obligations as the state does, such as the obligation to respect this right. With this, though the primary responsibility lies with the state to realise the health rights under Section 27,<sup>563</sup> in certain circumstances, private entities will be expected to have a 'degree of patience' with indigent patients which may not always be in the providers best patrimonial interest.<sup>564</sup> The consequence of this is that in some cases this results in financial losses.<sup>565</sup> This will depend on the circumstances of each case and where it is just and equitable.

The state has a duty to ensure that private emergency services are regulated so that they do not violate the right under Section 27(3).<sup>566</sup> This falls in with the state's obligation to protect, in that it has to prevent private providers, as third parties, from infringing the right to not be refused emergency medical treatment. The state also has to take measures to progressively realise this right within its available resources.<sup>567</sup> The legislation that the state has put in place to regulate both public and private healthcare providers concerning the right to not be refused emergency medical treatment will be discussed in the chapter to follow. While private healthcare providers do bear certain obligations in terms of Section 27(3), these obligations are limited compared to that of the state and it is the state that is ultimately responsible for the realisation of this right.

## V. REFUSAL OF EMERGENCY MEDICAL TREATMENT

In the ordinary sense of the words, refusal can be understood as to deny something, or 'to not allow someone to have or do' something.<sup>568</sup> Refusal of emergency medical treatment is not always as clear cut as one might think. It does not always mean that an emergency medical service has simply said no to somebody who has requested emergency medical treatment. In the *Oppelt* decision, the term 'constructive' refusal was used in the majority judgment to showcase that the applicant in the matter did not receive the proper emergency treatment that he required to prevent permanent disability.<sup>569</sup> The applicant in the matter did receive treatment, however, it was held that the respondent did not act reasonably in the administration of this treatment, resulting in a breach of duty in terms of Section 27(3).<sup>570</sup>

In *Oppelt*, the majority and minority judgments had conflicting views on whether or not the applicant in the matter was refused emergency medical treatment. In this matter, the applicant appealed the decision by the Supreme Court of Appeal, which had overturned the decision by the Western Cape High Court which had found in favour of the applicant in his case against the Head of the Western Cape Provincial Department of Health.<sup>571</sup>

<sup>563</sup> *Soobramoney* (n 58 above) par 19.

<sup>564</sup> *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd* 2012 (2) SA 104 (CC) par 100.

<sup>565</sup> *Dafel* (n 479 above) 612.

<sup>566</sup> General Comment 24 (n 61 above) par 22.

<sup>567</sup> Section 27(2) Constitution.

<sup>568</sup> Merriam-Webster 'Refuse' available at <https://www.merriam-webster.com/dictionary/refuse>, accessed on 7 April 2021.

<sup>569</sup> *Oppelt* (n 465 above) par 105.

<sup>570</sup> *Oppelt* (n 465 above) par 68.

<sup>571</sup> *Oppelt* (n 465 above) par 1.

Mr Oppelt, the applicant, was involved in a rugby injury when he was 17 years old that rendered him paralysed from the neck down due to the serious spinal cord injuries that he had sustained.<sup>572</sup> The incident causing the injury took place at around 14:15 pm, after which Oppelt was treated at three different public hospitals.<sup>573</sup> At the first hospital, Wesfleur Hospital, the treating doctor suggested that the applicant be transported by helicopter to Groote Schuur hospital but this never happened. He was transported by ambulance and arrived at the next facility at 17:40 pm.<sup>574</sup> At Groote Schuur, an urgent call was made by an orthopaedic surgery registrar to have the applicant transferred by ambulance to Conradie Hospital to be treated at the facility's specialised spinal cord injury unit.<sup>575</sup> The ambulance that transferred the patient was only dispatched well after midnight and the applicant arrived at the next facility at 01:25 am.<sup>576</sup> A 'closed reduction procedure' was then performed on Oppelt at 03:50 am, over 12 hours after his injury had occurred.<sup>577</sup> Unfortunately, even though the required procedure was performed, the applicant was permanently rendered quadriplegic.<sup>578</sup>

The applicant in the matter argued that his right to not be refused emergency medical treatment in terms of Section 27(3) had been violated by the respondent and its employees.<sup>579</sup> He further argued that the respondent did not act reasonably due to the delay in taking the applicant to Conradie, the most appropriate facility for his injury.<sup>580</sup> One of the key points of expert evidence in the matter was that in cases of injuries such as those sustained by the applicant, the 'cut-off' time within which the applicant should have received treatment to avoid paralysis was four hours after the occurrence of the injury.<sup>581</sup> In determining whether this applicant had a valid delictual claim, the court held that causation, wrongfulness, fault and harm had to be proven.<sup>582</sup> The 'but-for' test was raised in the question of causation, particularly whether Oppelt's permanent paralysis could have been avoided had he received the closed reduction procedure sooner, without the unnecessary delays in treatment.<sup>583</sup> The majority court agreed with the applicant's contention that it was the omission of the respondent in not promptly treating him that caused his quadriplegia.<sup>584</sup> He was denied the possibility of recovery in that the procedure was not performed within the four-hour window period, evidencing causation.<sup>585</sup> The majority further determined the wrongfulness on the part of the respondent in considering the respondent's legal duty to not cause harm.<sup>586</sup> According to the court, legally hospitals are required to provide 'urgent and appropriate emergency medical treatment' to persons finding themselves in situations such as that of Oppelt.<sup>587</sup> It later transpired that at the time a helicopter was called for

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<sup>572</sup> *Oppelt* (n 465 above) par 3.

<sup>573</sup> *Oppelt* (n 465 above) par 4.

<sup>574</sup> As above.

<sup>575</sup> *Oppelt* (n 465 above) par 5.

<sup>576</sup> As above.

<sup>577</sup> As above.

<sup>578</sup> *Oppelt* (n 465 above) par 3.

<sup>579</sup> *Oppelt* (n 465 above) par 10.

<sup>580</sup> As above.

<sup>581</sup> *Oppelt* (n 465 above) par 6.

<sup>582</sup> *Oppelt* (n 465 above) par 34.

<sup>583</sup> *Oppelt* (n 465 above) par 35.

<sup>584</sup> *Oppelt* (n 465 above) par 49.

<sup>585</sup> As above.

<sup>586</sup> *Oppelt* (n 465 above) par 51.

<sup>587</sup> *Oppelt* (n 465 above) par 54.

at the first facility, there was in fact a helicopter available and it had only been dispatched to a different scene an hour after it had been called for and never arrived in Oppelt's case.<sup>588</sup>

The court held that there was no acceptable reason as to why the applicant did not receive the necessary treatment within the required time frame and he should have been referred to the specialised spinal cord unit at Conradie in the first instance instead of being transported to Groote Schuur.<sup>589</sup> Regardless, the applicant should have been transported with more urgency between facilities and in any event, Groote Schuur had the facilities for the procedure to be performed there too.<sup>590</sup> The only reason given by the respondent for the delays in treatment were hospital policies, to which the court replied that 'reliance on rigid protocols cannot be allowed to trump Section 27(3) of the Constitution'.<sup>591</sup> In saying this, the court held that 'The respondent constructively refused to provide the necessary emergency medical treatment and breached its legal duty to provide the applicant with medical treatment promptly or within the required four hours and thus acted unlawfully'.<sup>592</sup>

Although the applicant had received the procedure typically performed on patients with these injuries, the court found that he had constructively been refused emergency medical treatment as the procedure was not performed timeously or with the required urgency. In doing so, the respondent did not take reasonable steps to avoid the irreparable damage to the applicant's spinal cord.<sup>593</sup> The minority judgement, however, disagreed with this finding and did not find that the respondent's employees were negligent in their treatment of the applicant and did not find that he had been refused emergency medical treatment.<sup>594</sup> In coming to this conclusion, the minority reported that the doctors on duty believed that the applicant would have received appropriate treatment at Groote Schuur but that they were 'tragically' wrong.<sup>595</sup> The minority considered the evidence presented and did not find that the respondent was 'negligently wrong' and sustained that the applicant was in fact treated as an emergency throughout the whole debacle, although the end results were not favourable.<sup>596</sup>

What this case illustrates, if we follow the reasoning of the majority judgment, is that refusal of emergency treatment for the purposes of Section 27(3) can also be construed to include improper treatment and undue delays in emergency treatment, even in cases where the required medical procedures are eventually performed. Undue delays in treatment in medical emergencies can therefore result in the violation of the right in Section 27(3).

## VI. CONCLUSION

This chapter provided an in-depth analysis of what is meant by the right to not be refused emergency medical treatment under Section 27(3) of the Constitution. It

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<sup>588</sup> *Oppelt* (n 465 above) par 64.

<sup>589</sup> *Oppelt* (n 465 above) par 66.

<sup>590</sup> *Oppelt* (n 465 above) par 67.

<sup>591</sup> *Oppelt* (n 465 above) par 68.

<sup>592</sup> As above.

<sup>593</sup> *Oppelt* (n 465 above) par 83.

<sup>594</sup> *Oppelt* (n 465 above) par 105.

<sup>595</sup> *Oppelt* (n 465 above) par 142.

<sup>596</sup> *Oppelt* (n 465 above) par 146.

established that this right is recognised more specifically in South Africa than under international law. This right applies to ‘everyone’ in the country, regardless of race, age, gender, social status or citizenship.

The Constitutional Court has provided some clarity on what emergency medical treatment means. Drawing from what the court in *Soobramoney* has said, emergency medical treatment is required where there has been a sudden, unexpected incident that has caused immediate or urgent treatment to be needed to stabilise a patient or to avert harm.

This chapter looked at the nature of state obligations arising from the right to not be refused emergency treatment. The state has both negative and positive obligations in terms of this right. Under the negative obligation, the state has the duty to respect the right by refraining from interfering with the enjoyment thereof. The state must not do anything that constitutes refusal of emergency medical treatment. It was argued that although the wording in this provision is negative, and there is a duty to refrain from refusing emergency treatment, there are still certain positive obligations placed on the state, as the state must take certain steps to ensure that this right is realised. The state has the duty to fulfil the right by taking reasonable measures within its available resources to progressively realise the right. Where a state hospital does not have the capacity to provide emergency medical treatment, it must refer the patient to a facility that has the means to provide such treatment.

It was shown that private entities are also bound by Section 27(3) and hold obligations in terms of this right to a more limited extent. Private entities also have the duty to respect the right and must refrain from refusing anybody emergency medical treatment if it is available. If somebody with a medical emergency needs to be assisted by a private healthcare provider, the private provider must provide the emergency medical treatment necessary to stabilise the patient. Private providers may not refuse anybody emergency medical treatment based on their inability to pay. If they are unable to provide the necessary treatment because of a lack of resources and facilities, they must refer the patient to the next appropriate facility that can provide such treatment.

In terms of the refusal element of the constitutional provision, it was shown that in instances where treatment is not administered within the right amount of time to mitigate adverse effects, this constitutes ‘constructive refusal’ of such treatment.

While this chapter looked at the right under Section 27(3) specifically, the chapter to follow considers the legislative framework giving effect to this right as a whole.

## CHAPTER 5

# THE STATUTORY FRAMEWORK GOVERNING EMERGENCY MEDICAL TREATMENT IN SOUTH AFRICA

### I. INTRODUCTION

The previous chapter provided an in-depth look at the right to not be refused emergency medical treatment under Section 27(3) of the Constitution. This chapter looks at the various legislation giving effect to this right. The main research question this chapter aims to answer is whether the current legislative framework governing emergency medical treatment in South Africa is adequate. The key pieces of legislation that will be assessed in this chapter are the NHA, the EMS Regulations and the Medical Schemes Act (MSA).

