

Access to Care

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Legal and human rights arguments for access to care

Barriers to access to Palliative Care

Summary



Legal and Human Rights Arguments for Access to Care

The UN Universal Declaration of Human Rights conceptualises human rights as based on inherent human dignity.¹ Death is inevitable. The provision of good health care at the time of death is less so. Throughout the world there are wide disparities in the capacity, resources, and infrastructure devoted to the care of people who are dying.²

The Constitution of the Republic of South Africa gives every person the right of access to health care services. Does this mean that all South Africans have the right to the provision of good health care at the end of life?

Every person in South Africa has a constitutional right to access health care services, a right detailed further in the National Health Act of 2003 which aims to promote the health of the inhabitants of the Republic so that every person shall be enabled to attain and maintain a state of complete physical, mental and social well-being.

In order to fulfil this right the necessary conditions for people to access health care must be created by providing positive assistance to patients, health care benefits and health care services. Government has an obligation to promote health by providing hospitals, clinics, medicines and staff to provide this care to all people in South Africa.

What does this Right really mean?

It is argued that in order to fulfil this right the following essential elements need to be fulfilled.

The Government and all citizens must respect the right of access to health care services by not unfairly or unreasonably obstructing people accessing existing health care services, whether in the public or private sector.

In the face of the current HIV pandemic and social attitudes that result in stigmatisation and discrimination against people who are HIV positive, health care workers have a responsibility to provide equitable health care to people living with HIV without discrimination. Managers of health care institutions should ensure that their staff are adequately trained in clinical care of patients and are supported in developing compassionate attitudes of care.

If a hospital refuses to treat a patient, they have recourse to the Department of Health or the Public Protector. The High Court can review and set aside the decision of the hospital to refuse to treat the patient.

In a recent matter in the Port Elizabeth High Court a two-week-old baby boy was given the chance of life when a High Court judge ruled in favour of a blood transfusion, against the religious beliefs of his Jehovah's Witness parents. This means that not even a child's parent can prevent a child from accessing existing health care services.

All patients have the right to be treated with respect. The Health Professions Council of South Africa (HPCSA) guidelines say that health care workers must not treat patients who are living with HIV differently to other patients. This applies to people with all illnesses including MDR or XDR TB (Multi resistant/extreme drug resistant tuberculosis.) There are guidelines to promote occupational

Terms you will read in this chapter:

Delirium: extreme restlessness, confusion caused by fever etc.

Discrimination: unfair treatment because of race, age, religion or gender

Dyspnoea: difficulty in breathing, often caused by heart or lung disease

Family respite: a brief period of rest or recovery from tiring and difficult home care

Ineluctable obligation: inescapable obligation – it must be done

Peripheral clinics: those not in the towns, but out in the rural or more inaccessible areas

Primary health care: care at community level such as at a clinic, GP practice, community health centre

Rationalisation of institution: made more efficient/profitable, e.g. by reducing workforce

Stigma/Stigmatisation: the shame/disgrace attached to illness not socially acceptable

Tertiary health care: care at a specialist hospital

health and safety for health care workers who care for patients with infectious conditions.³

Government has a responsibility to protect the right of access to health care by developing and implementing a comprehensive legal framework to facilitate individuals realising this right and to limit those who obstruct the access to health of others.

South Africa has two types of Health Care Service

1. The Private Health Care System where the individual carries the responsibility of health care with assistance from various medical schemes.
2. The State Health Care System: whereby the state provides health care for those unable to afford adequate medical cover. There is a scarcity of resources. This has seen a shift in focus from tertiary health care to primary health care, rationalisation of the academic institutions as well as reallocation of human resources to peripheral clinics.

Access to health care depends on access to doctors, nurses, dentists and pharmacists. In South Africa as well as internationally, there are several different crises confronting human resources within health care services, including:

- Personnel shortages in rural areas and poor urban areas.
- Many health care workers leaving the public health system and going to rich countries where payment and conditions are much better.
- The impact that HIV is having on the capacity of the health system by greatly increasing the numbers of people in need of care.

