Editorial

A health system that violates patients' rights to access health care

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Editor

During the apartheid era, disproportionate resource allocation policies by the state at a systemic level resulted in poor-quality and inferior services being available to black people. Healthcare services were not spared the discriminatory constraints of apartheid rule. As a consequence, there were treatment delays, drug and bed shortages, and black South Africans in psychiatric hospitals were refused sheets, made to sleep on the floor, and given inferior foods. In many instances, black women were made to leave healthcare facilities immediately after giving birth. No doubt the state had the resources to provide better care, but because of apartheid racist policies did not.[1]

In 1996, with the promise of the constitutional realisation of socio-economic rights for all citizens in this country, expectations ran high, in particular for South Africa's disadvantaged black citizens, the majority in the country. Section 27, which is relevant to healthcare, food, water and social security, places an obligation on the state to take reasonable legislative and other measures within the resources available to achieve the progressive realisation of each of these rights, hence introducing limits to socio-economic rights. However, an unqualified, uncompromising right contained within section 27 is that of treatment during emergencies – *'No one may be refused emergency medical treatment.'*[2]

With the promise of section 27, what are the lived experiences of citizens in the democratic South Africa of 2012? An unjust social order, leading to industrial action, demonstrations and civil unrest, is the order of the day. Poor service delivery or a lack of service delivery is a major contributor to the problems. Instead of a progressive realisation of socio-economic rights, the experience has been a progressive infringement of these rights, as evidenced by the progressive deterioration of most services. The trajectory in the evolution of our democracy is somewhat regressive rather than forward moving when viewed through the lenses of socio-economic rights. No doubt the state has the resources to provide better services, but our democracy fails to do so because it is plagued with inefficiencies, incompetent management, corruption and lack of accountability. And sadly it is the indigent, and black groups in the main, that are victims once more.

The *General Report on the National Audit Outcomes 2010 - 2011* reveals that national and provincial government departments and public entities wasted and misused more than R20 billion of taxpayers' money over the past financial year (2010/2011), with a 12% increase in wasteful and fruitless expenditure by provincial departments as compared with 2009/2010.[3] In the context of healthcare, a barrage of reports have underscored the decline in services, which impacts directly on the quality of care received by patients. The inability to provide quality care by healthcare practitioners, including emergency medical treatments, has been due to a lack of supplies, as suppliers of services have not been reimbursed – for example, in February this year in Gauteng province the debt to suppliers was close to R3 billion,[4] and some suppliers that were owed substantial sums had already sought legal counsel in this regard.[5] Several suppliers were driven to bankruptcy and forced to shut down. Despite the disruption in services, the State of the Province address delivered during the same month elaborately described the strides that were being made, with no acknowledgement of the crisis.[6]

Non-payment of suppliers is not restricted to Gauteng province. Limpopo was unable to pay public sector workers and catering companies, and as a consequence was placed under administration in January.[5] Section 100 of the Constitution is specific to national intervention in provincial administration. Where a province cannot or does not fulfil an executive obligation in terms of the Constitution or legislation, the national executive may intervene by taking appropriate steps. This includes issuing a directive to the provincial executive, stating the steps necessary to meet its obligations and assuming the responsibility for the relevant obligation in that province to the extent necessary to maintain essential national standards or meet established minimum standards for the rendering of a service.[2] It is ironical that while suppliers were not paid in Gauteng, there was a R2.2 billion under-spend in health in the province in the last financial year.[7] The question that begs an answer is why this province has not been placed under administration in terms of the Constitution's section 100.

The implications for patients are profound. They increasingly suffer preventable associated morbidity and mortality, including stillbirths, not only because of the lack of essential basic services but also because the situation impacts negatively on the training of healthcare practitioners. Age-old codes and declarations that emphasise the practitioner's calling are challenged, in the main because of faulty political systems. Healthcare practitioners find themselves in a quandary as a result of this violation of patients' rights to access health care by the health system itself. They are required by their codes to regard the health of their patients as of paramount importance. They are required by their calling not only to further the best interests and positive welfare of their patients, but also to advocate for the fulfilment of their patients' rights in the

face of abuse and infringements. Their problems are compounded when their professional conduct is constrained by powerful actors in the state. They face pressures and threats of professional harm. And the reality is that personal consequences can be quite severe. Practitioners may modify their practice to accommodate the constraints in the system, and in doing so become complicit in human rights violations despite their commitment to professional ethics and human rights. In addition, passive acceptance, a common form of complicity,[1] is seen quite often. Most unacceptable is the fact that some doctors who practise in both the public and private sectors apply glaringly different standards of care for equivalent medical conditions, depending on where they are treating a patient. On the other hand, many doctors in the private sector work willingly in poor public facilities in order to provide some service to those in need – they should be applauded for this.

Professionalism as it pertains to the healthcare practitioner demands a social pact in which society and its institutions expect to be guaranteed certain standards of practice in exchange for professional status, power and prestige. It is because of this social pact that practitioners have a particular obligation to respect and further their patients' rights.[1] Moreover, the social pact extends to include licensing and professional organisations that should take the lead in supporting practitioners when they are challenged in meeting their human rights obligations.

The time has come for collective action by practitioners, the South African Nursing Council, the Health Professions Council of South Africa, the South African Medical Association and other professional bodies. A combined voice advocating for a realisation of section 27 is required. This would go a long way in contributing towards the just and humane social order that South Africa ought to be.

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