In assessing these statutes, the first key concern is to establish the extent to which these statutes give effect to the right to not be refused emergency medical treatment. Consideration will be given to what extent these statutes protect the right for ‘everyone’, as envisioned in the Constitution. The chapter also looks at what obligations these statutes place on the state and what measures the state has to put into place to ensure that this right is realised. In analysing these statutes, any gaps or shortcomings will be highlighted. Consideration will be given to the provisions of the NHI Bill to determine whether it addresses and overcomes the shortcomings of the aforementioned health legislation insofar as emergency medical treatment is concerned.

### II. NATIONAL HEALTH ACT

As noted in previous chapters, Article 2(1) of the ICESCR obligates states to take steps towards realising covenant rights. This provision emphasizes legislative measures.<sup>597</sup> The importance of adopting legislation to give effect to covenant rights, particularly to health rights, is highlighted in General Comment 3.<sup>598</sup> Health rights are constitutionally entrenched in South Africa under Section 27 of the Constitution. As discussed in the previous chapter, the state is constitutionally mandated to take legislative measures to progressively realise these rights, which includes the right to not be refused emergency medical treatment.<sup>599</sup>

In meeting the state obligations imposed under international law, as well as by Section 27(2) of the Constitution, the NHA was enacted as a national framework for the South African health system.<sup>600</sup> This legislation is pivotal to the implementation of the right to not be refused emergency medical treatment. The Preamble of the NHA bears in mind that ‘Section 27(3) of the Constitution provides that no one may be refused emergency medical treatment’.<sup>601</sup> Section 5 of the NHA provides for emergency medical treatment. In a single sentence, it states that ‘a health care provider,

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<sup>597</sup> Art. 2(1) ICESCR.

<sup>598</sup> General Comment 3 (n 200 above) 3.

<sup>599</sup> See chap 4 p 59 above.

<sup>600</sup> Preamble NHA.

<sup>601</sup> As above.

health worker or health establishment may not refuse a person emergency medical treatment'.<sup>602</sup> Although this provision gives a bit more detail as to who may not refuse a person emergency medical treatment compared to the provision in the Constitution, it is still quite vague and does not provide any more detail about what emergency medical treatment entails.

The previous chapter established that the beneficiaries of the right to not be refused emergency medical treatment were all people in the country, regardless of their race, gender or citizenship.<sup>603</sup> In determining how the provision in the NHA implements the right to the benefit of everyone in the country, the wording of Section 5 should be noted. Section 27(3) of the Constitution provides that 'no one' may be refused emergency medical treatment. Section 5 states that 'a person' may not be refused such treatment. Although the wording may slightly differ, we know from the discussion in chapter 4 that 'no one' is a universal term that essentially means 'everyone',<sup>604</sup> in the same sense that 'a person' can be regarded to mean 'all natural persons within the territory of the Republic'.<sup>605</sup>

While this provision is more specific as to who the duty bearers are, i.e. health care providers, health workers and health establishments, Section 5 does not state that only public health providers, workers and establishments are bound by this provision and it is thus accepted that it applies to both the public and private healthcare sectors. In laying out the objects of the NHA, Section 2(a)(i) speaks about 'establishing a national health system which encompasses public and private providers of health services'. While the NHA itself does not define emergency medical treatment, it does provide clarity in defining a health establishment as

the whole or part of a public or private institution, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent or other health services.<sup>606</sup>

Through this definition, in providing that a health establishment may not refuse a person emergency medical treatment, it is evident that it is health establishments both in the private and public sectors that may not refuse such treatment and thus protects users of both private and public health care facilities.

In terms of the obligations that the NHA places on the state to realise the right, it is worth noting that Section 3 of the NHA details the state's responsibility for health. Section 3(2) provides that

the national department, every provincial department and every municipality must establish such health services as are required in terms of this Act, and all health establishments and health care providers in the public sector must equitably provide health services within the limits of available resources.<sup>607</sup>

The 'health services' provided for under this section are defined in Section 1 of the NHA as 'health care services, including reproductive health care and emergency medical treatment, contemplated in Section 27 of the Constitution'. By reading this definition in Section 1, read with Section 3(2), it is evident that the state, on a national,

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<sup>602</sup> S 5 NHA.

<sup>603</sup> See chap 4 p 48 above.

<sup>604</sup> As above.

<sup>605</sup> I Currie & J De Waal (n 152 above) 36.

<sup>606</sup> S 1 NHA.

<sup>607</sup> S 3(2) NHA.

provincial and municipal level, is responsible for establishing health services which must include emergency medical treatment and that such treatment must be provided equitably, within the state's available resources. This emphasises the fact, that in implementing the right to not be refused emergency medical treatment, such implementation should be for the benefit of everyone.

Chapter 4 established that the state does not provide free healthcare and emergency medical treatment to everyone.<sup>608</sup> Section 4 of the NHA deals with the eligibility for free health care provided by the public health sector. Section 4(1) states that ‘the Minister, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed’. Notably, the Minister is yet to determine the conditions subject to which certain categories of people are eligible for free health services.<sup>609</sup> Under Section 4(3), there are certain groups of people who are eligible for free health care services, which at present are not restricted by any conditions set out in Section 4(1). Under Section 4(3) of the NHA, clinics and healthcare centres funded by the state must provide

- (a) Pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services;
- (b) All persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free primary health care services; ...

Looking at subsection (a) above, this can be understood to mean that the state must provide free emergency medical treatment to pregnant or lactating women and children under six years old, provided that none are beneficiaries of a medical aid scheme. This is given that the definition of ‘health services’ under Section 1 of the NHA expressly includes emergency medical treatment. Considering the provisions of section 4(b), the Act does not provide much clarity for what is considered ‘primary health care services’. This section provides that everyone, except medical aid beneficiaries or people who are receiving compensation for compensable occupational diseases, must receive free primary healthcare from the state. Section 1 defines these services to mean ‘such health services as may be prescribed by the Minister to be primary health care services’. If one looks at the National Treasury’s 2020 estimates of national expenditure for the Department of Health, emergency medical services have been classed under primary healthcare.<sup>610</sup> If we accept emergency medical treatment to be a subset of emergency medical services, it arguably also falls under primary health care services. This is however not evident from the NHA itself. The scope of the free healthcare services under Section 4 has been criticised as not being clear, which arguably affects what can and cannot be regarded as ‘actual tangible free health care services’ that the general public has access to.<sup>611</sup>

Section 4(3) of the NHA is clear in that it is binding on the state only. Nowhere does it state that private entities must provide emergency medical treatment free of charge to those who cannot afford it. Therefore, if somebody presents to a private facility or establishment with a medical emergency, that private entity is within their rights to issue a fee for the service provided. Likewise, under Section 4(3), if somebody

<sup>608</sup> See chap 4 p 56 above.

<sup>609</sup> S Stevenson *et al* (eds) *The National Health Act Guide* 3 ed (2019) 55.

<sup>610</sup> National Treasury Republic of South Africa (n 17 above) 14.

<sup>611</sup> M Buchner-Eveleigh ‘Children’s rights of access to health care services and to basic health care services: a critical analysis of case law, legislation and policy’ 2016 *De Jure* 317.

who is a medical aid scheme member presents to a public healthcare provider or facility for emergency services, the state is not obligated to provide emergency medical treatment free of charge.

Section 41 of the NHA pertains to the provision of health services by public health providers and states that the Minister may prescribe a schedule of fees for different categories of users and different treatments provided in different public healthcare facilities.<sup>612</sup> Chapter 4 explained that state-provided healthcare and emergency treatment is not free for everyone, but rather that the amount which must be paid by each person would be determined by a means test.<sup>613</sup> In line with Section 41, the Department of Health has a Uniform Patient Fee Schedule,<sup>614</sup> which sets the tariffs for public healthcare providers.<sup>615</sup> Not all patients will pay the full amount according to these tariffs, as some people falling under lower income brackets will either be subsidised by the state to a certain extent depending on which income category they fall into, or they will receive full subsidisation, meaning that these services are provided free of charge.<sup>616</sup> This subsidisation only applies to public healthcare providers and private healthcare providers are not bound to do so.

Section 25(2)(m) of the NHA provides that the head of the provincial department of health must 'provide and co-ordinate emergency medical services'. The provision and coordination of emergency medical treatment in the public sector is the responsibility of the provincial department of health in each respective province.<sup>617</sup> The failures of the Eastern Cape Department of Health concerning the provision of emergency medical treatment will be discussed in chapter six.

The NHA itself is very limited with its provisions relating to emergency medical treatment. The scope of emergency medical treatment is not defined and there is no clarity as to what could be classified as such. Section 90(1)(m) of the NHA does however provide that

(1) The Minister, after consultation with the National Health Council, may make regulations regarding

...

(m) emergency medical services and emergency medical treatment, both within and outside of health establishments;

With this provision, the state, through the Minister of Health, is given the opportunity to expand on the provision of emergency medical treatment and the regulation thereof. The NHA came into effect in 2004, but the EMS Regulations were only recently promulgated, in December of 2017. It is unfortunate that it took so many years to promulgate them.

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<sup>612</sup> S 41(1)(c) NHA.

<sup>613</sup> See chap 4 p 56 above.

<sup>614</sup> Republic of South Africa Department of Health 'Uniform Patient Fee Schedule' available at <https://www.health.gov.za/uniform-patient-fee-schedule/>, accessed on 16 October 2021.

<sup>615</sup> Western Cape Government 'Western Cape Government hospital tariffs: an overview' available at [https://www.westerncape.gov.za/general-publication/western-cape-government-hospital-tariffs-overview?toc\\_page=1](https://www.westerncape.gov.za/general-publication/western-cape-government-hospital-tariffs-overview?toc_page=1), accessed on 16 October 2021.

<sup>616</sup> As above.

<sup>617</sup> McIntyre & Ataguba (n 24 above) 33.

### III. EMERGENCY MEDICAL SERVICE REGULATIONS

The promulgation of the EMS Regulations is significant in the realisation of the right to not refuse emergency medical treatment. They set out the relevant standards, rules and procedures that need to be followed in the operation of emergency medical services.

While the Constitution and NHA do not define emergency medical treatment and other terms, Regulation 1 of the EMS Regulations defines various terms relating to emergency medical treatment such as ‘ambulance’, ‘advanced life support’, or ‘response time’.<sup>618</sup> While the EMS Regulations also fail to define ‘emergency medical treatment’, it does define ‘emergency care’ to mean ‘the evaluation, treatment and care of an ill or injured person in a situation in which such emergency evaluation, treatment and care is required, and the continuation of treatment and care during the transportation of such person to or between health establishments’.<sup>619</sup> The word ‘treatment’ is used in this definition, which means that emergency medical treatment is included in the definition and the broader scope of emergency care.

This definition looks quite different from how the Constitutional Court defined emergency medical treatment in *Soobramoney*.<sup>620</sup> There is no mention of the elements of suddenness, unexpectedness or providing urgent or immediate treatment to somebody specifically to avert harm.<sup>621</sup> This definition in the EMS Regulations does not define ‘medical emergencies’. All it does is state rather vaguely that this emergency care would be provided if upon evaluation it was so required.