In April 2006, the Department of Health published a human resource plan in an attempt to overcome this crisis. However, this plan is weak and lacks concrete targets and proposals to address either the short or long term crisis of human resources. It is likely that it will be subject to severe criticism, and possibly even constitutional challenge, in coming years.

The Government needs to strive to improve the state health care system, which is currently inadequate, and to eradicate gross inequities in service provision and ensure greater access to health care for the poorest people in our country.

A clear example of Government's failure is the Human Rights working group in the Eastern Cape calling on the National Executive to intervene in the problems facing the Eastern Cape Health Department in terms of Section 100

of the Constitution. There are systemic problems, which must be resolved in order to ensure an adequate standard of public health care for the people of the province. Failure to do so can only result in the perpetuation of inadequate public health services in the Eastern Cape. Public Service Accountability Monitor (PSAM) has documented financial mismanagement, staff shortages, poor strategic planning and lack of transparency and accountability that have impacted on service delivery.

According to the Department's Draft Human Resources Plan (DHRP) 2007/08 – 2010/11, there is a 34 per cent overall vacancy rate in the Clinical Branch. The DHRP recorded a 61 per cent vacancy rate for medical specialists, 54 per cent vacancy rate for medical officers, 28 per cent vacancy rate for all categories of nursing staff (professional nurses, staff nurses and nursing assistants), 50 per cent vacancy rate for pharmacists, 55 per cent vacancy rate for dentists, 65 per cent vacancy rate for physiotherapists and a 48 per cent vacancy rate for emergency medical officers. With regard to emergency medical services, section 27 (3) of the Constitution states that 'no one may be refused emergency medical treatment'. In the Eastern Cape, however, only 44 per cent of the population has access to emergency services (RAS, p. 19).⁴

Despite our Constitution, Health Act and the International Covenant on Economics, Social and Cultural Rights (ICESCR), it is widely accepted by our Courts that there is not an absolute right to most of the socio-economic rights contained in our Constitution, but that there must be a progressive realisation of this right as resources become available.

The rights described in ICESCR are termed aspirational rights. This means that there is no express right to care, but that Government must strive to gradually increase the right to health services in a manner which will uphold and develop the rights enshrined in the Constitution² and that the Government agrees to core obligations towards the realisation of these rights. The provision of palliative care is one part of a continuum of health care for all persons. Therefore, an argument can be made that a right to palliative care can be implied from the overall international human right to health. General Comment 14, from the Committee for ICESCR, documents palliative care as a human right.

Access to palliative care is impacted by the lack of palliative care training for all health care professionals, and the current lack of integration of palliative care into the formal health care sector. In 2007 South African hospices cared for approximately 14 per cent of patients requiring palliative care. What was the experience for the patients who died without this care?

Barriers to access to Palliative Care

Understanding and awareness of Palliative Care

There is a significant lack of understanding regarding palliative care in South Africa. Many health care professionals and communities consider palliative care to be terminal/end-of-life care. The WHO definition of palliative care emphasises that palliative care is applicable early in the course of the illness, in fact from the time of diagnosis of the illness. Palliative care should be provided alongside disease-oriented care. This lack of understanding means that patients are referred late to hospice care. They suffer unnecessarily, alone in their homes. Family members who are not equipped to deliver palliative care have the burden of care placed on them at a time when they themselves need care and support.

This might be due to misconceptions about hospice or to the lack of information relating to services offered by palliative care organisations. To overcome these challenges, more information materials need to be developed and more work needs to be done with the general media. The availability of this information must be found in all health facilities so as to assist patients, their families and carers and health personnel. More palliative care campaigns are needed to provide the necessary information and to influence attitudes.

The structural arrangement of a health care system can also contribute to problems concerning palliative care and its administration. Many primary health clinics do not have staff trained in palliative care. This is often the case with private and public hospitals as well. The lack of staff suitably trained in palliative care and designated palliative care beds or wards contribute to patient distress.

If more staff in these institutions could be trained in palliative care there would be changes in attitudes towards death and dying. Patients would receive better management of their pain and more holistic care. And family members would receive better support and experience better bereavement outcomes.

