

“Don’t send your sick here to be treated, our own people need it more”: immigrants’ access to healthcare in South Africa

Theresa Alfaro-Velcamp

Abstract

Purpose – *Asylum seekers, refugees and immigrants’ access to healthcare vary in South Africa and Cape Town due to unclear legal status. The purpose of this paper is to shed light on the source of this variation, the divergence between the 1996 South African Constitution, the immigration laws, and regulations and to describe its harmful consequences.*

Design/methodology/approach – *Based on legal and ethnographic research, this paper documents the disjuncture between South African statutes and regulations and the South African Constitution regarding refugees and migrants’ access to healthcare. Research involved examining South African jurisprudence, the African Charter, and United Nations’ materials regarding rights to health and health care access, and speaking with civil society organizations and healthcare providers. These sources inform the description of the immigrant access to healthcare in Cape Town, South Africa.*

Findings – *Asylum-seekers and refugees are entitled to health and emergency care; however, hospital administrators require documentation (up-to-date permits) before care can be administered. Many immigrants – especially the undocumented – are often unable to obtain care because of a lack of papers or because of “progressive realization,” the notion that the state cannot presently afford to provide treatment in accordance with constitutional rights. These explanations have put healthcare providers in an untenable position of not being able to treat patients, including some who face fatal conditions.*

Research limitations/implications – *The research is limited by the fact that South African courts have not adjudicated a direct challenge to being refused care at healthcare facility on the basis of legal status. This limits the ability to know how rights afforded to “everyone” within the South African Constitution will be interpreted with respect to immigrants seeking healthcare. The research is also limited by the non-circulation of healthcare admissions policies among leading facilities in the Cape Town region where the case study is based.*

Practical implications – *Articulation of the disjuncture between the South African Constitution and the immigration laws and regulations allows stakeholders and decision-makers to reframe provincial and municipal policies about healthcare access in terms of constitutional rights and the practical limitations accommodated through progressive realization.*

Social implications – *In South Africa, immigration statutes and regulations are inconsistent and deemed unconstitutional with respect to the treatment of undocumented migrants. Hospital administrators are narrowly interpreting the laws to instruct healthcare providers on how to treat patients and whom they can treat. These practices need to stop. Access to healthcare must be structured to comport with the constitutional right afforded to everyone, and with progressive realization pursued through a non – discriminatory policy regarding vulnerable immigrants.*

Originality/value – *This paper presents a unique case study that combines legal and social science methods to explore a common and acute question of health care access. The case is novel and instructive insofar as South Africa has not established refugee camps in response to rising numbers of refugees, asylum seekers and immigrants. South Africans thus confront a “first world” question of equitable access to healthcare within their African context and with limited resources in a climate of increasing xenophobia.*

Keywords *Human rights, Immigrants, Constitutional law, Asylum seekers/refugees, Healthcare access, Immigration law*

Paper type *Research paper*

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Introduction

In November 2014, in the IOL news, Journalist Zelda Venter reported that a 27 year-old Ethiopian man was refused dialysis at the Helen Joseph Hospital in Johannesburg and died soon after because as a non-South African citizen, he did not qualify for an organ transplant (Venter, 2014). On-line postings expressed a fear of foreigners taking advantage of limited South African resources. One person commented: "Ethiopian president should take note of this. Don't send your sick here to be treated, our own people need it more." Another person posted: "So now we must treat the whole damn world for free?????" (Venter, 2014). This story, unfortunately, is not unique. The following paper shows that despite an international human rights discourse embedded in the 1996 South African Constitution, South African statutes and regulations diverge from the Constitution with respect to healthcare access. They confuse healthcare providers and arguably reflect xenophobic attitudes. There are many explanations for this divergence such as the ongoing tensions between native South Africans and foreign nationals and the perception that foreigners deplete South African resources. This confusion is furthered by the South African nomenclature that refers to most immigrants as "refugees" whether they have achieved this status or not. The term refugee refers to someone lawfully present in South Africa who is fleeing political or social persecution in his/her home country. A person applies for an asylum seeker permit (Section 22 permit) that can be renewed various times before the Department of Home Affairs (DHA) makes an actual refugee status determination and receives a Section 24 permit[1]. In this context, refugees become conflated with economic migrants, internal South African migrants, medical tourists, and wealthy foreigners with emergency care needs. Furthermore, the South African Constitution and South Africans, more generally, do not consistently differentiate the legal status among immigrants for everyday purposes ranging from health access to informal labor.

The 1996 South African Constitution, Section 27, states that "everyone has the right to have access to health care services," yet there is a dearth of information on how refugees, migrants, and other non-citizens exercise this right to healthcare in South Africa (Constitution of the Republic of South Africa, 2013, p. 14). How South Africans negotiate their socio-economic rights, and access to healthcare in particular, in the post-apartheid era has been adjudicated in the courts resulting in precedents such as giving mothers and new-born children with HIV free anti-retroviral medications (*Minister of Health v. Treatment Action Campaign*)[2]. As of this writing, however, the Constitutional Court has not handled a specific case relating to foreign nationals; the court has not articulated whether asylum seekers, refugees, and economic migrants may exercise the right of access healthcare and under what conditions. The absence of case law leaves a discursive space for hospital administrators[3] to become interpreters of the law and has arguably led to the deaths of two foreign nationals in a tertiary hospital in the Western Cape Province in South Africa. These cases show how the law hampers healthcare providers (such as doctors and nurses) and compels them to engage civil society organizations (CSOs) for assistance. Hospital administrators, for their part, confront limited resources and must weigh progressive realization against individual cases. (Progressive realization is the idea that the state pays for what it can and makes future efforts to change where socio-economic rights for everyone cannot be achieved currently.) This legal divergence between the constitution's socio-economic aspirations and South African statutes and regulations places healthcare providers in an untenable situation.