Regulation 1 also defines ‘emergency medical service’ to mean ‘an organisation or body that is dedicated, staffed and equipped to operate an ambulance, medical rescue vehicle or medical response vehicle in order to offer emergency care’.<sup>622</sup> This definition provides some clarity on who could be classified as an emergency medical services provider. It is important to note that Regulation 2 of the EMS Regulation expressly states that these regulations apply to both public and private emergency services operating in South Africa. Both private and public emergency medical services, therefore, have to adhere to these regulations and have certain duties placed on them.

The EMS Regulations deal mainly with the technical aspects of running an emergency medical service, such as the licenses required to run an emergency medical service,<sup>623</sup> the fees to be paid to start up an emergency medical service,<sup>624</sup> inspections,<sup>625</sup> and offences and penalties applicable where the regulations are not adhered to.<sup>626</sup> Of relevance to this discussion is Regulation 26. Ensuring the proper management of these services is crucial to the implementation of the right to not be refused emergency medical treatment. Regulation 26(1) provides that

an Emergency Medical Service must appoint, in a full time capacity, an Emergency Medical Services Manager who is qualified and registered with the Health Professions

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<sup>618</sup> Reg 1 EMS Regulations.

<sup>619</sup> As above.

<sup>620</sup> *Soobramoney* (n 58 above).

<sup>621</sup> *Soobramoney* (n 58 above) par 20.

<sup>622</sup> Reg 1 EMS Regulations.

<sup>623</sup> Reg 7 EMS Regulations.

<sup>624</sup> Reg 19 EMS Regulations.

<sup>625</sup> Regs 22 & 23 EMS Regulations.

<sup>626</sup> Reg 30 EMS Regulations.

Council of South Africa, as, at least, an Ambulance Emergency Assistant, to manage the Emergency Medical Service.<sup>627</sup>

What this provision essentially means is that somebody qualified and registered, at least at the level of an Ambulance Emergency Assistant – which is a paramedic at a certain skill set and qualification level – is to be appointed as the manager of an emergency medical service. This manager has certain duties as set out in Regulation 26(3). Of these duties worth noting, is one that lines up with the quality element of the essential elements to the right to health mentioned in General Comment 14, as discussed in chapter 2.<sup>628</sup> Regulation 26(3)(b) places a duty on an emergency medical services manager to ‘ensure that the Emergency Medical Service is operated in a way that provides quality care and does not compromise the safety of the public, patient or personnel’. This regulation is important in that, to ensure the proper implementation of the right to not be refused emergency medical treatment, the operation of emergency medical services needs to be done in a way that promotes the adequate and efficient provision of emergency medical treatment for all people. The quality of this treatment and care is important and this regulation highlights that the safety of the patient, as well as the general public and the emergency services personnel, is paramount.

Another noteworthy duty of an emergency medical services manager set out in Regulation 26, is that they must ‘ensure that a patient is not refused emergency medical treatment by the Emergency Medical Service because of the patient’s inability to pay, or on any other ground’.<sup>629</sup> This provision is significant as it places a responsibility on the emergency services manager to make sure that in the operation of the emergency medical service, that emergency medical treatment is not refused to patients who cannot afford to pay for it. Such protection is essential in a country such as South Africa where many people live in poverty and cannot afford even basic healthcare services.

While the EMS Regulations place this duty on the emergency medical services manager, these regulations fail to ever place a duty on the emergency medical services themselves to not refuse a patient emergency medical treatment. It would have been preferable to see a similar provision in these regulations prohibiting the emergency medical services themselves and placing a duty on them from refusing a patient emergency medical treatment because of a patient’s inability to pay, or on any other grounds. The inclusion of such a provision would solidify the fact that inability to pay is no ground of justification to refuse a patient such treatment. At least Section 5 of the NHA, which these Regulations flow from, does provide that health care providers, health workers and health establishments may not refuse any person emergency medical treatment, and emergency medical services should fall under health care providers and health workers. As Section 5 of the NHA does not specifically address emergency medical services as duty bearers, it would have been preferred if the EMS Regulations had its own express regulation relating to Section 5 to affirm that emergency medical services may not refuse somebody emergency medical treatment, especially not if they are unable to pay therefor, or on any other ground.

Regulation 28 confers certain powers on emergency care personnel so that they may effectively provide emergency medical treatment to those who require it. According to this regulation,

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<sup>627</sup> Reg 26(1) EMS Regulations.

<sup>628</sup> See chap 2 p 15 above.

<sup>629</sup> Reg 26(3)(e) EMS Regulations.

Emergency care personnel may, whenever they regard it necessary or expedient in order to perform their functions of saving life or preventing bodily harm, perform any act reasonably necessary, in order to enable them to perform their functions, and may also subject to the applicable law –

- (a) Close any road or street;
- (b) Enter or break into any premises;
- (c) Damage or destroy any property;
- (d) Cause to be removed from the scene any person who is dangerous, or is in danger or who obstructs the Emergency Care Personnel in the performance of their duties; and
- (e) Cause to be removed from the scene any Emergency Care Personnel that refuses appropriate levels of care to a patient that requires higher qualification intervention.<sup>630</sup>

This regulation expressly confers certain powers onto those who would provide the emergency medical treatment to take certain actions to ensure that emergency medical treatment can be given or to remove obstacles preventing the adequate provision of such treatment.

Perhaps of most value to the actual provision of emergency medical treatment, and thus the implementation of the right, are Annexures A and B to the Regulations. Annexure A sets out the requirements that have to be met by emergency medical services such as the service levels,<sup>631</sup> medical waste management and storerooms.<sup>632</sup> It also sets out the number of personnel that have to be operational on an ambulance or medical response vehicle<sup>633</sup> and how many staff members at different qualification levels have to be operational per emergency medical service.<sup>634</sup> Annexure A also sets out certain requirements that vehicles in the emergency services have to be compliant with,<sup>635</sup> including that emergency telephone numbers must be visible on emergency medical vehicles.<sup>636</sup>

Annexure B of the EMS Regulations sets out in very specific detail the equipment that each different level of response vehicle and ambulances have to be equipped with, including specific quantities, so that emergency medical treatment can be properly administered to those who require it. These standards apply to both public and private emergency medical services. These very detailed staff and equipment requirements are essential to the proper implementation of the right to not be refused emergency medical treatment.

Whether these regulations are adhered to in reality is a different discussion, which is briefly touched on in the chapter to follow.

#### IV. MEDICAL SCHEMES ACT

While Section 27(3) of the Constitution, the NHA and the EMS Regulations were enacted for the benefit and protection of ‘everyone’, the MSA was not. According to the Act itself, the MSA was enacted ‘to protect the interests of members of medical

<sup>630</sup> Reg 28 EMS Regulations.

<sup>631</sup> S 1 Annexure A EMS Regulations.

<sup>632</sup> S 2 Annexure A EMS Regulations.

<sup>633</sup> S 3 Annexure A EMS Regulations.

<sup>634</sup> S 4 Annexure A EMS Regulations.

<sup>635</sup> S 5 Annexure A EMS Regulations.

<sup>636</sup> S 6 Annexure A EMS Regulations.

schemes<sup>637</sup> – which cover about 16.4 per cent of the population.<sup>638</sup> People pay to be part of a medical aid scheme so that, should the occasion arise, the scheme will pay for their medical expenses – and so that they may be able to make use of the private healthcare facilities, including private emergency medical services.

The MSA does not make much provision for emergency medical treatment, and only assists with the implementation of the right to not be refused emergency medical treatment for a very small proportion of the population. What it does do is regulate medical aid schemes.

Section 1 of the MSA defines a ‘relevant health service’ to mean ‘any health care treatment of any person by a person registered in terms of any law... and includes ambulance services’. While the MSA itself doesn’t speak to emergency medical treatment, the MSA Regulations do define an ‘emergency medical condition’ as

The sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s life in jeopardy.<sup>639</sup>

This definition is arguably the most extensive definition relating to emergency medical care or treatment in South African law, although it is labelled as an emergency medical condition, instead of an express definition of emergency medical treatment. This definition also speaks to the elements of suddenness and unexpectedness and the need for immediate treatment to avert harm, which mirrors the definition given by the Constitutional Court in *Soobramoney*.<sup>640</sup> It is unfortunate that this definition is contained in the Regulations of the MSA, which is only intended to protect the beneficiaries of medical aid schemes. Ideally, the same definition must apply to all people in the country.

The MSA and its regulations also deal with the prescribed minimum benefits which members of medical aid schemes may enjoy.<sup>641</sup> According to Regulation 7, a prescribed minimum benefit consists ‘of the provision of the diagnosis, treatment and care costs of ... any emergency medical condition’. This means, at the very least, those who can afford to be members of a medical aid scheme will have the costs of emergency medical treatment covered by their medical aid scheme. This Act and its regulations assist in making emergency medical treatment more accessible for members of these medical aid schemes.

Further protection is afforded to members of these schemes through Regulation 8(6), which provides that

A medical scheme may not prohibit, or enter into an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition.

This provision prevents a medical aid scheme from stopping emergency medical treatment from being administered to a member before the medical scheme authorises

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<sup>637</sup> Preamble MSA.

<sup>638</sup> Statistics South Africa (n 6 above) 26.

<sup>639</sup> Reg 7 Medical Schemes Act Regulations in GN 1262 of 20 October 1999 (MSA Regulations).

<sup>640</sup> *Soobramoney* (n 58 above) par 18 and 20.

<sup>641</sup> Section 29(1)(o) MSA and Reg 8 MSA Regulations.

the administration of such treatment. This means that the treatment may proceed without the need of prior approval from a scheme. It is up to the emergency medical services to decide what treatment should be administered to the patient based on the medical emergency at hand.

Taken together, the MSA and its regulations offer better protection of the right to not be refused emergency medical treatment for members of medical schemes than for those who cannot afford a medical scheme.

## V. NHI BILL

For many years, the South African government has mentioned the introduction of a National Health Insurance (NHI) policy and the NHI Bill has been a hot topic for debate in recent years.<sup>642</sup> As the NHI Bill was introduced into Parliament in 2019 and is a real possibility, the question is whether it adequately addresses the gaps in the current legal framework relating to the right to not be refused emergency medical treatment.

The preamble of the NHI Bill acknowledges the various international law standards discussed in the previous chapters, such as the right of everyone to enjoy the highest standard of health under Article 12 of the ICESCR. It also refers to Section 27 of the Constitution, which recognises the right to access health care services, right to not be refused emergency medical treatment, and the duty of the state to take steps within the available sources towards the progressive realisation of the right.

Like the NHA, EMS Regulations or even in the MSA, the NHI Bill does not explicitly define 'emergency medical treatment' as a term in its own right. Section 1 of the NHI Bill does, however, define 'emergency medical services' to mean 'services provided by any private or public entity dedicated, staffed and equipped to offer pre-hospital acute medical treatment and transport of the ill or injured'. This provision does not define emergency medical treatment or what a medical emergency entails. This definition also differs from the definition of emergency medical service in the EMS Regulations, in that the latter is more specific in that it applies to both private and public entities. Furthermore, the EMS Regulations speaks about ambulances, emergency response vehicles and medical rescue vehicles, all of which are relevant to emergency services and treatment.<sup>643</sup>

Section 1 of the NHI Bill defines 'health care services' almost exactly as the NHA does, and this expressly includes emergency medical treatment, although emergency medical treatment is never further defined. One would have expected to see at the very least the definition of emergency medical treatment, or at least a medical emergency, similar to the definition of an 'emergency medical condition' in the MSA.<sup>644</sup> The legislature could have followed the wording in the MSA, or at the very least the definition provided in *Soobramoney*, to finally provide South Africa with a legislative definition of emergency medical treatment. As argued above, the definition of an emergency medical condition in the MSA Regulations remains the most extensive definition in this regard, but the MSA does not apply to those not covered by a medical aid scheme.