Place of Care

Barriers to palliative care exist even for patients who have access to the hospice system. Most hospice programs deliver care to persons who are dying in their own homes. This is appropriate for the South African setting and acknowledges patient preference for home care. Admission

to an in-patient hospice unit (IPU) is appropriate for symptom control and family respite. However very few in-patient hospices exist and these usually have a limited number of beds because of funding constraints. Patients with symptoms such as dyspnoea and delirium, as well as terminally ill patients requiring intensive nursing, may be disadvantaged in accessing care when the local hospice does not have an IPU. However, hospices do provide other services through their home-based care and day hospice. For many patients these services are usually available only during office hours. When a patient has problems at night, advice can be given over the telephone – if there is one. Travelling at night can be dangerous in certain areas so hospice management have instructed their staff not to do house-visits at night. Hospice day centres operate well since they provide the services of doctors, professional nurses and social workers.

Referrals

Most hospice patients are referred by hospitals, private doctors and other NGOs. Due to funding issues, some organisations may hold on to their patients and not refer them for palliative care, as the drop in the NGO patient numbers could result in a drop in funding. A solution to this issue is training all NGO staff in palliative care.

Lack of Palliative Care education

Until recently, training programmes at South African medical and nursing schools did not include palliative care in their curricula. This has resulted in the lack of knowledge of both palliative care and in particular in pain management.

Palliative care is an integral part of every health care professional's role. This means that training in palliative care is an essential part of preparation for doctors and nurses. Traditional medical and nursing training focuses on cure, so that health care professionals are not equipped to deal with the clinical and emotional issues in caring for patients for whom cure is no longer an option. These patients often have severe symptoms and emotional distress. Health care professionals need to develop the skills and knowledge to provide compassionate care and to commit to non-abandonment of patients.

In addition to including palliative care in health sciences curricula, financial support is needed to conduct research to assess the knowledge that health professionals have of palliative care and to develop evidence-based practice. Hospices and hospitals need to have good working relationships so that hospices can become mentors for

those hospitals which need to expand their practical experience of palliative care.

Shortage of Palliative Care staff

Member hospices within the Hospice Palliative Care Association (HPCA) of South Africa have experienced increasing numbers of patients from 2000 onwards. Professional staffing for South African hospices is a continuing challenge. The recruitment and retention of professional staff requires hospices to compete with public and private sectors with regard to staff salaries. Hospices are funded through donations and have no guaranteed income, which creates challenges to meet professional salaries. Staff shortages may mean that hospices have to limit the number of patients they can care for. With the advent of the HIV pandemic, patient numbers at hospices have increased and hospice services include prevention strategies, treatment support, holistic palliative care, poverty alleviation, food security and care of orphaned and vulnerable children⁵.

The social problems resulting from HIV/AIDS include unemployment and child-headed households. Hospices provide holistic care which involves responding to patients needs, so that addressing these social problems has become a significant part of hospice care.

Pain relief

A report for World Hospice and Palliative Care Day 2007, published by Help the Hospices for the Worldwide Palliative Care Alliance, states that access to pain relief is an essential human right.

Research shows that pain can be controlled with careful assessment and management of pain, addressing psychosocial and spiritual factors that impact on the pain experience and using relatively inexpensive oral medications. Pain that is difficult to control, such as neuropathic pain in HIV, can still be improved through the WHO⁶ approach to pain management which describes using non-opioid medication for mild pain, weak opioid for moderate pain and strong opioids such as morphine for severe pain.

However there is inadequate access to morphine and other opioids for pain relief in many parts of the world. Many people are being denied adequate pain relief – the majority (but not all) of these people are in developing countries. In South Africa, current legislation restricts opioid prescription to doctors. In the light of shortage of doctors

and the need to provide care for seriously ill patients in the home this logistically restricts access to pain medication for these patients. However, the South African Nursing Council and civil society are working on regulations to allow suitably qualified professional nurses to prescribe and administer medication up to Schedule 6, which includes opioids.