That socio-economic rights have not been systematically applied to foreigners does not seem particularly surprising in the global climate of xenophobia. Yet, South Africa's progressive Constitution which enshrines socio-economic rights makes the interaction between foreign nationals and native-born citizens significant with regard to public health and progressive realization. The premise that the state works within its means affects the core idea of the Bill of Rights that socio-economic rights are for everyone, suggesting all citizens in the post-apartheid period, rather than all residents in South Africa. Because access to healthcare has not yet been applied to everyone consistently and systematically lacuna exist in law and practice. To clarify, this paper focuses on access to healthcare in acute circumstances where treatment is costly and not readily available. By contrast, it appears that access to routine healthcare for pregnant immigrants and their children under six-years old has been functioning in the Western Cape as stipulated by the National Health Act of 2003, unless there are medical complications (CSO personal communications with author February 12, 2015).

This paper begins from a legal rights perspective with an overview of how international law informs South African laws with respect to asylum seekers, refugees and immigrants' access to healthcare. The overview leads to a discussion of the national and provincial contexts. In particular, the Department of Home Affairs' management of asylum seekers, refugees, and cross border migrants – including the DHA's own self-reported 89 percent rejection rate of asylum seekers – leaves thousands in legal limbo because they are either awaiting an appeal to be heard or they have received notification of a final rejection of their refugee claim, giving them 30 days to leave the country (Chief Directorate Asylum Seekers Management, Immigration Services, 2014). The inefficiency of DHA's processing of appeals and overstays after final rejections causes confusion about which asylum seeker permits are valid and which have expired. This effectively empowers hospital administrators to decide who is legal and worthy of limited resources and who, for practical purposes, may and may not access to healthcare. The paper concludes with case studies showing the untenable situation for doctors who seek to honor their Hippocratic Oath while trying to obey South African law and international norms as they confront patients of uncertain, undocumented and/or liminal status.

The author uses an interdisciplinary approach informed by social science, public health, and legal scholarship. This paper was initiated as an effort to integrate knowledge from scholarly and community-based work in 2014-2015 conducted as a volunteer in the UCT Refugee Rights Clinic and with the Adonis Musati Project (AMP). It is informed by legal research, communications with physicians about past, deceased patients, and permission from AMP to use information from a de-identified client file. The case study of Cape Town and South Africa speaks to increased interest in migration studies about mixed migrants and access to healthcare, and the doctors and nurses caught between the law and their professional obligations (Van Hear *et al.*, 2009). How South Africa navigates its legal framework can be instructive to other nation-states weighing progressive realization and humanitarian needs.

Defining refugees

According to the 1951 United Nations Convention Relating to the Status of Refugees (also known as the Refugee Convention), a refugee is someone who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country” (UN General Assembly, 1951, Ch. 1, Art. 1). The 1951 UN definition of a refugee lays out the terms for a nation-state to grant someone refugee status. However, only if a state recognizes them as such can refugees invoke rights to the basic entitlements of a host country. Moreover, although the 1951 Refugee Convention states in Article 5 that “nothing in this Convention shall be deemed to impair any rights and benefits granted by a Contracting State to refugees apart from this Convention,” the 1951 UN Refugee Convention appears silent on the right to access healthcare.

The *UNHCR Handbook 2011* is also quiet with regard to the right to healthcare. In terms of scope of responsibility, paragraphs 62-64 of the *2011 UNHCR Handbook* do, however, mention the blurring between economic migrants and refugees which is relevant to the South African context. These paragraphs state, “what appears at first sight to be primarily an economic motive for departure may in reality involve a political element, and it may be the political opinions of the individual that expose him to serious consequences, rather than his objections to the economic measures themselves” (UNHCR, 2011, paragraph 64). The *UNHCR Handbook* does not expand nor advocate for a reconsideration of the refugee definition explicitly, but it could be read as a basis for a state to more broadly interpret the category of refugee.

In tethering refugees and access to human rights, a 2008 UNHCR report entitled, “Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas,” describes how the access to healthcare and public health, more generally, vary by a refugee-camp setting as compared to a non-camp setting. The report notes, “the public health role of UNHCR is more complex and less well defined in non-camp settings” (UNHCR, 2008). The dispersal of a refugee population in a host country warrants a different access-to-health analysis than a refugee-camp situation (see Toole and Waldman, 1997). In the case of

South Africa, refugees, asylum seekers, and immigrants integrate into society and use health clinics and hospitals as native South Africans (Coovadia *et al.*, 2009). Thus, the barriers to access healthcare are often rooted in a lack of understanding of how healthcare works in South Africa, differences of language and culture, progressive realization, and confusing legislation.