<sup>642</sup> McIntyre & Ataguba (n 24 above) 26.

<sup>643</sup> Reg 1 EMS Regulations

<sup>644</sup> Reg 7 MSA Regulations

One of the stated objectives of the proposed Act is to 'achieve sustainable and affordable universal access to health care services'.<sup>645</sup> Section 4 of the Bill provides that health care services must be purchased on behalf of all citizens, permanent residents and refugees.<sup>646</sup> The Bill also states that asylum seekers will be protected if they need emergency medical treatment, thus widening the scope of the beneficiaries of the insurance.<sup>647</sup>

Section 6 of the Bill details the rights of the users of the NHI 'within the state's available and appropriate resources', which includes 'receiving necessary quality health care services free at the point of care from an accredited health care provider or health establishment' provided that the person is registered with the fund.<sup>648</sup> The section further provides that health care services may not be refused on unreasonable grounds.<sup>649</sup> Emergency medical treatment is included under the premise of health care services under Section 1 of the Bill. Emergency medical treatment may thus not be refused on unreasonable grounds under the Bill. Section 6 does not expressly highlight the inability to pay to be a ground upon which emergency medical treatment may not be refused, as we have seen in the EMS Regulations.<sup>650</sup>

Perhaps one of the most contentious provisions of the Bill is Section 33 which provides that once the NHI is fully in place, medical aid schemes 'may only offer complementary cover to services not reimbursable by the fund'.<sup>651</sup> This would change the whole dynamic currently in place where only a small portion of the population has access to medical aid cover. Where emergency medical services are provided by either public or private services, these service providers would 'be reimbursed on a capped case-based fee basis with adjustments made for case severity, where necessary'.<sup>652</sup> Where public ambulance services are reimbursed, this would be done 'through the provincial equitable allocation'.<sup>653</sup> These provisions propose to change the way that emergency medical treatment is accessed and the way that it is paid for. This is concerning, however, if one looks at the lack of resources in the emergency services in public hospitals and clinics especially in the poorer provinces as will be illustrated in the chapter to follow.

Section 39 provides that accredited health care providers or medical facilities have to 'deliver the appropriate level of care to users who are in need and entitled to health care service benefits that have been purchased by the fund on their behalf'.<sup>654</sup> The NHI Fund has to enter into a legally binding contract with these medical facilities as they provide emergency medical services, which must contain clear performance expectations relating to the quality of and access to these services.<sup>655</sup> The Bill further provides that the performance of the healthcare provider would be monitored and evaluated, with possible sanctions should these expectations not be met.<sup>656</sup> In theory,

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<sup>645</sup> S 2 NHI Bill.  
<sup>646</sup> S 4(1) NHI Bill.  
<sup>647</sup> S 4(2) NHI Bill.  
<sup>648</sup> S 6(1) NHI Bill.  
<sup>649</sup> S 6(d) NHI Bill.  
<sup>650</sup> Reg 26 EMS Regulations.  
<sup>651</sup> S 33 NHI Bill.  
<sup>652</sup> S 35(4)(a) NHI Bill.  
<sup>653</sup> S 35(4)(b) NHI Bill.  
<sup>654</sup> S 39(1) NHI Bill.  
<sup>655</sup> S 39(4) NHI Bill.  
<sup>656</sup> S 39(6) NHI Bill.

this provision is promising as it aims to ensure that quality emergency medical assistance is provided to those in need.

In terms of payment to the health care providers, emergency medical services will be paid for by the fund on a capped case-based fee, which can be adjusted based on the severity of each case. Section 57 of the Bill suggests that the NHI be implemented gradually, with a phased approach.<sup>657</sup>

At the time of writing, the Bill had not yet been enacted and the current remaining legislative framework regulating the provision of emergency medical services should still be relied on. There remain many gaps in the law relating to the regulation of emergency medical treatment, and the concept is still ill-defined. While the intentions behind the NHI Bill may be to further access to healthcare in general for the population, it is questionable whether the Bill has adequately addressed all the current gaps in the law relating to emergency medical treatment.

## VI. CONCLUSION

This chapter analysed the statutory framework that is currently in place which gives effect to the constitutional right to not be refused emergency medical treatment. To determine if the current legislative framework in place is adequate insofar as the implementation of the right is concerned, consideration was given to what extent this legislation implements the right, and to what extent the legislation covers the rights of 'everyone' in the country. It was established that the NHA and the EMS Regulations cover the rights of 'everyone' as beneficiaries of the right to not be refused emergency medical treatment, regardless of whether they are users of the private or public health sectors. The MSA, on the other hand, was enacted purely for the benefit and protection of persons who are members of medical aid, which forms a small portion of the population. The MSA thus only covers the rights of medical aid members insofar as the right to not be refused emergency medical treatment is concerned.

Through the NHA, the state has met their international obligation under Article 2(1) of the ICESCR to take legislative steps towards realising the covenant right to the highest attainable standard of health.<sup>658</sup> It was ascertained in chapter 2 that the right to emergency medical treatment is implied under the broader right to the highest attainable standard of health.<sup>659</sup>

Pursuant to Section 27(2) of the Constitution, South Africa has taken legislative measures to realise the rights under Section 27, which includes the right to not be refused emergency medical treatment, including the NHA and the EMS Regulations. Although it has taken many years to come into effect, the EMS Regulations are a step in the right direction towards the proper implementation of the right to not be refused emergency medical treatment, as they contain very detailed standards which emergency medical services have to meet in terms of operational requirements, proper management, service levels and the minimum numbers of qualified staff and appropriate equipment. The provisions of the EMS Regulations have to be followed by both private and public emergency medical services, thus creating a universal standard for all emergency medical services in the country.

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<sup>657</sup> S 57 NHI Bill.

<sup>658</sup> Art 12 ICESCR.

<sup>659</sup> See chap 2 p 13 above.

Although these measures are meant to implement the right to not be refused emergency medical treatment, none defines 'emergency medical treatment'. Arguably, the best definition so far is of 'emergency medical condition' found in the MSA Regulations. This is not ideal as these Regulations only apply to a small minority of the population – those with a medical aid plan. A similar, more extensive definition of emergency medical treatment which applies to all people within the Republic is still needed.

Unfortunately, the proposed NHI Bill does not provide such a definition. In fact, the definition of 'emergency medical services' in that Bill is even less extensive. It is notable that the NHI proposes to change the way that healthcare is funded in the country, and this would affect emergency medical treatment too. Whether the NHI will make emergency medical treatment more accessible to all, especially the poor, remains to be seen.

Overall, there are some weaknesses in the existing legislation, such as the vague or lack of definitions, or the fact that the emergency medical services providers are never directly required not to refuse any person emergency medical treatment based on their inability to pay.

Evidently, South Africa does have an existing statutory framework aimed at realising the right to not be refused emergency medical treatment. The question that remains is, how is this framework and the right itself implemented in practice? The next chapter turns to this question.

## CHAPTER 6

### HURDLES FACED BY THE POOR TO ACCESS EMERGENCY MEDICAL TREATMENT IN SOUTH AFRICA

#### I. INTRODUCTION

The chapters before established that there is a constitutional right to not be refused emergency medical treatment, as well as a legislative framework giving effect to this right in South Africa. This chapter aims to determine whether the current legislative framework is effectively implemented in practice. If it is not, the discussion will identify which challenges stand in the way of such effective implementation. With this in mind, the chapter addresses whether the existing legislative provisions are only ideals in light of the many challenges faced by many in the country in accessing emergency medical treatment.

Access to healthcare is generally harder to attain for individuals from developing countries.<sup>660</sup> Poor people in any country have to face many more barriers in accessing health care services than those who are better off.<sup>661</sup> South Africa is a country that is no stranger to poverty. Peters *et al* have referred to a ‘larger cycle’ where poverty perpetuates poor health, and poor health sustains poverty in turn.<sup>662</sup> One of the focal points of this chapter is assessing the barriers that prevent access to emergency medical treatment for the poor in South Africa and in doing so, highlighting the extent to which one’s economic standing can serve as a barrier to accessing emergency medical treatment. In assessing the barriers faced by the poor in accessing and receiving emergency medical treatment, consideration should be given to factors such as geographical positioning, lack of resources, inadequate service delivery and affordability of these services. To illustrate these barriers preventing access for the poor, the study will draw on the report of the SAHRC on access to emergency medical services in the Eastern Cape.<sup>663</sup> While this chapter questions the extent to which the current legislative framework governing emergency medical treatment impacts the provision of this treatment in practice, it should be noted that the EMS Regulations only came into effect after this SAHRC report was published.

The main research questions this chapter attempts to answer are: to what extent does the current legislative framework impact the realisation of the right to not be refused emergency medical treatment in South Africa? Is this effectively implemented in practice? What hurdles do people in South Africa face in receiving emergency medical treatment? How do these barriers affect the effective implementation of the right to not be refused emergency medical treatment and the legislative framework surrounding this right? More specifically, in light of these challenges, to what extent is this right realised for the poor in South Africa?

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<sup>660</sup> D.H. Peters *et al* ‘Poverty and access to health care in developing (2008) 1136 *Annals of the New York Academy of Sciences* 161.

<sup>661</sup> As above.

<sup>662</sup> As above.

<sup>663</sup> SAHRC (n 27 above).

## II. HEALTH CARE RIGHTS IN GENERAL

This dissertation has established that, under international law, all people have the right to the highest attainable standard of health,<sup>664</sup> and that states have to take legislative and other steps towards the realisation of this right.<sup>665</sup> It has further established that Section 27 of the Constitution provides for the right to health care in South Africa, and the state has to take legislative and other measures to ensure that the rights under Section 27 are realised.<sup>666</sup> In line with these international and constitutional obligations, the NHA came into effect as the healthcare framework legislation of the country, as was discussed in more detail in Chapter 5 of this dissertation. We know from that discussion that, under Sections 3 and 4 of the NHA, the state has certain responsibilities to provide healthcare to the people of South Africa.<sup>667</sup> Whether these state responsibilities are being met in the public healthcare sector and whether these provisions are being effectively implemented is open to question.

The figures presented in the first chapter showed that while the majority of the country rely on the public healthcare sector, the level of satisfaction with public health facilities is relatively low compared to that of users of private healthcare services.<sup>668</sup> Problems within the public healthcare sector, in general, can be found throughout South Africa across the provinces. This is evident from the investigative reports of the SAHRC into public health facilities and hospitals in Mpumalanga and KwaZulu-Natal, and the emergency medical services in the Eastern Cape. While the main focus of this dissertation is emergency medical treatment, the complaints relating to the inadequacies in public healthcare facilities, in general, are relevant to the shortcoming of the public healthcare sector as a whole.

The 2013 SAHRC report details the complaint by the Democratic Alliance against the Mpumalanga Department of Health alleging that the respondent had not provided ‘adequate health care services in public hospitals in the province’.<sup>669</sup> In its investigation, the Commission assessed various hospitals in the province in an urban area,<sup>670</sup> a rural area,<sup>671</sup> and a semi-urban area respectively.<sup>672</sup> It was found that there was a shortage of competent doctors and nurses in these hospitals, which is a contributing factor to the inadequate provision of healthcare.<sup>673</sup> The Commission highlighted challenges relating to ineffective management, a lack of proper infrastructure and insufficient human resources necessary to provide quality health care.<sup>674</sup> In light of these difficulties, the SAHRC found that the Mpumalanga Department of Health had ‘violated the right of the public’ to their right to health care services in terms of Section 27 of the Constitution.