The World Health Organisation has recommended that all nations should have a national policy for the implementation of palliative care services, that the care of people with life limiting illnesses should stand equal to all other health issues. In 2002 a group of palliative care educators met in Cape Town and produced the Cape Town Declaration which states that:

Palliative care is the right of every adult and child with a life limiting disease; appropriate drugs including strong opioids, should be made accessible to every patient requiring them in every sub-Saharan country and at all levels of care, from hospitals to community clinics and homes.⁷

Policy change will only occur if governments understand the importance of palliative care and the need to increase access to drugs for palliative care within their countries. Although the South African Government has long recognised the administration of morphine for pain relief as an important aspect of primary health care, terminally ill patients do not have access to pain relief as a right and their ability to get pain relief depends on the accessibility of doctors and pharmacists.

Licensing of suitably qualified professional nurses to prescribe palliative care medication would improve access to pain relief for patients at home. Currently nurses are concerned that they are not able to deliver true palliative care since they cannot prescribe the appropriate analgesics.

Current prescribing legislation constitutes a failure of the South African Government to take steps to progressively realise the right to health care services. It could be considered discriminatory, as the effect of this omission – not legislating for nurses to prescribe the necessary pain medication – is that poor people in rural areas, with limited access to health care services, bear the brunt of it. This leads to unnecessary suffering and painful deaths which is in breach of the constitutional right of human dignity contained in Section 10 of the Constitution.

South African dispensing laws have failed to consider the question of access to medication for home bound patients.

In effect patients who have no access to transport or who are too weak to attend clinics do not have access to pain control medication. Patients desperate for pain control in the last days of life have died in transport attempting to get to the clinic. This certainly amounts to death without dignity.

Pain control is achievable when patients are cared for by practitioners trained in pain management and palliative care. In the light of current constraints in human resource capacity within the health sector, the solution for adequate management of patients with life-threatening illness in the home is the licensing of palliative care professional nurses to prescribe Schedule 6 medication.

International experience in Uganda⁸ has proven that there are benefits in allowing nurses to prescribe morphine which results in better quality of life for the patient and their family members and a peaceful and dignified end to life for those patients who are in fact dying. This benefits not only patients and their families, but also the clinical teams who previously had to witness the intense and unnecessary suffering of patients.

Possible solutions for access to medication

Once the patient is referred to a hospice, they continue to be cared for in partnership with the referring public health facility according to the Integrated Community Health Care (IHC)⁹ model. Ideally, they should continue to access their medication through the referring public health facility. However, the medication prescribed on referral to a hospice will often need to be changed based upon the symptoms. Patients at this stage are often bed bound and will not be able to return to a public health facility for collection of medication. Therefore, the ideal would be a partnership with the hospice whereby:

- a. Hospices could order drugs through the district health system if they have a licensed pharmacy.
- b. An agreement could be reached between the hospice and the local clinic or district hospital allowing the hospice doctor or professional nurse to prescribe palliative care medicines on the patient's file.
- c. Primary health clinics ensure that the essential medicines for palliative care be available for dispensing to hospice patients.

Recommendations/areas of concern

Pack size is understandably limited at a clinic level, but the availability of some bulk items for palliative care patients needs to be considered e.g. paracetamol, ibuprofen, sienna and loperamide. The pack sizes for clinic level are

specified in the Provincial Code List, not in the primary health care Essential Drug List¹⁰. There is therefore scope for regional flexibility with respect to pack sizes, which clinics may stock.

Paediatric formulations are useful for the elderly, weak and those with swallowing difficulties, as well as for children. These formulations should be available to conform with a principle of the essential drugs concept, namely that essential drugs should be available at all times, in the proper dosage forms.

The difficulties in achieving access to Palliative Care

Geographic challenges

Geographical barriers to access to care in rural areas are a big problem. The infrastructure is bad e.g. poor road conditions and poor or non-existent public transport. Home-based teams cover large, sparsely populated areas, the conditions become worse if it is raining, the roads become muddy and mushy, the rivers overflow and in some instances poor bridge construction means that the team cannot cross the river and reach the patients.

Some of the areas do not have proper physical addresses, which makes it difficult for the palliative care team to find the patient after he/she has been referred to a hospice. Distance is another issue; the team has to cover a large area, which limits the number of patients who can be seen per day and adds to the cost of care because of transport costs.