Access to healthcare as a human right for refugees and immigrants in international law

Although there are many international laws that help to inform those working with refugees and public health, there is a lack of specificity applicable to immigrants. Specifically, state parties who have signed international treaties are only obligated to abide by refugee rights (and immigrant rights) to access to healthcare in the context of the states' domestic laws. Therefore, states are not obligated to provide services, such as healthcare, if the domestic context does not direct it to do so. The variation among state parties on the right to access of healthcare could be explained by the difficulty of trying to motivate states to implement domestic laws regarding resource allocation. Thus, although the human rights discourse includes refugees and their right to access healthcare, the question of immigrants receiving access to healthcare has been more difficult. Recent scholarship in public health has tried to address how undocumented immigrants access healthcare in Europe; however, it is a cumbersome task because of the lack of reliable numbers of the undocumented population (Biswas *et al.*, 2012).

The doctrines of the WHO, the UN, and the Organization of African Unity on the right of access to healthcare bear on the South African case. In theory, human rights apply to everyone residing in a state's territory, regardless of citizenship or migratory status; however, progressive realization addresses the practical limitation of states not being able to pay for adequate health services for everyone. As a starting point, the 1946 Constitution of the World Health Organization includes the right to healthcare as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Constitution of the WHO, 1946). According to Brigit Toebes, "the right to health covers a range of health-related issues; [...] the right to health care may therefore be considered part of the right to health" (Toebes, 1999, p. 19). The 1948 Universal Declaration of Human Rights does not, however, explicitly address the right to health. Rather Article 25(1) of the Declaration states, "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family" (Gross, 2007, p. 293). The notion of a right to health was first recognized in Article 55 of the United Nations Charter which states, "[...] the United Nations shall promote (b) solutions of international economic, social, health, and related problems [...]" (United Nations, 1945, Ch. IX). The Constitution of the World Health Organization aimed to include health of "all peoples" – "The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States" (Constitution of the WHO, 1946).

Building on these early international doctrines, the United Nations' International Covenant on Economic, Social, and Cultural Rights (ICESCR) of 1966 Article 12 strived to establish healthcare for everyone, and it states:

- (1) The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- (2) The steps taken by the States Parties [...] shall include those necessary for:
[...]
 - d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Although the International Covenant on Economic, Social and Cultural Rights (ICESCR) served as an aspiration for the South African Constitution of 1996, South Africa did not ratify the Covenant until January 2015 (South African Human Rights Commission, 2015)[4]. With South Africa's ratification, the Covenant is binding and will likely affect the continued development of socio-economic rights jurisprudence (Currie and de Waal, 2014, p. 570). The enforcement of the Covenant lies with the UN Committee on Economic, Social and Cultural Rights, which was established in 1987 to monitor the compliance of states and their obligations under the Covenant (UN Economic and Social Council, 2000, paragraph 9; Hathaway, 2005, pp. 511-12, n1094)[5]. To date, 164 other states have ratified the Covenant.

In addition to the Covenant, the UN Committee on Economic, Social and Cultural Rights states, “health is a fundamental right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity” (UN Economic and Social Council, 2000, paragraph 1). The Committee continues to recognize the financial limitations of this right[6]. This is important to South Africa because it undergirds the notion of progressive realization whereby states only pay for what they can and make strides to improve in the future.

In bridging health rights and economic constraints, the General Comment No. 14 asserts, “the right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect, protect and fulfill” (General Comment No. 14 2000, paragraph 33). States parties are offered guidance on how to implement these obligations, and are encouraged to seek international cooperation and to look to the Alma-Ata Declaration. The Alma-Ata Declaration refers to the 1978 International Conference on Primary Health Care in which health was deemed, “[...] a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector” (Declaration of Alma-Ata, 1978).

Although General Comment 14 mentions violations of the obligations in paragraphs 46-52, the General Comment does not indicate the level of recourse available to those who suffer in these violations[7]. Legal Scholar Danwood Chirwa adds that “the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (Maastricht Guidelines) stipulate that a state party violates the minimum essential level of the right to health if a significant number of its people are deprived of ‘essential primary health care’” (Chirwa, 2003, p. 549). In short, there are no meaningful enforcement mechanisms, and these guidelines and the General Comment are not legally binding.

A regional framing of human rights and healthcare access presents similar contours. The Organization of African Unity Convention of 1969, for example, lacks a provision that explicitly addresses access to healthcare. Like the UN Convention, the OAU Convention focuses primarily on status determination of refugees, rather than defining refugee entitlements in host countries. Another critical regional instrument is the African Charter on Human and Peoples’ Right (Article 16). It states that, “every individual shall have the right to enjoy the best attainable state of physical and mental health [...] [and] State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick” (Organization of African Unity, 1981). Chirwa indicates that the African Charter gives direct entitlements to individuals or groups rather than to the states. The ICESCR, on the other hand, emphasizes rights in the framework of economic, social, and cultural rights “as ideals to be attained depending on the availability of resources, as opposed to civil and political rights, which are deemed to be precise and immediately claimable” (Chirwa, 2002, p. 15). In examining the applicability of the African Charter as international law, Currie and de Waal (2014) call it a “soft law” instrument (p. 573). In sum, the African Commission and UN legal instruments provide interpretations of socio-economic rights to healthcare, but with little guidance for implementation and enforcement.

Among international doctrines relating to access to healthcare, the Convention on Elimination of all Forms of Racial Discrimination (Article 5.e [iv]) calls for the “right to public health, medical care, social security, and social services” (UN General Assembly, 1965); and the UN Convention on the Rights of the Child, Article 24 states:

- (1) [...] State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. [...]
- (4) State Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries (UN General Assembly, 1989).