Similarly, in its 2017 investigative report, the SAHRC had to look into a complaint by Dr Imran Keeka against two hospitals and the Department of Health in

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<sup>664</sup> See chap 2 p 13 above.

<sup>665</sup> See chap 2 p 25 above.

<sup>666</sup> See chap 4 p 58 above.

<sup>667</sup> See chap 5 p 71-72 above.

<sup>668</sup> See chap 1 p 1 above.

<sup>669</sup> SAHRC (n 72 above) 3.

<sup>670</sup> SAHRC (n 72 above) 10.

<sup>671</sup> SAHRC (n 72 above) 12.

<sup>672</sup> SAHRC (n 72 above) 15.

<sup>673</sup> SAHRC (n 72 above) 36.

<sup>674</sup> SAHRC (n 72 above) 38.

KwaZulu-Natal.<sup>675</sup> This complaint also related to shortages of qualified staff and alleged that oncology patients in the province were being negatively impacted by a lack of operational medical equipment, which causes delays in treatment of oncology patients.<sup>676</sup> In its investigation, the SAHRC held interviews with oncology patients and many expressed how they had to wait months to get an appointment at these healthcare facilities, and often much longer to receive actual treatment.<sup>677</sup> One patient revealed that her daughter had to take out a loan so that she could pay for a procedure at a private healthcare facility because she was not receiving the necessary treatment from the public health system which did not have functioning machines.<sup>678</sup> Aside from dysfunctional equipment, it was found that the shortage in qualified staff was because ‘experienced oncologists leave public hospitals for the private sector’.<sup>679</sup> This revelation is problematic, considering that the vast majority of the population rely on the public health sector, but many of the experienced healthcare professionals move over to the private sector, which serves only a fortunate minority. This report also concluded that the state hospitals and KwaZulu-Natal Department of Health had violated the rights of oncology patients in the province to health, as well as their inherent right to dignity and the right to life.<sup>680</sup> These SAHRC reports provide evidence of the state’s failure to fulfil the duties placed on it by both the Constitution and the NHA to provide health care.

The constitutional right to not be refused emergency medical treatment has been at the epicentre of discussion in this dissertation. We also know from the previous chapter that Section 5 of the NHA confirms this right by stating that health care providers, workers, and establishments may not refuse anyone emergency medical treatment. While these and other provisions were intended to implement the right to not be refused emergency medical treatment, many factors hinder the realisation of this right. For many people in South Africa, particularly those relying on the public health sector, several barriers must first be overcome before they can access emergency medical treatment, despite what the statutes state. Accessibility is one of the biggest obstacles preventing the effective implementation of the right to not be refused emergency medical treatment and its relevant legal framework. The barriers preventing access will be identified and discussed below.

### III. AFFORDABILITY AS A FACTOR DETERMINING ACCESS TO EMERGENCY MEDICAL TREATMENT

The first chapter briefly touched on the inequities that exist between the private and public healthcare sectors. It is argued that to have meaningful access to emergency medical treatment, these services need to be provided by qualified and trained persons at affordable prices.<sup>681</sup> As will be demonstrated below, one of the biggest barriers that many people in South Africa face in accessing emergency medical treatment is financial. While there is an increase in private emergency medical services and these services run firstly as businesses, the international standards set in General Comment

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<sup>675</sup> SAHRC (n 73 above).

<sup>676</sup> SAHRC (n 73 above) 2.

<sup>677</sup> SAHRC (n 73 above) 29.

<sup>678</sup> SAHRC (n 73 above) 30.

<sup>679</sup> SAHRC (n 73 above) 56.

<sup>680</sup> SAHRC (n 73 above) 64.

<sup>681</sup> R H Marsh & S A Rouhani ‘Gaps in physical access to emergency care in Sub-Saharan Africa (2018) 6 *The Lancet* 240.

24 should be upheld.<sup>682</sup> These private services must be affordable so that they may be accessible to all.<sup>683</sup> The state ultimately has to ensure that these private entities are regulated to ensure accessibility.<sup>684</sup> It has been established that the vast majority of people in South Africa do not belong to a medical aid scheme and most people rely on the public healthcare sector.<sup>685</sup> General Comment 24 is also clear in stating that with the privatisation of these services, a person's inability to pay should not prevent them from accessing such services which are necessary to enjoy covenant rights, such as the right to the highest attainable standard of health, and in consequence, emergency medical treatment.<sup>686</sup>

*a) Ethics and payment of fees before receiving emergency treatment*

It is maintained that in medical emergencies, the ability (or inability) to pay must not be a deciding factor in determining whether or not quality emergency treatment is administered.<sup>687</sup> McQuoid-Mason states that in the spirit of patient autonomy, one can decide whether or not to belong to medical aid or to pay cash for medical treatment.<sup>688</sup> This is debatable, as it has been established that the overwhelming majority of South Africans cannot afford to belong to a medical aid scheme and it is not as simple as making a choice. Being a member of a medical aid scheme does, however, assist greatly in terms of allowing access to private healthcare facilities. For the most part, patients in private hospitals almost always belong to medical schemes.<sup>689</sup> We have also seen from the previous chapter, that being a member of a medical aid scheme allows one further legislative protection in the form of the MSA,<sup>690</sup> which has additional provisions relating to emergency medical treatment in conjunction with the existing national legislative framework governing emergency medical treatment.

Doctors are at liberty to refuse to treat any patient unless it is an emergency or such refusal is based on a constitutional violation such as unfair discrimination.<sup>691</sup> It has been made clear in the chapters above that Section 27(3) does not have qualifying factors when it states that nobody may be refused emergency medical treatment and the beneficiaries of this right are all natural persons in the country. Regulation 26(3) of the EMS Regulations is also clear in placing a duty on managers of emergency medical services to ensure that emergency service providers do not refuse emergency medical treatment to somebody based on their inability to pay. Doctors may not abandon patients simply because they cannot make payment before receiving treatment.<sup>692</sup> Notwithstanding these legal obligations, there are significant ethical obligations on doctors to assist in medical emergencies.<sup>693</sup> McQuoid-Mason argues that it would only be ethically permissible to request payment before treatment if it was not an emergency and the patient belonged to a medical aid, or even if the non-

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<sup>682</sup> See chap 2 p 32 above.

<sup>683</sup> As above.

<sup>684</sup> As above.

<sup>685</sup> See chap 1 p 2 above.

<sup>686</sup> General Comment 24 (n 61 above) par 22.

<sup>687</sup> Stein et al (n 242 above) 161.

<sup>688</sup> McQuoid-Mason (n 46 above) 789.

<sup>689</sup> McIntyre & Ataguba (n 24 above) 8.

<sup>690</sup> See chap 5 p 78 above.

<sup>691</sup> McQuoid-Mason (n 46 above) 798.

<sup>692</sup> McQuoid-Mason (n 46 above) 799.

<sup>693</sup> As above.

emergent patient did not belong to a medical aid but was informed of the costs beforehand and could afford the treatment.<sup>694</sup> In medical emergencies, no patient should be asked to pay for treatment before receiving said treatment and if the patient cannot afford the treatment, they first have to be stabilised and then taken to an appropriate public healthcare facility.<sup>695</sup>

*b) Poverty and access to emergency medical treatment*

In developing countries, such as South Africa, where many hurdles stand in the way of accessible healthcare for the poor majority, emergency medical services are often the first point of contact with the healthcare system.<sup>696</sup> Despite this, not enough advancements have been made to develop emergency medical systems in low- and middle-income countries.<sup>697</sup> A recent survey has revealed that as a continent, only nine per cent of Africans are served by emergency medical services.<sup>698</sup>

The 2015 SAHRC hearing report on access to emergency medical services in the Eastern Cape reflects the epitome of the provision of emergency medical treatment for the poor in South Africa.<sup>699</sup> This report contains many testimonies of members of communities in the Eastern Cape and the many obstacles that need to be faced to access emergency medical treatment, if at all possible.<sup>700</sup> The investigation by the SAHRC revealed countless violations of the right entrenched by Section 27(3) for those living in the rural areas of the Eastern Cape.<sup>701</sup> Despite being the second-largest province in the country, the Eastern Cape is arguably one of the most poverty-stricken provinces.<sup>702</sup> This investigation was triggered after a complaint in 2013 indicating the lack of access to emergency services in the rural areas of the province.<sup>703</sup> The SAHRC had previously made a finding on the inadequate provision of emergency services in 2007,<sup>704</sup> with many of the pitfalls still being present in the country.<sup>705</sup>

One of the major allegations in the complaint was that in many of the rural areas, such as Xhora Mouth, there are no ambulances. This means that those needing to be transported for medical purposes need to acquire this transportation at their own cost.<sup>706</sup> It was reported that, at the time, private transportation could cost anywhere between R400 and R800 at a time,<sup>707</sup> and with the rate of poverty in the country, it means that people could often spend up to half of their monthly income simply on transportation to the medical facilities.<sup>708</sup> One harrowing statement by a community member details that

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694 As above.  
 695 As above.  
 696 Marsh & Rouhani (n 681 above) 240.  
 697 As above.  
 698 Stein et al (n 242 above) 158.  
 699 SAHRC (n 27 above).  
 700 SAHRC (n 27 above) 10.  
 701 SAHRC (n 27 above) 12.  
 702 SAHRC (n 27 above) 16.  
 703 SAHRC (n 27 above) 12.  
 704 SAHRC (n 27 above) 16.  
 705 SAHRC (n 27 above) 17.  
 706 As above.  
 707 SAHRC (n 27 above) 68.  
 708 SAHRC (n 27 above) 86.

Our health emergencies are financially devastating. They drive us deeper into poverty and make it even harder for us to climb out. We face not only the health issue requiring the emergency care, but also the hunger and debt that accompanies a medical emergency. The financial consequences cripple families and indeed whole communities.<sup>709</sup>

McIntyre and Ataguba maintain that 'affordability of health services is influenced by the costs of health care on the one hand and household resources to cover these costs on the other hand'.<sup>710</sup> This is evident by the testimony above as well as the testimonies of countless others in rural areas in South Africa who often have to either face financial devastation or not receive the proper emergency medical treatment that they or their household members require. Out-of-pocket payments have been described as the 'most inequitable type of financing' in the healthcare system as poor and vulnerable persons have to face the biggest hardships to receive medical treatment.<sup>711</sup> Many have found themselves sacrificing other necessities such as food to pay for transport to medical facilities.<sup>712</sup> Notwithstanding the cost of transport to medical facilities in low-income countries, user fees are problematic in the public healthcare sector.<sup>713</sup> The poor often bear a greater burden of disease, despite having less access to medical treatment due to either affordability, geographic positioning or resource constraints.<sup>714</sup>

Taking into account the testimony of community members recounting how medical emergencies are financially crippling, one can see the value of the provisions of the MSA in its protection of medical aid members and the minimum prescribed benefits which include emergency medical treatment.<sup>715</sup> In a medical emergency, medical aid members have peace of mind knowing that the medical scheme will cover the costs of their medical emergency as a bare minimum standard of their membership. It is unfortunate that it is the small minority of the population that can afford medical aid membership and have this protection by the MSA, and do not have to bear the heavy burden of these severe financial barriers in accessing emergency medical treatment. There are significant inequalities between the haves and the have-nots in the country, and those who can afford private emergency medical treatment, and those who have to rely on the state to receive such treatment.