Cultural and social challenges

Seriously ill people or their families are often reluctant to contact hospice at an early stage because of the stigma attached to their illness. There may be denial about the illness and difficulty in accepting the severity of the illness until a very late stage.

People may delay contacting hospice because they fear stigmatisation should a hospice vehicle be seen outside a home. Other people may see illness as a business opportunity, taking advantage of vulnerable people by offering assistance in return for financial gain, whereas hospice services are provided free of charge.

Other families prefer to care for their loved ones on their own, which can result in delayed referrals to palliative care. Families may not be aware of the support and information on home-care that is available to assist them.

Many communities associate hospice with death and are reluctant to approach hospice as this means acknowledging that their loved one may be dying.

Different languages used in South Africa present a problem, as communication between care-givers and patients with different languages or from diverse racial groups present barriers to proper care.

Some cultures believe that talking about death invites death in. Other cultures do not openly express grief, which then leads to them not accepting their illness, which in turn leads to a delay in accessing palliative care.¹¹

Religious beliefs can also act as a barrier to care, as some people believe in the power of prayer to the exclusion of medical care. Sometimes the delay in bringing the patient to a medical practitioner means that by the time he/she is consulted, it is too late for medical intervention.

Gender considerations

Women have a nurturing role in society and this extends to women being the custodians of the family's health. Men often distance themselves from caring for the very ill as they see it as a woman's task. This puts a burden on the female members of the family.

Women are more accustomed to attending health facilities, and health facilities are open during working hours which favour the people at home. Health care staff, especially in the nursing profession, are more often women and men may be reticent in taking health problems to a female health care provider. Hospices have found good uptake of services when male carers and counsellors are employed and an after-hours VCT and ARV clinic is more accessible to men in the town.

In the HIV setting, women often test at antenatal clinics and their husbands/partners choose not to test. Under these circumstances women are offered ARVs earlier and men often present with more advanced HIV and lower CD4 count at first testing with more severe opportunistic infections. Some male patients do not present for care themselves, but send their wives and then take their wife's medication.

Child-headed households

Child-headed households experience the problem of not knowing whom to approach for assistance if one of the children is not well. Children in child-headed households tend to have many roles, they are expected to care for their siblings, make sure that there is something to eat and have

other responsibilities so that the child replaces the parent within the family relationship. The responsibility is an onerous one on a child and is made worse if one of their brothers or sisters is on medication, they may get the dosage incorrect or forget to ensure that medication is taken.

Poor compliance is a big problem in these families. Transport is problematic as the responsible child in many cases needs to ensure that siblings are transported to clinics or hospitals. The lack of transport money or somebody to accompany the child to health facilities is a reality. The guilt associated with caring for a terminally ill family member contributes to the isolation that children experience as heads of households. The fear of being ostracised from your community and peers leave long-lasting emotional scars.

Traditional healers

Traditional healers are still very much a part of everyday health care for many South Africans. They are respected by the communities they live in and therefore find it relatively easy to treat community members. Traditional Healers have a long history of providing treatment and care and therefore understand the patient culture within their community. In remote rural areas where western health facilities are few and far between, traditional healers are available and able to care for patients.

Once it has been established that there is no curative care and the patient is removed from the hospital setting, the traditional healer may be involved as the sole provider of health care and acts as adviser to the patient and the family. In Africa, 80 per cent of people consult traditional healers.¹² Some patients have a mixed belief in both traditional and western medicines. Others opt for only contacting the palliative care team after they have already contacted traditional healers. The HPCA has encouraged a dialogue with traditional healers in order to collaborate and provide the best possible care to patients and families.

There needs to be a move towards the empowerment of traditional healers, informing them of palliative care techniques and practices. This will certainly strengthen the sector as well as increase the quality of care which patients receive from traditional healers. The WHO made this call when in 1978 they declared at Alma Ata, USSR that traditional healers should be recognised and should be part of the primary health team.

According to Mr Tobias Mkhize, Traditional Complementary Healer Support Manager, eThekweni Municipality, who works closely with traditional healers based in KwaZulu-Natal, patients must have the freedom of choice to attend both western and traditional medicine,

it is important that the patients are not discouraged from going back to the traditional healers after attending western facilities. In the eThekweni district some of the traditional healers have developed referral forms, which they use when they refer patients for western medicine. According to Mr Mkhize the traditional healers' concern is that nurses and doctors don't take these referral forms seriously;

they ignore or don't acknowledge them and patients are not treated.