Both of these international doctrines provide socio-economic rights and the right to access healthcare; yet progressive realization is acknowledged and accommodated in the developing world contexts, such as South Africa. Reflecting on the importance of accommodation, refugee scholar James Hathaway asserts, “the affirmative element of the right to health is by and large

subject to the usual duty of progressive implementation” (Hathaway, 2005, p. 511). Although socio-economic rights such as access to healthcare are acknowledged and the state parties are making progress to realize such rights (Currie and de Waal, 2014, p. 580), where rights are not or not yet realized, vulnerable people can and sometimes do die. As James Hathaway opines, “even states with insufficient resources must nonetheless give priority to the realization of the right to health without discrimination of any kind” (Hathaway, 2005, p. 512, n1096). The spirit of trying to accommodate socio-economic rights in light of the constraints is thus incorporated within international doctrines and South African law.

South African legal framing

The 1996 South African Constitution is the authority that healthcare providers and CSOs look to in evaluating access to healthcare for refugees, asylum seekers, and immigrants. South African legislation, however, differs from the Constitution and causes confusion.

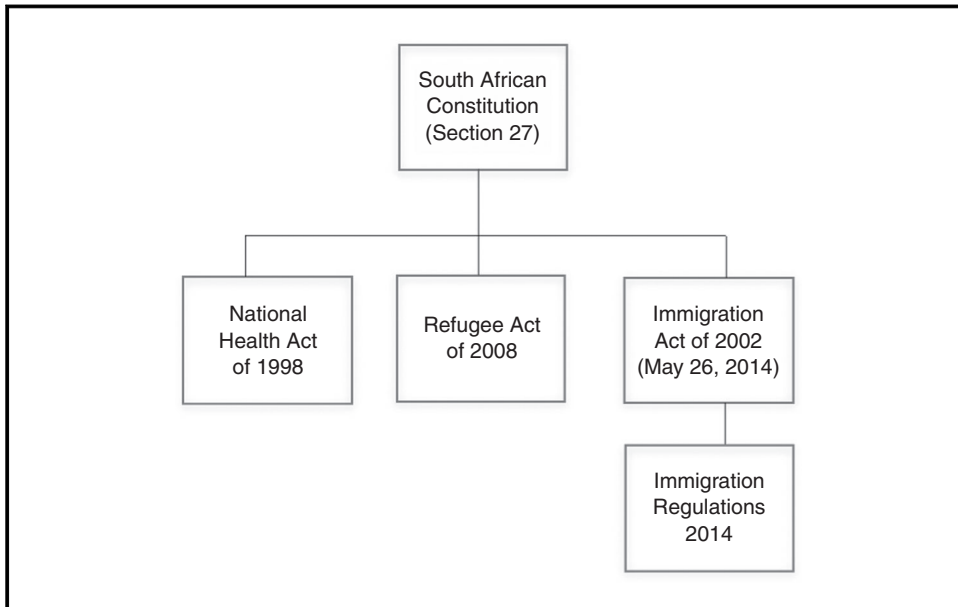
In certifying the final Constitution, the Constitutional Court noted that the Bill of Rights states: “everyone shall enjoy the universally accepted fundamental rights and civil liberties, which shall be provided for and protected by entrenched and justiciable provisions in the Constitution [...]” (Certification of the Constitution of the Republic of South Africa, 1996, paragraph 48). The Constitutional Court also explained that the drafters of the Constitution, “[...] were avowedly determined [...] to create a new order in which all South Africans will be entitled to a common South African citizenship in a sovereign and democratic constitutional state in which there is equality between men and women and people of all races so that all citizens shall be able to enjoy their fundamental rights and freedoms” (Certification of the Constitution of the Republic of South Africa, 1996, paragraph 48 n45). As the idea of “everyone” is described, it appears the initial intent was for South African residents of all races to be entitled to socio-economic rights, but not necessarily foreign nationals.

It is also important to note that the term citizenship is used sparingly in the 1996 Constitution – appearing mainly in Section 19 on political rights and in Section 20 on citizenship explicitly. Throughout the Bill of Rights and large parts of the Constitution, the term “everyone” is used to describe the rights enshrined to those residing in South Africa. And this stems from the history and institutionalization of racism. Judge Mahomed in *Makwanyane* wrote: “The past was redolent with statutes which assaulted the human dignity of person on the grounds of race and colour alone [...] and the Constitution expresses in its preamble the need for a ‘new order [...]’” (*Makwanyane*, 1995 paragraph 65)[8].

This new order includes socio-economic rights for everyone, such as the right to access health and emergency care. Article 27 (1) (a) states: “everyone has the right to have access to health care services [...] 2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights; 3) No one may be refused emergency medical treatment” (The Constitution of the Republic of South Africa, 1996). Emphasis on “everyone” in the above quote raises the question of whether the original framers of the Constitution nevertheless or inadvertently meant to include foreign nationals among those who have socio-economic rights or not. The “Constitutional Assembly, Constitutional Committee Sub-Committee Draft Bill of Rights, Volume One: Explanatory Memoranda (entire document embargoed until October 9, 1995),” states that, “what is ‘reasonable’ will be judged against the capacity and available resources of the state.” Under Section 20 on Health, the Draft Bill of Rights reads, s(1)(a) “everyone has the right to health care which the state must take responsible and progressive measures to improve and make accessible to all; [and] (2) ‘any measures taken by the state in terms of s(1)(a) must include, at least necessary medical attention for anyone without adequate resources[9].’” Again, the key provision links the availability of resources to providing access to healthcare to everyone.