Chapter 3 recounted rife discrimination in the provision of emergency healthcare during the apartheid era. The gut-wrenching reality for many people in the former homelands and other rural areas is that there are still drastic inequalities that have persisted in the provision of healthcare in South Africa.<sup>716</sup> Unfortunately, there is an evident intersection of factors including race, disability and class that indicate that discrimination in the provision of emergency medical treatment is still very much alive some 27 years after entering into the new democratic era.<sup>717</sup>

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<sup>709</sup> SAHRC (n 27 above) 85.

<sup>710</sup> McIntyre & Ataguba (n 24 above) 16.

<sup>711</sup> Peters et al (n 660 above) 163.

<sup>712</sup> As above.

<sup>713</sup> Peters et al (n 660 above) 165.

<sup>714</sup> Peters et al (n 660 above) 168.

<sup>715</sup> S 29(1)(o) MSA and Reg 8 MSA Regulations.

<sup>716</sup> SAHRC (n 27 above) 10.

<sup>717</sup> As above.

#### IV. BARRIERS IN PHYSICAL ACCESS: TRANSPORTATION AND GEOGRAPHIC POSITIONING

Notwithstanding the evident financial barriers many people in South Africa face in accessing emergency medical treatment, many people in the country also face countless challenges in physically accessing emergency medical treatment. Timing in medical emergencies is incredibly important and receiving treatment quickly can considerably lower mortality rates.<sup>718</sup> General Comment 14 has also confirmed that receiving ‘timely and appropriate health care’ forms part of the right to the highest attainable standard of health under Article 12 of the ICESCR.<sup>719</sup> In an international study involving 48 African countries, only 16 of these countries met the international standard set that 80 per cent of the population should be living no more than two hours away from a hospital facility.<sup>720</sup> The majority of South Africans rely on the public healthcare sector and physical access to emergency medical treatment is a big problem in Africa in general.<sup>721</sup> The African Federation for Emergency Medicine has raised the necessity to expand access to emergency services in the continent and has recommended that by the year 2030, at least 80 per cent of each population should have access to emergency care to attain universal emergency health coverage.<sup>722</sup> Physical access to hospitals is severely lacking in Africa, but South Africa has fared considerably well in comparison to other African countries in terms of the percentage of the population that live within two hours of a hospital.<sup>723</sup> This study found that just over five per cent of South Africans live further than two hours away, compared to countries with significantly higher percentages, such as Madagascar or Niger, which both have over half the population living further away from public hospitals.<sup>724</sup> This study reflects that over 90 per cent of the South African public live within the two-hour benchmark away from a public hospital,<sup>725</sup> but transport to these facilities as well as lack of access due to geographic positioning and the location of resources remains an issue in rural areas.<sup>726</sup>

##### *a) Ambulances and emergency medical transport services*

In South Africa, the three main private hospital groups are Netcare, Life Healthcare and Mediclinic.<sup>727</sup> Netcare and Mediclinic each own the two largest private emergency medical service companies respectively, with Netcare 911 belonging to Netcare and ER24 belonging to Mediclinic.<sup>728</sup> Netcare, the largest private emergency service company, reported that in 2019 it had 202 emergency response vehicles, 6 helicopter ambulances and 83 emergency bases.<sup>729</sup> ER24, on the other hand, has over 130

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<sup>718</sup> P O Ouma *et al* ‘Access to emergency hospital care provided by the public sector in Sub-Saharan Africa in 2015: a geocoded inventory and spatial analysis’ (2018) 6 *The Lancet* 342.  
<sup>719</sup> General Comment 14 (n 109 above) par 11.  
<sup>720</sup> As above.  
<sup>721</sup> As above.  
<sup>722</sup> Ouma *et al* (n 718 above) 343.  
<sup>723</sup> Ouma *et al* (n 718 above) 345.  
<sup>724</sup> As above.  
<sup>725</sup> Ouma *et al* (n 718 above) 348.  
<sup>726</sup> Stein *et al* (n 242 above) 160.  
<sup>727</sup> McIntyre (n 53 above) 12.  
<sup>728</sup> McIntyre (n 53 above) 13.  
<sup>729</sup> Netcare Limited ‘Annual integrated report’ 2019 at 112 available at [https://www.netcare.co.za/InvestorReport/Netcare\\_annual-2019/documents/netcare-annual\\_integrated\\_report\\_2019.pdf](https://www.netcare.co.za/InvestorReport/Netcare_annual-2019/documents/netcare-annual_integrated_report_2019.pdf) accessed 23 May 2020.

response vehicles.<sup>730</sup> It has already been established that a very small portion of the country can rely on private healthcare and it is therefore prudent to look at the issue of ambulances and response vehicles in the public health sector in comparison to the private sector to determine if any inequalities persist.

Bearing in mind that the provision of emergency medical services in the public sector is the ‘exclusive function’ of provincial health departments,<sup>731</sup> national standards, as set out by the National Department of Health, dictated that one ambulance is required for every 10 000 people in the Eastern Cape.<sup>732</sup> Despite this, the fleet numbers in the Eastern Cape are far under what they should be.<sup>733</sup> At the time of the SAHRC hearing report in 2015, it was found that in the Nelson Mandela Metropolitan Municipality, there were only 12 operational ambulances to serve a population of well over one million people.<sup>734</sup> This is ten per cent of the number of ambulances that should have been available.<sup>735</sup> In the OR Tambo district, 28 operational ambulances served the largest population in the province of 1.3 million people and in the district with the smallest population, Cacadu, there were 31 ambulances available for 450 000 people.<sup>736</sup> These figures are alarming, as are the response times of many of these vehicles. Many of the testimonies to the SAHRC portray long waiting times and many occasions where ambulances do not arrive at all.<sup>737</sup> In one instance an ambulance was called for at 9:00 am in the morning to treat a child that required emergency care and the family was told that there was a delay as the ambulance was stopping to fill up on fuel.<sup>738</sup> The ambulance only arrived at 14:00 pm the next day, despite the child passing away the afternoon before.<sup>739</sup> The members of the community reflected on how waiting for over 14 hours to be attended to is the norm and is to be expected.<sup>740</sup> This has caused a severe distrust in the public health system, so much so that one carer in a frail-care home reported that because of the struggle to actually be attended to by a government-provided ambulance, the staff at the care home would rather call for a private ambulance ‘in a true medical emergency’.<sup>741</sup>

This is deeply problematic considering the costs associated with private medical facilities and private transport, particularly for those finding themselves in vulnerable groups. In response to these allegations, the Superintendent General of the Eastern Cape Department of Health conceded that is simply unacceptable that patients call for ambulances and wait for hours without ever being attended to.<sup>742</sup>

A nurse at a clinic in Cradock, a small town in the Eastern Cape, testified that she does not even consider calling for ambulances at the clinic because during the

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<sup>730</sup> McIntyre (n 53 above) 12.

<sup>731</sup> McIntyre & Ataguba (n 24 above) 33.

<sup>732</sup> SAHRC (n 27 above) 47. Bearing in mind that the EMS Regulations only came into effect after the SAHRC Report.

<sup>733</sup> SAHRC (n 27 above) 48.

<sup>734</sup> SAHRC (n 27 above) 57.

<sup>735</sup> As above.

<sup>736</sup> As above.

<sup>737</sup> SAHRC (n 27 above) 59.

<sup>738</sup> As above.

<sup>739</sup> As above.

<sup>740</sup> As above.

<sup>741</sup> As above.

<sup>742</sup> SAHRC (n 27 above) 63.

seven years that she had worked there, she had never seen an ambulance arrive.<sup>743</sup> One community member from Xhora Mouth testified that he did not even know what an ambulance was and was ‘grateful to hear’ that government ambulances even existed.<sup>744</sup> Even those who do get attended to by state ambulances are not always better off. One recurring complaint by community members in the Eastern Cape is that when these ambulances do arrive, they are not properly equipped with the necessary tools to administer life-saving treatment.<sup>745</sup> One of the biggest problems reported is the lack of oxygen and regulators.<sup>746</sup> Despite the minimum standards that were in place by the HPCSA, many patients in these rural areas find themselves being attended to by empty ambulances with no equipment in them.<sup>747</sup> It is questionable whether they are truly receiving emergency treatment if the emergency response services are not properly equipped to administer the necessary treatment to patients. Further, if one follows the Constitutional Court’s reasoning in the *Oppelt* decision, improper treatment caused by a lack of proper equipment and undue delays in treatment is tantamount to the constructive refusal of emergency medical treatment, and thus a violation of Section 27(3).<sup>748</sup> One could argue that this would not happen if one was attended to by one of the well-known private ambulance services, but unfortunately, the sad reality is that the private healthcare sector caters to a small margin of the population who can afford the costs associated therewith.

*b) Terrain and geographical positioning*

Geographic position is a large factor determining access to healthcare in low- and middle-income countries.<sup>749</sup> The legacy of apartheid still lives on in the rural parts of the Eastern Cape in the former homelands.<sup>750</sup> There are tremendous inequalities persistent between rural and urban areas throughout South Africa, and the Eastern Cape province is no exception.<sup>751</sup> The province is notorious for its terrible roads and service delivery.<sup>752</sup> Out of all the provinces, the Eastern Cape has ‘the lowest per capita investment in infrastructure in the country’.<sup>753</sup> The terrain and geographic positioning of communities in the rural parts of the province have a direct impact on access to healthcare facilities for patients, such as public clinics, and even for medical supplies as delivery vehicles often cannot reach the facilities to deliver medicine and equipment if the weather and road conditions are not favourable.<sup>754</sup>

The large majority of the roads in the Eastern Cape are in a terrible state.<sup>755</sup> This has had not only a direct negative impact on the economy and social-economic circumstances of those living in the province, but it also has a direct impact on the ability of ambulances to reach patients who call for their services.<sup>756</sup> It is argued that

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<sup>743</sup> SAHRC (n 27 above) 65.

<sup>744</sup> As above.

<sup>745</sup> SAHRC (n 27 above) 52.

<sup>746</sup> As above.

<sup>747</sup> As above.

<sup>748</sup> See chap 4 p 68 above.

<sup>749</sup> Peters et al (n 660 above) 165.

<sup>750</sup> SAHRC (n 27 above) 66.

<sup>751</sup> As above.

<sup>752</sup> As above.

<sup>753</sup> As above.

<sup>754</sup> As above.

<sup>755</sup> As above.