To improve the access of care, the eThekweni Department of Health (eThekweni District) have developed a pilot project to employ a professional nurse to work with both traditional healers and western medicine teams.

CASE STUDY

I went to see a patient in a township; he was referred to me by a concerned neighbour. He had a small shack between two low cost houses.

He was lying on a mattress outside in the sun. He lived with his mother, who was an informal trader – selling sweets outside a local school. She left a cup of water and a plate of porridge covered with a plate in the shack for him. When I arrived it was about 10h00, and the food and water were untouched. He tried to sit-up to greet me, but was groaning with pain and grimacing. I told him to lie down. After a chat, I learned that he had been a long distance driver, and had contracted HIV. He learned of this 11 months before, but had never attended a clinic or hospital.

He complained of diarrhoea, and severe abdominal pain and headaches, On clinical examination, he was emaciated, dehydrated and his abdomen was swollen and tender to touch. His liver was palpable and hard. He was unable to walk without assistance. He said he waited for his neighbour if he needed to go to the toilet, although I noticed the mattress was soiled. His voice was strained and he battled to talk. He had Panado tablets from the clinic, which his mother had obtained for him; these did not help (possibly because of the liver damage?).

Without intervention, it was clear to me that this man would die. The most difficult thing to witness was the extreme pain he seemed to experience. Advice was given to the neighbour regarding hygiene and managing the diarrhoea. Nutritional advice was also given to improve his physical condition, his mother appeared to care for him, and tried her best to keep him comfortable in her absence. What he needed was pain control.

I had to travel back to the office to consult a doctor telephonically for a script. The doctor was unavailable. The next day, when I spoke to the doctor he was unwilling to prescribe anything stronger than Brufen without seeing the patient, and was unwilling to travel to the patients' home. I travelled out to the patient again, arming him with a referral letter to the CD Clinic at the government hospital, asking for pain medication – preferably an opiate. I also gave him travel money (from hospice).

The following week, at the home visit, the patient was not there, The neighbour came out to greet me. The patient had passed away on the weekend. He had not been able to make the trip to the hospital; they had tried taking him to the taxi rank in a wheelbarrow, but he cried with every bump, so much so that they carried him home before even reaching the rank. The neighbour had been with the patient and his mother throughout the last two days. She said he groaned a lot and didn't want anyone to touch him because his whole body hurt so badly. In the last few hours he became still and unresponsive (possibly a coma), and then taken a deep breath and died.

I knew that had I had morphine syrup, I would have been able to relieve him of some, if not most, of his pain. The agony he and his mother and neighbour went through are unimaginable and could have been prevented if only I could have given him something stronger for his pain. I felt hopeless and deeply saddened by this case, I have seen a number of cases similar to this, and every time I wonder, am I really helping at all?

An examination of Case Law dealing with Access to Care

On 11 June 2007 the Department of Health dismissed 41 health care workers in Khayelitsha for participating in the public sector strike. Before the industrial action started on 1 June, Khayelitsha's clinics were already seriously understaffed. The strike exacerbated the staff shortage, but the dismissals made it impossible for at least two of Khayelitsha's three health facilities to offer adequate care. At all times before the dismissals in Khayelitsha, essential services were being provided and workers who participated in industrial action did so peacefully without any destruction to property or endangering patients lives.¹³

Most of the workers were dismissed from Site B Clinic. On 31 May, workers at this facility, in conjunction with the facility manager, agreed to a skeleton staff system that ensured that treatment for patients with chronic illnesses would still be available, as well as emergency services.

Following a meeting with some of the remaining health workers at Site B, the Treatment Action Campaign (TAC) together with five patients who use Khayelitsha's health services proceeded with urgent litigation in the Cape High Court to compel Government to restore health services in Khayelitsha, including re-instating the dismissed workers. The first applicant was TAC. The second to sixth applicants were Sizeka Maya, Nomafrica Velem, Neliswa Nkwali, Norute Nobola and Fanelwa Angel Gwashu. They described how they are dependent on Khayelitsha's clinics to treat their and their children's chronic illnesses which include HIV, TB and asthma.