Under the Constitution, there are three main laws and immigration regulations that guide South Africans on questions relating to refugee and migrants’ access to health and emergency care. Among these, the National Health Act of 1998, the Refugee Act of 2008, and the Immigration Act 13 of 2002 should better specify the intent of the South African Constitution with respect to socio-economic rights and access to health and emergency care. The laws are not consistent and create contradictory and confusing situations for patients and medical practitioners (Figure 1).

Figure 1 Primary South African laws on access to healthcare



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

protecting, respecting, promoting and fulfilling the rights of:

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

Populations distinctly missing from the vulnerable groups list include asylum seekers, refugees, and indigent immigrants. Arguments that immigrants, especially those without papers, should be considered vulnerable because of their unclear legal standing extend to contexts such as health access (McLaughlin and Alfaro-Velcamp, 2015). The lacunae in South Africa associated with healthcare access place medical providers, such as doctors and nurses, in difficult situations when evaluating a patients' needs and the levels of care that patients can afford. The National Health Act has language in the statute that suggests an aspiration to care for all South Africans. Accordingly the National Health Act 2003 3(1) provides:

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

The South African Legislature passed the Refugees Act 130 of 1998 in which Chapter 5, Section 27 (g) states, "a refugee is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time" (South African Refugees Act 130 of 1998, 20)[10]. The Refugees Act, consistent with the National Health Act, reinforces the notion that refugees are also entitled to basic health services; but it does not explicitly refer to asylum seekers or other foreign nationals.

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

[...] when possible, any organ of state shall endeavor to ascertain the status or citizenship of the persons receiving its services and shall report to the Director-General any illegal foreigner, or any person whose status or citizenship could not be ascertained, provided that such requirement shall not prevent the

rendering of services to which illegal foreigners and foreigners are entitled under the Constitution or any law (Immigration Act 13 of 2002, Section 44 substituted by Section 42 of Act 19 of 2004, p. 51).

Furthermore, the immigration statute indicates under Section 49 (4) that, “anyone who intentionally facilitates an illegal foreigner to receive public services to which such illegal foreigner is not entitled shall be guilty of an offence and liable on conviction to a fine.” (Immigration Act 13 of 2002, Section 44 substituted by Section 42 of Act 19 of 2004, p. 52). This provision points to the divergence between the Constitution and Immigration Law with respect to healthcare access.

The Immigration Act 13 of 2002 clearly contradicts South African doctors’ Hippocratic Oath in which doctors swear to uphold “the health of patients and the health of their communities,” and “[...] will not permit considerations of age, gender, race, religion, ethnic origin, and sexual orientation, disease, disability or any other factor to adversely affect the care” to be given (University of Cape Town, 2014). Doctors and nurses are thus compromised in their ability to provide care to their patients if they adhere to South African immigration law. And they are not well positioned to confront a rule of law that may itself be illegal in South Africa’s Constitutional democracy (Mattei and Nader, 2008; Fassin, 2001; Ticktin, 2011).

To further compound the situation, hospital administrators (i.e. the medical superintendents and managers in medical services), in trying to meet budget restrictions, have sometimes conflated indigent migrants with medical tourists. Medical tourists are those foreign nationals with the means to pay for their healthcare services. According to the Immigration Act of 2002, Immigration Regulations 16(1); these medical tourists need the following documentation before entering South Africa: letter from a registered medical practitioner, estimated costs of treatment, proof of financial means to cover medical costs, valid return flight tickets, and proof of sufficient financial means or provisions for the costs indirectly related to the treatment (Immigration Regulations 2014, Section 16 (1): 25). Doctors and healthcare providers have become easily confused by the legislation demarcating asylum seekers, refugees, migrants, and medical tourists who are all seen to be competing for limited South African resources. The divergence between the Constitution’s socio-economic aspirations and the statutes places healthcare providers in an untenable situation.

Law in action

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

In 2012, the International Organization for Migration (IOM) produced “Your Guide to Government Health Services: Learn how clinics and hospitals work, Understand your rights as a patient, Know what health services expect from patients” to explain how clinics treat common health needs and problems, and hospitals are for serious emergency treatment that cannot be treated at the Clinic (International Organization for Migration, 2012, p. 5). The 36-page, how-to guide also cites a 2007 Department of Health letter indicating that “refugees and asylum seekers, with or without a permit, that do access public health care should be assessed according to the current means test” (IOM, 2012, p. 15). This is quite different than medical tourists who enter South Africa to receive specific medical treatment and are expected to pay in full their medical costs. Medical tourists need proof of financial means to cover medical costs and proof of sufficient financial means or provisions for the costs indirectly related to the treatment (Immigration Regulations 2014, Section 16 (1): 25). The IOM Guide also clearly states, “you cannot be refused medical treatment just because you do not have an identity document” (IOM, 2012, p. 22). This also extends to refugees and asylum seekers, with or without a permit, who are exempted from paying for antiretroviral treatment (ART). Although this IOM Guide is legally accurate, it has received varied reception in terms of supporting consistency in patient admissions. Patients, healthcare providers, and CSOs continue to struggle to navigate an ambiguous space between theory and practice.