<sup>756</sup> SAHRC (n 27 above) 67.

one of the biggest contributing factors as to why the Eastern Cape Department of Health is not able to properly administer emergency treatment to patients in rural areas, is the fact that the emergency medical response vehicles simply cannot get past the difficult terrain in the mountains of the Eastern Cape to get to their patients.<sup>757</sup> The majority of the state emergency response vehicles, including ambulances, are ‘Quantum vehicles’.<sup>758</sup> This means that physically, those driving these vehicles and responding to calls for emergency assistance, cannot get to many of the rural living areas of the communities because they do not have 4x4 capabilities.<sup>759</sup> At the time of the hearing report, 59 4x4-capable ambulances were working for the state but the Department of Health expressed that it was prioritising the procurement of more ambulances with these capabilities.<sup>760</sup>

The unfortunate reality is that many people living in these rural areas often do not receive timely treatment because of their geographical positioning.<sup>761</sup> It takes longer for ambulances to respond to these areas and many people simply cannot afford to wait so long before receiving life-saving treatment or transportation to a hospital.<sup>762</sup> This is where, again, many people have to sacrifice other necessities to fork out funds to pay for alternative transport arrangements to get their loved ones to medical facilities.<sup>763</sup> For many in the rural areas, private transport is not even an option and they have to travel far, with the assistance of neighbours and other community members, to get to a main road to access transport.<sup>764</sup> Multiple members of the community testified that they have had to carry their family members in blankets or push them in a wheelbarrow or donkey cart to try to find alternative means of transport to try get them to a healthcare facility.<sup>765</sup>

As the terrain and the state of the road network have had an evident impact on access to healthcare, consideration should be given to the fact that although the provincial Department of Health is responsible for the provision of emergency medical services, the Department of Roads and Public Works has also played a significant role in the prevention of proper emergency medical treatment being administered due to the poor state of the roads preventing ambulance access.<sup>766</sup> The Department has been unable to properly maintain the road networks but in the spirit of co-operative governance, inter-departmental programs have been set out with an aim to improve access to emergency medical services.<sup>767</sup>

Another problem is that many living in rural villages and informal settlements do not have fixed addresses.<sup>768</sup> This creates issues for emergency service staff who are dispatched to a call and are unable to locate the patient.<sup>769</sup> Emergency services should not always be solely blamed for slow response times as in many instances they may get lost trying to get to their destination and first have to consult the nearest police

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757 As above.  
 758 As above.  
 759 As above.  
 760 As above.  
 761 As above.  
 762 As above.  
 763 As above.  
 764 As above.  
 765 As above.  
 766 SAHRC (n 27 above) 66.  
 767 SAHRC (n 27 above) 82.  
 768 SAHRC (n 27 above) 67.  
 769 As above.

station to ascertain where they need to respond to.<sup>770</sup> In many instances, a family member or other community member must run out to wait for the emergency services in the street so that they can direct them to where to find the patient.<sup>771</sup>

Although we are all equal before the law and Section 27(3) enshrines the right to not be refused emergency medical treatment, those in rural areas are hit the hardest by inadequate service delivery and inept emergency services.<sup>772</sup> Vulnerable groups such as the poor, elderly and physically or mentally disabled, as well as pregnant women and persons with chronic conditions, are even more so oppressed by the inequalities in the healthcare system.<sup>773</sup> There are instances reported in this hearing report that can only be described as heinous violations of the right to dignity,<sup>774</sup> as well as the right to not be unfairly discriminated against.<sup>775</sup> Examples of this are testimonies indicating that private means of transportation often refuse to transport wheelchair users.<sup>776</sup> Despite the Department of Health confirming that all of their ambulances have the capacity to transport wheelchairs, many people have reported that they are not allowed to take their wheelchairs with them when they are being transported to a hospital, nor are they allowed to be accompanied by a friend or family member.<sup>777</sup> These people are often left abandoned and uncared for.<sup>778</sup> One concerning testimony revealed that an elderly man residing at a care home needed to go to the hospital for surgery on his ankle.<sup>779</sup> Hours after arriving at the hospital the man called the manager of his care home pleading for help as he had been ‘abandoned in the hallway in his wheelchair’.<sup>780</sup> This man was not treated with dignity and the proper care as he should have been. The food packed in for him and his luggage had gone missing and he was not fed, nor was he administered his diabetes medicine.<sup>781</sup> The care home manager tried to check in on the man at the hospital but the hospital staff said that they did not know where he was and that he had been checked out.<sup>782</sup> This vulnerable man was found two whole days later on the floor, crying on a mattress with gangrene that had spread across his leg, which subsequently had to be amputated.<sup>783</sup> This can only be described as pure negligence and a clear violation of the constitutional rights to access to healthcare,<sup>784</sup> dignity,<sup>785</sup> equality and bodily integrity.<sup>786</sup> Not allowing wheelchairs onto ambulances that have capacity, or the accompaniment of loved ones or carers for vulnerable people is not responding to the specific needs of vulnerable members of society. It is submitted that particularly in situations such as the man in the wheelchair who was neglected, the state has failed to meet its international obligations in terms of the ICESCR and the right to the highest standard of health.

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<sup>770</sup> SAHRC (n 27 above) 68.

<sup>771</sup> As above.

<sup>772</sup> As above.

<sup>773</sup> As above.

<sup>774</sup> S 10 Constitution.

<sup>775</sup> S 9(3) Constitution.

<sup>776</sup> SAHRC (n 27 above) 69.

<sup>777</sup> As above.

<sup>778</sup> As above.

<sup>779</sup> As above.

<sup>780</sup> As above.

<sup>781</sup> SAHRC (n 27 above) 69.

<sup>782</sup> As above.

<sup>783</sup> As above.

<sup>784</sup> S 27 Constitution.

<sup>785</sup> S 10 Constitution.

<sup>786</sup> S 12(2) Constitution.

c) *Devastation caused by delays in treatment*

As seen in *Oppelt*, undue delays in treatment can result in ‘constructive refusal’ of emergency medical treatment in terms of Section 27(3).<sup>787</sup> The barriers the poor and rural communities in the Eastern Cape face in accessing emergency medical treatment have far-reaching consequences. The lack of patient transport has a significant effect on persons who suffer from medical conditions such as epilepsy, cerebral palsy and strokes.<sup>788</sup> In the case of epileptic fits, the negative impacts of seizures can be prevented but if there are delays in receiving emergency treatment, the consequences can be devastating for these patients and their families.<sup>789</sup> In many cases where emergency services do not arrive in time when somebody is having a seizure, those around the patient often are not able to do much for them other than wait for the seizure to end.<sup>790</sup>

In a written submission to the SAHRC, an occupational therapist from a surrounding hospital expressed how one of the common side effects of delays in treatment in the province, is that many children end up with cerebral palsy due to delays in labour, untreated epilepsy and head injuries.<sup>791</sup> Another medical officer testified that there is a ‘high rate of perinatal death’ because of the lack of transport and the delays in treatment and many children are born with permanent disabilities because of complications during delivery.<sup>792</sup> It has been stated that many of these permanent conditions can easily be avoided by increasing the availability of emergency medical services.<sup>793</sup> Community members in these areas have died and have watched their loved ones die because of the unavailability of emergency services.<sup>794</sup> It has left people feeling as if they are ‘second-class citizens who are unworthy of government’s protection and respect’.<sup>795</sup>

## V. CONCLUSION

The main takeaway from this chapter is that although there may be a constitutional right to not be refused emergency medical treatment, and a legislative framework in place to give effect to this right, this right is not always realised in practice for many people in South Africa. This legislative framework is adhered to haphazardly and in an inequitable manner. In many instances, the state has failed to discharge its duties to provide health care for many people in the country and the right to not be refused emergency medical treatment is often only implemented to a limited extent for many in the country. In some cases, it is not realised at all.

The most significant barriers to accessing emergency medical treatment are financial and physical. Additionally, lack of transport, geographical position, terrain and poor service delivery are also significant barriers preventing such access. The

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<sup>787</sup> *Oppelt* (n 465 above) par 68.

<sup>788</sup> SAHRC (n 27 above) 84.

<sup>789</sup> As above.

<sup>790</sup> As above.

<sup>791</sup> As above.

<sup>792</sup> SAHRC (n 27 above) 85.

<sup>793</sup> As above.

<sup>794</sup> SAHRC (n 27 above) 86.

<sup>795</sup> As above.

constitutional rights of many South Africans have been violated, particularly in the Eastern Cape. Many have to try find funds, which they do not have, to pay for transport to gain access to emergency medical treatment and suffer devastation when there are delays in receiving treatment. They find themselves diving deeper into poverty in an attempt to realise their basic human rights in terms of the Constitution, rights that should be protected and realised by the state. Those who are fortunate enough to be covered by medical aid and can afford private healthcare facilities are less affected by this burden.

In many respects, the right to not be refused emergency medical treatment is often not realised for the poor in South Africa.

## **CHAPTER 7**

### **CONCLUSION**

#### **I. INTRODUCTION**

The main research question for this dissertation was to determine the extent to which the right to not be refused emergency medical treatment is protected and realised in South Africa. Before assessing the South African right, consideration was given to whether this is a recognised right under international law and comparative constitutional law, and what the nature of state and non-state entity's obligations are in terms of these rights. The right to not be refused emergency medical treatment under Section 27(3) of the Constitution was analysed to determine its meaning. The current legislative framework giving effect to the right was also analysed. Consideration was given to whether or not this framework is being implemented and the challenges to effective implementation.

#### **II. RECOGNITION OF EMERGENCY MEDICAL TREATMENT AS A RIGHT UNDER INTERNATIONAL LAW AND COMPARATIVE CONSTITUTIONAL LAW**

This dissertation established that under international law, there is no express provision for emergency medical treatment being recognised as a right on its own. Rather, it is implied in the broader right to the highest attainable standard of health under Article 12 of the ICESCR and other human rights treaties, including Article 16 of the ACHPR and Article 24 of the CRC.

Under comparative constitutional law, a handful of states, including South Africa, expressly recognise emergency medical treatment as a specific right in their respective constitutions. Some states, such as Sudan and South Sudan, recognise the right in a positive fashion, where the state has to actively provide such treatment, whereas other states, such as South Africa, recognise the right in the negative, prohibiting the refusal of emergency medical treatment. Section 27 of the Somalian Constitution prohibits refusing anyone emergency healthcare for any reason, especially on grounds related to economic capability. Out of all states recognising emergency medical treatment as a right, this is the best constitutional provision as it is the most inclusive and specifically protects the rights of poor and vulnerable people. A provision like this would have been beneficial in South Africa which is heavily affected by poverty.

The nature of state obligations flowing from the right to emergency medical treatment was also considered. In considering the nature of state obligations under international law, Article 2(1) of the ICESCR is significant in that it sets out that states must take active steps towards the realisation of covenant rights, including the implementation of legislation. States must respect, protect and fulfil covenant rights, which includes the right to the highest attainable standard of health, and by implication, the right to emergency medical treatment. While most of the constitutional provisions under comparative constitutional law providing for the right to emergency

medical treatment are phrased in the negative, positive obligations are still placed on states to take active steps to ensure that emergency medical treatment is provided to everyone in need of it.

Though emergency medical treatment is an emerging right under international law, this sphere of international law remains underdeveloped, particularly insofar as the obligations of non-state actors are concerned. It was established that both states and non-state actors may not refuse emergency medical treatment to anyone and that states have to regulate private healthcare providers as they perform the functions of the state in the provision of emergency medical treatment.<sup>796</sup>

### III. THE RIGHT TO NOT BE REFUSED EMERGENCY MEDICAL TREATMENT IN SOUTH AFRICA

The history of emergency medical treatment as part of South Africa's previously segregated and discriminatory healthcare system was discussed. It was ascertained that before the implementation of the Bill of Rights, there was no right to emergency medical treatment in South Africa and many people did not receive vital medical treatment based on their race, despite the international law standards in place at the time. The systemically racist policies and geographic positioning of certain groups of people have had a significant impact on how emergency medical treatment is accessed in South Africa to this day.