The Cape High Court granted an interim interdict ordering the Western Cape Provincial Government and the Ministers of Health and Public Works and Administration to restore the reasonable functioning of health care services in Khayelitsha. It found that they acted unconstitutionally by violating the rights of patients. The evidence of doctors and nurses who work in Khayelitsha demonstrated to the Court that service provision had been affected because of the dismissals.

Judge Desai in his judgment found that the dismissals in Khayelitsha disrupted the delivery of health services and that this constituted a violation of the constitutional right to access to health care service.

In the 1998 case of *Soobramoney vs the Minister of Health* (KwaZulu-Natal, 1998(1) SA 765), the Constitutional Court said that the Government was justified in restricting access to kidney dialysis, because of the high cost of this type of care, and the need for the Government to have reasonable plans for spending its health care resources.¹⁴

In 2002 the now well known Treatment Action Campaign case dealing with the provision of drugs for the prevention of mother-to-child transmission of HIV/AIDS came before the Constitutional Court. TAC launched legal action to demand broader access to Nevirapine in 2001. In December 2001, Judge Botha of the Transvaal High Court *declared that 'a countrywide MTCT programme is an ineluctable obligation of the state'*. The High Court's order instructed the Government to allow Nevirapine to be prescribed where it was 'medically indicated' and where, in the opinion of the doctors acting in consultation with the medical superintendent, there was capacity to do so. The High Court also ordered the Government to develop 'an effective comprehensive national programme to prevent or reduce MTCT' and to return to the court with this programme for further scrutiny before 31 March 2002.¹⁵

The Minister of Health appealed this ruling directly to the Constitutional Court. Unanimously, the Constitutional Court decided that the Government's policy had not met its constitutional obligations to provide people with access to health care services in a manner that was reasonable and took account of pressing social needs.¹⁶ The Court said that the Government was wrong to restrict access to the antiretroviral medicine, Nevirapine, that is effective in reducing the risk of mother-to-child HIV transmission. It ordered the Government to make the medicine available to pregnant women living with HIV.

Access to treatment for prisoners

Since October 2005 the TAC and the AIDS Law Project (ALP) have assisted HIV positive inmates at Westville Prison in acquiring ARVs that have routinely been refused to them by prison authorities. Situated in KwaZulu-Natal, one of the provinces most severely affected by HIV/AIDS, Westville Prison had steadfastly prevented TAC or other NGOs from conducting treatment workshops, treatment literacy programs, or any form of HIV awareness training. When this case came before Court, Judge Pillay cited various precedents where Government has been forced to uphold the rights of prisoners dating as far back as 1912, and concluded relatively early on that there was no dispute and that these fifteen prisoners as well as any others in similar condition should have been receiving ART. The Government was given leave to appeal this decision but the court ordered the interim operation of the Court order.¹⁷

On 18 August 2006 the State filed an urgent application before Judge Nicholson for a hearing to appeal this interim execution order. To date the State has not pursued the appeal and the parties have attempted unsuccessfully to resolve the matter without further litigation. The interim order needs to be implemented unless and until such time

as it is successfully appealed by the State. South Africa has 237 prisons with twelve to thirteen sites currently accredited to provide ART thus the majority of prisoners in South Africa are not likely to have access to ART in prison.

Summary

Section 27 of the Constitution of the Republic of South Africa gives every person the right of access to health care services. The Health Act aims to promote the health of the inhabitants of the Republic so that every person shall be enabled to attain and maintain a state of complete physical, mental and social well-being.

The South African Patients' Rights Charter states that 'Everyone has the right of access to health care services that include:

provision for special needs in the case of ... patients in pain ... palliative care that is affordable and effective in cases of incurable or terminal illness'

In order to realise these rights there needs to be Government policy regarding palliative care for all persons living with life-threatening illness, training of all health care professionals to provide palliative care and access to essential palliative care medications.

Palliative care should form part of comprehensive health care and should be integrated into the formal as well as informal health care sector.

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