According to the Western Cape Government in examining total admissions to hospitals, foreign nationals represented only 1.6 percent (Western Cape Government Health Department, 2014, p. 10). This figure is artificially low because hospital admissions require that postal codes in the Western

Cape be given for follow-up, thereby reducing the patient's ability to list two addresses (that is his/her local address in the Western Cape and his/her place of origin address). As Nesbert Zinyakatira from the Directorate of Health Impact Assessment of the Western Cape Government Health indicates, "[...] from the limited data available and small studies that have been undertaken, it would be safe to assume that there will be an increase in the use of public health services by people from outside the province [...]" (Western Cape Government Health Department, 2014, p. 11). As the Western Cape faces the "quadruple burden of disease – pre-transitional diseases and poverty related conditions, emerging chronic diseases, an extremely high burden of injuries and the HIV/AIDS epidemic – the migrants are also affected by this, hence they will ultimately end up using public health facilities that are in the province thereby increasing the strain on the services" (Western Cape Government Health Department, 2014, p. 11).

The divergence between the guarantee of access to healthcare and patients' legal standing is evident under the Western Cape provincial guidelines and the efforts of Cape Town City officials to secure funding for resource-strapped clinics and hospitals. In the Western Cape Provincial Government's "2030: Road to Wellness" and Western Cape Government Health Annual Report – 2013, officials describe their efforts to provide wellness in the context of "burdening diseases." Migrants, foreign nationals, and changing demographics are scantily noted; yet for Cape Town 2030 under key demographic trends, the report notes that Cape Town's population will continue to grow each year because of migration (Western Cape Government, 2014, p. 157). The document states, "the nature and extent of migration, both internal and trans-national, are the most prominent unknown variables. The number of refugees and displaced persons is likely to increase adding to Cape Town's population growth through migration" (Western Cape Government, 2014, p. 157). The concern with migration (internal and cross-border), foreign nationals, and government's limited resources plays out in access to health and emergency care. In examining Cape Town's projected trends from 2010-2030, a 2010 "Demographics Scenario Discussion Paper," noted, "the number of refugees and displaced persons is likely to increase possibly adding to Cape Town's in – migration into the future" (Strategic Information Strategy and Planning Directorate, 2010, p. 15).

This intersection between asylum seekers, refugees, and immigrant rights in South Africa and access to health and emergency care is in some measure driven (and sometimes hampered) by the healthcare providers themselves. Laurel Baldwin-Ragaven, Jeanelle de Gruchy and Leslie London have advocated for accountability to their patients, and the need to "recognise and empower vulnerable groups. [...] Health professionals need to be sensitive to the needs not only of vulnerable patients but also vulnerable groups" (Baldwin-Ragaven *et al.*, 1999, p. 211). According to the National Public Service Access Survey conducted in 2007-2008 with 3,000 international migrants in Cape Town, Durban, Johannesburg, Port Elizabeth, and Pretoria (Vearey, 2011, pp. 127-8) by the Migrant Rights Monitoring Project (coordinated by the African Centre for Migration and Society (ACMS) at the University of Witwatersrand), "thirty percent of respondents who reported ever needing healthcare experienced challenges when attempting to access public healthcare services" (Vearey, 2011, p. 128). This builds on earlier work from the National Refugee Baseline Survey in 2003 in which 17 percent of African asylum seekers and refugees who sought emergency services were refused access, and of these cases, 45 percent indicated that administrative personnel at public hospitals were identified as those refusing care. The 2003 study also showed that 26 percent of asylum seekers and refugees were refused medical service because they were unable to pay, while 14 percent argued that the medical facility did not accept their documents (Belvedere *et al.*, 2008, pp. 272-3, n37). Subsequently, the asylum seekers and refugees relied on their own income to pay for services or would approach friends and family for assistance (Belvedere *et al.*, 2008, p. 273, n46). Although these two studies are limited by their sample size and do not necessarily reflect the current situation, they do illustrate the divergence between the intent of the South African constitution, the right to access to healthcare, and the practices.

On September 19, 2007, the Department of Health issued a "Revenue Directive – Refugees/Asylum Seekers with or without a Permit" that was circulated to Provincial Health Revenue Managers and HIV/AIDS Directorates to remind them of the refugees and asylum seekers' rights according to the South African Constitution Article 27 and the Refugee Act, Act. No. 130 of 1998.

This 2007 Revenue Directive was given to many asylum seekers, refugees, and undocumented immigrants when seeking access to healthcare. A copy of the Revenue Directive presented to healthcare facilities seemed to resolve many healthcare access issues. Fatima Khan and Tal Schreier describe the Health Department's Directive of 2007 as corresponding to Hathaway's notion that refugees, particularly those in the less developed world, have the right to "essential primary health care" (Khan and Schreier, 2014, pp. 228-9; Hathaway, 2005, p. 513). Although the 2007 Revenue Directive illustrates the department's attempt to align with the Constitution with respect to basic healthcare access in clinics, there is evidence that challenges persist. For one Zimbabwean woman with an asylum seeker permit, she was denied antiretroviral treatment for six months (November 2014-March 2015) by a Cape Town clinic because she was a foreigner. (Whether this was due to xenophobia or lack of resources is unclear.) Eventually, a doctor at a tertiary hospital intervened and she has been able to receive her medication. (Interview with author September 11, 2015 in Phoenix, Cape Town, South Africa).

In the Gauteng province, access to healthcare issues seem to receive more widespread attention as evidenced by the establishment of the Migrant Health Forum in 2008 and its ongoing work. Scholars at the ACMS and CSOs have been pushing for the recognition of migrant health issues and established the Migrant Health Forum to circulate guidelines on how to advocate for basic healthcare rights, and how to document complaints and difficulties in accessing healthcare (Vearey, 2011, 2014).