South Africa has taken many positive steps relating to human rights since the new constitutional dispensation came into place. Section 27(3) of the Constitution expressly provides that 'no one may be refused emergency medical treatment'. This constitutional provision has been dissected and analysed in this dissertation to determine the meaning of the right. It was ascertained that the beneficiaries of this right are every natural person within the geographical boundaries of the country.<sup>797</sup> The meaning of the term 'emergency medical treatment' was deliberated as it is not clear from Section 27(3) itself. The Constitutional Court's interpretation of the term in *Soobramoney* has been heavily relied on and it was ascertained that certain elements need to be present for emergency medical treatment. Following this interpretation, emergency medical treatment is required where there has been a sudden, expected event causing a patient to require immediate medical treatment to avert harm or stabilise the patient.<sup>798</sup>

The state has both negative and positive obligations in terms of the right to not be refused emergency medical treatment. The state must not do anything that would be tantamount to refusing somebody emergency medical treatment. Although Section 27(3) is phrased negatively, the state must still take steps to ensure that this right is realised progressively within its available resources. Where a state facility does not have the necessary resources to provide emergency medical treatment, it must refer the patient to the next appropriate facility. Private entities are also bound by Section 27(3) but to a more limited extent than the state. They may also not refuse anybody emergency medical treatment, even if somebody is unable to pay for such treatment.

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<sup>796</sup> General Comment 24 (n 61 above) par 22.

<sup>797</sup> See chap 4 p 48 above.

<sup>798</sup> See chap 4 p 51 above.

At the very least, they have to stabilise a patient and provide emergency medical treatment, before transferring the patient to a state facility.

In the ordinary sense of the word, ‘refusal’ means to not allow somebody to have emergency medical treatment. However, *Oppelt* held that one can also be ‘constructively refused’ emergency medical treatment, such as where such treatment is not delivered timeously or effectively.<sup>799</sup>

#### IV. THE STATUTORY FRAMEWORK GOVERNING EMERGENCY MEDICAL TREATMENT IN SOUTH AFRICA

In meeting the international law obligations under Article 2(1) of the ICESCR, as well as part of the steps that have to be taken by the state under Section 27(2) of the Constitution, there is an existing statutory framework giving effect to the right to not be refused emergency medical treatment in South Africa. The extent to which various pieces of legislation give effect to this right was assessed and discussed. It was found that the NHA on its own makes provision for emergency medical treatment to a limited extent through the one-liner that is Section 5.<sup>800</sup> It is only quite recently that the EMS Regulations came into effect, which provided more detail and scope into the provision of emergency medical treatment in South Africa.

The EMS Regulations bind both public and private emergency medical services and set out detailed standards that have to be met in terms of staff, equipment and procedures to be taken by emergency medical services. The adoption of the EMS Regulations is a step in the right direction towards providing quality emergency medical services for all people in South Africa.

Some shortcomings have, however, been identified. The EMS Regulations, like the NHA, does not define ‘emergency medical treatment’ or what constitutes a medical emergency. This is a missed opportunity given that this is subsidiary legislation solely focused on emergency medical services to give effect to Section 5 of the NHA and Section 27(3) of the Constitution.

Regulation 26 of the EMS Regulations places a duty on emergency medical service managers to ensure that patients are not refused emergency medical treatment based on their inability to pay for such treatment, but fail to place this duty on the emergency medical services themselves to not refuse a patient emergency medical treatment. This duty should be explicitly placed on the emergency medical services themselves in addition to the duty placed on the emergency services manager.

It would be better if there was a separate section dealing specifically with the rights of indigent patients to ensure more deliberate and specific protection of the rights of many of the nation’s most vulnerable people. While Regulation 26 can remain as is, an additional section is needed, at the very least, stating that no emergency medical service may refuse any person emergency medical treatment for any reason, especially inability to pay for such treatment.<sup>801</sup>

<sup>799</sup> *Oppelt* (n 465 above) par 68.

<sup>800</sup> S 5 of the NHA provides that ‘a health care provider, health worker or health establishment may not refuse a person emergency medical treatment’.

<sup>801</sup> Inspiration for the wording of this hypothetical section would come from S 27 of the Somalian Constitution, which has been praised earlier.

Despite this gap, the EMS Regulations address many technical aspects of emergency medical service provision and sets standards for both public and private providers. The NHA and the EMS Regulations promote the implementation of the right to not be refused emergency medical treatment for all people in the country.

In contrast, the MSA provides additional protection only to the fortunate minority of the population who can afford a medical aid scheme.<sup>802</sup> The MSA also does not define emergency medical treatment but does define an emergency medical condition in words very similar to how the Constitutional Court in *Soobramoney* defined emergency medical treatment.<sup>803</sup> Medical scheme members, no matter what plan they are on, have the protection of prescribed benefits which include emergency medical treatment.<sup>804</sup> Members thus do not bear the potentially heavy financial burden often associated with emergency medical treatment. The way that medical schemes operate, however, may be turned on their heads once the NHI Bill comes into full effect.

The NHI Bill was discussed to determine whether it addresses any of the gaps identified in the current statutory framework regarding the right to not be refused emergency medical treatment. For one thing, the NHI Bill also does not define emergency medical treatment, which seems a further missed opportunity. It is recommended that the legislature amends this to include a concrete definition of emergency medical treatment so that reliance does not have to be made on a judgment made over two decades ago to define emergency medical treatment. If this is done, the wording used in *Soobramoney* and the MSA Regulations should be used as a guide, so that this definition is applicable in legislation that applies to everyone in the country, not just medical aid scheme members. The intentions behind the NHI Bill may seem honourable as it aims to widen access to healthcare in general (and consequently emergency medical treatment) for all, but whether this can be effectively implemented is questionable if one considers the challenges to implementing the existing statutory framework governing healthcare and emergency medical treatment.

## V. CHALLENGES HINDERING EFFECTIVE IMPLEMENTATION OF THE EXISTING STATUTORY FRAMEWORK

While we do have an existing right to not be refused emergency medical treatment in the Constitution, and there is an existing statutory framework in South African law giving effect to this right, whether this statutory framework is effectively implemented in practice is doubtful. For many in South Africa, particularly the poor and most vulnerable members of our society, the right under Section 27(3) is not realised in reality due to many factors.

The majority of people in the country rely on the state for their healthcare needs, but this dissertation showed that those who rely on the state for emergency medical treatment are often left in the dark or in financial turmoil as they have to pay for private assistance which they cannot afford. Affordability is one of the most significant barriers preventing access to emergency medical treatment in South Africa. To illustrate these barriers, the SAHRC Report on emergency medical services in the

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<sup>802</sup> Preamble MSA.  
<sup>803</sup> Reg 7 MSA Regulations.  
<sup>804</sup> Reg 8 MSA Regulations.

Eastern Cape was relied on. It highlighted that the poor and most vulnerable members of our society have been unable to access emergency medical treatment either because they cannot afford it, or because they cannot afford private transport.<sup>805</sup> Many people in South Africa are still affected by the inherent divisions created during apartheid such as geographic location, class or race discrimination.<sup>806</sup>

Along with severe financial barriers preventing access to emergency medical treatment for many people in the country, many physical barriers prevent access. Geographic location, terrain and lack of adequately equipped or appropriate ambulances and emergency medical vehicles are significant barriers preventing physical access.<sup>807</sup> Even when ambulances do arrive, there have been reports that they have not been appropriately equipped.<sup>808</sup> It is testimonies such as these that show the value of the newly implemented EMS Regulations, which have strict equipment requirements that all emergency medical services have to adhere to.<sup>809</sup> Whether these standards will be adhered to is remains to be seen. The many testimonies recounted in the SAHRC report reveal the unfortunate lived realities of many people struggling to access emergency medical treatment.

## VI. CONCLUSION

In conclusion, although there is arguably an existing broader right under international law, and an express, more specific right under South African constitutional law to not be refused emergency medical treatment, this right is often not realised for many people in South Africa. Both the state and private entities have certain duties towards this right. While South Africa has taken progressive steps towards the realisation of the right, such as adopting legislation, this is not enough to ensure that everyone enjoys this right.

Those who can afford to be members of medical aid schemes are fortunate enough to have additional protection provided by the MSA in that access to private facilities is made easier, and emergency medical treatment is provided as a minimum prescribed benefit, meaning that they would not have to face the financial devastation that those who rely solely on public healthcare may face in medical emergencies. This only perpetuates inequalities between the rich minority and the poor majority of the population. While on paper the right under Section 27(3) and its supporting legislative framework may seem to protect the rights of ‘everyone’ to emergency medical treatment to some extent, the sad reality is that many do not have their rights realised where the state has not fully complied with its obligations. What is entrenched in the Constitution on paper is not the lived reality of many people in South Africa.

## VII. RECCOMENDATIONS

A few recommendations can be made to address the problems identified in this dissertation. Firstly, though emergency medical treatment is an emerging right under

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<sup>805</sup> See chap 6 p 86 above.

<sup>806</sup> See chap 6 p 90 above.

<sup>807</sup> SAHRC (n 27 above) 67.

<sup>808</sup> See chap 6 p 90 above.

<sup>809</sup> See chap 5 p 76 above.

international law, this aspect of international health law needs further development. International human rights would benefit from the express recognition of emergency medical treatment as a basic human right, and further development is required insofar as setting out the duties of both state and non-state actors in the provision of emergency medical treatment are concerned.

Though the South African Constitution does expressly recognise the right to not be refused emergency medical treatment, our law is lacking insofar as a definition of 'emergency medical treatment' is concerned. A clear definition of emergency medical treatment, or a medical emergency, is required in South African legislation. This definition should form part of legislation that applies to all people in the country, such as the NHA, and not just the minority who have medical aid cover. This definition needs to be extensive enough to not raise any further questions as to what is regarded as emergency medical treatment. It is recommended that the definitions provided in *Soobramoney* and the MSA Regulations should be looked at in the development of this definition. Ideally, emergency medical treatment would be defined as the treatment required by an ill or injured person as a result of a sudden, expected onset of a health condition that requires immediate or urgent medical or surgical treatment, where failure to receive such treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, would place such person's life in jeopardy or cause harm to such person. This definition needs to be included in legislation that applies to the general population and while such a definition should preferably be included in the NHA, or at the very least in the EMS Regulations, the legislature has an opportunity to include it under Section 1 of the NHI Bill as this has yet to come into effect.

It is recommended that the EMS Regulations, or even the NHA itself, should be amended to include clear specific guidelines relating to the rights of indigent patients and emergency medical treatment. The EMS regulations, in particular, should be amended to include an express provision placing a duty on both public and private emergency medical services or hospitals to not refuse anybody emergency medical treatment on any grounds, especially not the inability to pay. It is further recommended that Section 6 of the NHI Bill should be amended to include the right of NHI users to not be refused emergency medical treatment based on the inability to pay for such treatment, or any other grounds.

These amendments would provide further protection of the right to not be refused emergency medical treatment for the most vulnerable members of the population. While amendments can be made to legislation, effective implementation is required to properly realise the right to not be refused emergency medical treatment. The state must take measures to address the barriers faced by many in access emergency medical treatment, taking into account the spirit of cooperative governance. Given the EMS Regulations and the standards set out therein, the state should ensure that there is sufficient financial and physical access to emergency medical treatment and should prioritise minimizing barriers in physical access by procuring sufficient and capable ambulances and emergency response vehicles that are equipped to provide emergency medical treatment to as many people as possible within available resources.

While the NHI Bill is yet to come into effect, the hope remains that the necessary amendments will be made to address the gaps in the law surrounding emergency medical treatment to ensure that the best interests of all people, including

indigent persons, are upheld to realise the right to not be refused emergency medical treatment.

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