João and Joy[11]

The stories of João and Joy represent the growing number of indigent foreign national patients in Cape Town, both with and without legal status, who face grave medical conditions and need access to health and emergency care. In both situations, a hospital administrator denied them admission for care because of the cost of the treatments each needed. Both died as a result of not receiving adequate, timely care.

In 2010, João, a 27 year-old patient from Angola was denied life-saving treatment in Cape Town and died, wrote his attending physician (letter on file with author June 3, 2014). In a district hospital on October 25, 2010, he had signs of severe aortic regurgitation and was treated with diuretics and vasodilator therapy. João was then transferred to a tertiary hospital for work up for aortic valve replacement. The cardiology unit declined to assess João because it was their understanding that they could not provide healthcare to a foreign patient until the Medical Superintendent had given approval. He did not receive the replacement and died shortly thereafter.

In corresponding with João's doctor, a "Protocol for the provision of Health Services to Foreign Nationals" dated December 13, 2010 from the tertiary hospital was communicated. This circular appears to serve as a rubric for a doctor's care for foreign nationals seeking "elective" health services. However, the document also states under "General Principles," that care for "Foreign Nationals without permanent residency or refugee status," should proceed in accordance with "an evaluation of the optimal conservative treatment that can be provided" (Protocol, 2010, p. 2). It can be read to instruct conservation of health resources to the point of restricting physicians in the exercise their best medical judgments in treating foreign patients. The document further notes under "Admission and Treatment Protocol that other than an emergency, only those foreign patients specifically referred to the hospital and authorized by the respective Medical Superintendent [...] may be admitted and treated" (Protocol, 2010, p. 3). Three pages later, the document instructs the following:

4.5 Staff should be aware that if they do not comply with the procedures as outlined, and foreign patients are admitted without the necessary consent and deposit, the responsible staff member **may be held liable for the account [author's emphasis]**. This applies to Admin [sic] Reception staff who admit foreign patients, and doctors who arrange to admit a foreign patient without having obtained the necessary Manger: Medical Services authority (Protocol, 2010, p. 6).

Informal conversations with clinicians working at this tertiary hospital suggest that they have heard about such protocols from medical supervisors, but have never seen them (November 20, 2014, at the University of Cape Town, 2014). The 2010 protocol not only put legal authority into medical administrators' hand, but also puts doctors in an untenable position of trying to help

patients while ascertaining their patients' legal status. And the protocol makes the doctors financially liable for their decisions. João was a bona fide asylum seeker with a Section 22 Permit; however, his care was too costly, under progressive realization, for the hospital to provide the treatment João required.

The story of Joy came to the author's attention in August 2014. The AMP, a CSO located in Cape Town, e-mailed to inquire about how to get Joy papers in order to receive chemotherapy. Joy was a 26 year-old Zimbabwean, spoke no English, and entered South Africa without documents in 2012. She was diagnosed with Kaposi Sarcoma, a type of cancer related to her HIV infection. Kaposi is treatable with chemotherapy and patients can have a good prognosis; however, without treatment, Joy was likely to die. She was also diagnosed with HIV during her second pregnancy in South Africa, and had not taken anti-retroviral therapy. She first went to a district hospital and was referred to a tertiary hospital for chemotherapy. The tertiary hospital administered her first round of chemotherapy, but denied her second treatment on September 2, 2014 because the hospital administrator determined Joy had "no papers."

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

Joy's case illustrates the problematic nature of healthcare providers trying to determine someone's legal standing along with accessing appropriate medical treatment. Joy's doctors reached out to AMP for guidance and several individuals worked with Joy to provide her legal and medical assistance[12]. Joy self-identified as someone who came to South Africa looking for work – an economic migrant. As such, she could not attain legal status in South Africa (or would have to seek a work visa). In retrospect, her treatment did not seem to either use or conserve resources effectively. After she was denied the second round of chemotherapy, she ended up in the district hospital for several days. In speaking with the doctors, Joy's case was extreme, and it is difficult to ascertain the different possible outcomes with certainty. However, it is worth asking the question of whether an initial denial because of legal status truly yielded a cost savings in the end.

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

1. the health professional should recognize that refugees and immigrants have a human right to equal access to health care;
2. health professionals should not report immigrants who lack legal status to government authorities;
3. health professionals should not disclose information gained in the course of treatment of refugees to state authorities;
4. health professionals should not participate in medical examinations on behalf of the state for the purpose of refugee's eligibility for entering into the country [...];
5. health professionals should insist that medical services for refugees and immigrants, and examination for determination of status include interpreters; and
6. health professionals acting as evaluators in asylum procedures and court procedures should be aware of potential dual loyalty conflicts if providing treatment to refugees as well" (Physicians for Human Rights, 2002).

As physicians struggle to fulfill their obligation to treat everyone to a high standard of health services, they are also keenly aware of state policies that limit access to healthcare, through

“either legal requirements or limitations on reimbursements for services” (Physicians for Human Rights, 2002). The Dual Loyalty document aims to offer guidance and support for health professionals, but is constrained by law in action. In Cape Town and the Western Cape Province more generally, asylum seekers, refugees, and immigrants often encounter medical service providers facing dual, conflicting loyalties of patient care and respect for hospital constraints.

Conclusion

In conclusion, this paper shows a key divergence between the core idea of the South African Bill of Rights that grants socio-economic rights for everyone and access to healthcare for asylum seekers, refugees, and immigrants in South Africa. Across international doctrines, the human rights discourse increasingly calls on states to recognize responsibility extending to all peoples residing in a sovereign nation-state; progressive realization tempers this aspiration. By employing progressive realization within South African law, socio-economic rights for everyone are not secured and achieved. Relevant statutes have not been uniformly or consistently implemented causing a disjuncture between law and practice.

The legal authority has been misplaced onto hospital administrators who are not authorized to decide people's legal standing and should not do so. In the South African context, their practices violate human dignity for asylum seekers, refugees, and immigrants. As hospital administrators determine patients' status, doctors are largely unclear about whom they can treat and to what degree, and patients are not getting the healthcare that they are entitled to receive. Patients, many of whom have fled traumatic circumstances, would benefit from a more coherent and compassionate approach as has been argued about refugee and asylum seeker health needs in comparable contexts (Liebling *et al.*, 2014). Doctors in South Africa have turned to CSOs for clarification on the law and how they can help their patients.

Although no litigation is pending on refugee and migrant access to health and emergency care, this circumstance speaks more to the resources necessary to litigate than the need to advocate for change. As Jonathan Crush and Godfrey Tawodzera note, “South Africans [...] [ultimately] think that the right of access to health services should depend on citizenship and legal status. Only 50% of those surveyed felt that migrants who were legally in the country should enjoy the right to access social services (including health) and even fewer wanted to extend this right to refugees (27%) and undocumented migrants (13%)” (Crush and Tawodzera, 2013, p. 656). To return to the aspiration of the South African Constitution to grant everyone access to health and emergency care, perhaps future cases will have to tackle the notion of everyone receiving socio-economic rights. South Africans will have to answer the on-line commentator who scolded the Ethiopian President with the words, “Don't send you sick here [...]” by determining whether and how to help the sick immigrants who reside in South Africa with unclear immigration status. Until South African law and regulations change and reconcile progressive realization with humanitarian needs, healthcare providers will continue to be compromised in their ability to administer care and assist their immigrant patients.

Notes

1. An asylum seeker permit (Section 22) allows an immigrant to open a bank account, work, enroll his/her children in school, and access healthcare; however it is often short-term and requires renewal. The asylum seeker permit will have a functioning bar code that is linked to the South African National Refugee Database. The refugee status permits (Section 24) is similar to the Section 22 permits in its benefits. The author's on-going research on these permits suggests that some immigrants (whether asylum seekers, refugees, or undocumented immigrants) are purchasing these permits to be able to access healthcare for themselves and their families. This immigrant document project has received Ethics Approval by the University of Cape Town Faculty of Law Research Ethics Committee on February 26, 2015 (L02-2015).
2. *Minister of Health v. Treatment Action Campaign (No. 2)* 2002 (5) SA 721 (CC). The case involved government policy and the right to access healthcare. The use of the anti-retroviral drug Nevirapine (which could prevent mother-to-child transmission of the HIV virus) was limited to a number of research and training sites. The Courts ordered that Nevirapine be made available to infected mothers giving birth in state institutions and that the government present to the court an outline of how it planned to extend provision of the medication to its birthing facilities, country-wide.

3. Hospital administrators are often called medical superintendents or managers of medical services depending on the hospital, clinic, or professional group such as the South African Society of Medical Managers: www.medicalmanager.org.za/old/ (accessed October 4, 2015).
4. In developing socio-economic rights in the Bill of Rights, Sandra Liebenberg (as one of the advisors to the constitutional assembly) notes South African reliance on the United Nations' International Covenant on Economic, Social, and Cultural Rights (ICESCR) of 1966, Liebenberg (2010) notes "the Court has adopted a flexible approach to the sources that may be referred to during the process of interpreting the Bill of Rights [with respect to the use of international law]" (p. 103, 106).
5. The UN Committee on Economic, Social and Cultural Rights consists of 18 independent experts, elected by the Economic and Social Council of the UN for four-year terms. It does not have adjudicative functions; rather "its principal activities are the adoption of 'General Comments' on the content of the ICESCR and the examination of reports submitted by state parties. Since 1991, the Committee has been drafting a draft optional protocol to the ICESCR intended to permit communications (complaints) by individuals or groups alleging violations of their economic, social and cultural rights" (Currie and de Waal, 2014, p. 571, n35).
6. "The committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties" (UN Economic and Social Council, 2000, paragraph 5).
7. For a full discussion of implementation ICESCR reporting procedures, see Chapter III and Annex 2 Reporting Guidelines, Toebes (1999) pp. 367-71.
8. In *Lawyers for Human Rights and Other v. Minister of Home Affairs and other* (2004), Judge Yacoob argued that illegal foreigners had rights to human dignity, equality and freedom (paragraph 26); however access to healthcare was not made explicit in the judgment.
9. Professor Halton Cheadle shared with the author his original copy of "Constitutional Assembly, Constitutional Committee Sub-Committee Draft Bill of Rights, Volume One: Explanatory Memoranda (entire document embargoed until October 9, 1995)," 156 (Meeting with author April 30, 2014).
10. The Refugee Amendment Bill of 2007 (No. 29976 GG 07 June 2007) reiterates many of the principles of the 1967 Protocol Relating to the Status of Refugees (South African Refugees Act 130 ,1998, p. 20).
11. Patient names have been changed to respect privacy.
12. Author communications with doctors September 3, 2014, November 10, 2014 and November 12, 2014 – on file with author.

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