Chapter 8

The rights and duties of users of the health care system
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8.1 Introducing health care rights

At various points in their lives, every one of the more than 45 million people living in South Africa will need to access health care services. Today, all of them have a constitutional right to such access. But this was not always the case. Under apartheid, a privileged few – mainly white people – were entitled to access better-resourced public health services, as well as having access to expensive private health care.

For the majority of the population, the public health services offered were of a poor quality. A person’s racial classification had a significant impact on his or her ability to access health care services and the quality of health care provided. Many people’s rights were violated when they tried to access health care services, especially their rights to equality, dignity and privacy.

The end of apartheid has not seen an end to all of these inequalities. Many inequalities still exist and are strongly influenced by socio-economic factors such as class and income. In South Africa, race, class and income remains closely linked.

Since 1994, various laws and policies have been put into place to make sure that the rights of all people who need to access health care services are respected, protected, promoted and fulfilled. These laws and policies are specifically aimed at improving access to and the quality of public health services, as well as ensuring that more people are able to access private health care services.

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ACCESSING HEALTH CARE SERVICES IN SOUTH AFRICA TODAY

**In the Kaiser Health Survey (1999) conducted in South Africa:**
- 73% of participants stated that when last ill they had consulted a health care provider.
- Of those who did not go to a health service when they were ill, 66% said that they did not seek care because they could not afford the service. Other reasons for non-use of health care services included unavailability or inaccessibility of services (23%) and time involved in going to a health service (21%).
- Nurses attended to 66% of people using the public health system, whereas doctors treated 88% of people who accessed a private facility.
- South Africans visiting a private facility were much happier with the service than those attending a public facility.
The rights and duties of users of the health care system

**Users instead of patients**

The National Health Act refers to users instead of patients, clearly signalling that people who utilise health services are no longer to be regarded as passive recipients of a service for which they should be grateful. Instead, they are seen as people who choose to make use of a particular service and who are entitled to a certain standard of care and respect.

This chapter will focus on the key laws and policies that affect the rights of users of the health system. According to the National Health Act 61 of 2003, a user is a person receiving treatment or care in a health establishment, whether public or private. The term "user" also includes a child’s parent or guardian (or any other person authorised to act on the child’s behalf) if the person accessing treatment or care is a child. Where the user is incapable of taking decisions, his or her spouse or partner, parent, grandparent, adult child or sibling (or any other person authorised by law to make decisions on his or her behalf) will be regarded as a user. In this chapter, reference to a user is limited, referring only to the rights of the persons who access health services.

The laws and policies that form the focus of this chapter are as follows:
- The Constitution of the Republic of South Africa
- Patients’ Rights Charter
- Batho Pele Principles
- National Health Act
- Medical Schemes Act.

**In the HSRC’s South African National HIV Survey (2005):**

- 39.5% of people surveyed reported that they usually attend a public hospital for health care, 35.2% attend a public clinic or doctor, 8.9% attend a private hospital and 14.4% attend a private clinic or doctor. Only 1.1% of people surveyed reported that they use the services of a traditional healer.
- Race, income and location still determine access to public and private health care services. 84.2% of Africans use public health care services and 80.8% of whites use private health care services. People residing in poorer provinces are more likely to make use of public as opposed to private health care services. Most of the people surveyed from rural informal, urban informal and rural areas indicated that they made use of public health care services.
This chapter begins by explaining some of the rights people have when accessing health care services, followed by a focus on the specific duties of health care users in respect of such rights. It then considers the various available complaint mechanisms you can use to enforce your rights as a user of the health care system.
8.2 What rights do users of the health care system have?

This part sets out some of the key health rights provided for in laws, policies and court decisions. Where any of these rights have been violated, you should refer to the last part of this chapter, dealing with complaint mechanisms, for assistance.

There are two broad categories of users’ rights: rights in respect of health care services; and rights in respect of the health care system that is tasked with delivering such services. These can be further broken down as follows:

Health service rights, which include:
- rights regarding the health care services which a user is entitled to access;
- rights necessary for accessing health care services; and
- rights regarding the way users are to be treated when accessing their health rights.

Health system rights, which include:
- the right of access to information;
- the right to just administrative action; and
- the right to participate in decisions about the health care system.

There are significant overlaps between – as well as within – both categories. For example, the right to just administrative action can be used to challenge health systems concerns as well as a decision regarding the provision of a particular health care service to a specific user. In addition, the right of access to information regarding the availability of health care services (a right necessary to access such services) must be satisfied if a person is to be able to make an informed choice about which health service to access. Nevertheless, the categorisation is helpful in that it helps us to understand the complexity and breadth of users’ rights.

Health service rights

Access to health care services

The rights regarding the health care services in respect of which a user is entitled to access can be divided into four areas:
- the general right of access to health care services;
- the right to emergency medical treatment;
- rights of access in the public health system; and
- rights of access in the private health system.
Together, these four areas of rights set out what health services should be available, who should provide them and who should ensure that they are available. Importantly, they also consider the role of the state in dealing with each of these issues.

**General right of access to health care services**

Section 27(1)(a) of the Constitution provides that everyone has the right of access to health care services, including reproductive health care. As has already been discussed in chapter 2 dealing with the Constitution and public health policy, the right does not mean that government must provide free health services immediately to everyone. Instead, it must take appropriate steps to create an environment that makes it possible for people to access health services. Although people who access health services are often expected to pay user fees, these fees must be affordable to poor people. Where people cannot afford to pay anything, they may not be turned away from public health services.

This chapter does not explore the constitutional right in significant detail because this has already been done in chapter 2 of the handbook. Instead, it considers the impact of the Patients’ Rights Charter, the Batho Pele Principles and the National Health Act on that right. Simply put, the constitutional right of access to health care services is given expression in these three important documents. While only the National Health Act can be enforced directly, all three documents help to expand our understanding of the content and scope of the constitutional right.

In terms of the Patients’ Rights Charter, everyone has the right of access to health care services without discrimination, coercion or violence. In particular, the Charter states that:

- health care services include effective palliative care in cases of incurable and terminal illness;
- users have the right to choose a particular health care provider and health facility for treatment, provided that the choice is in line with prescribed service delivery guidelines;
- users have the right to be treated by clearly identified health care providers; and
- once a health care provider (or a health facility) has taken responsibility for a person’s health, he or she or it may not abandon that person.
Other than the Constitution itself, the most important source of health service rights is the National Health Act (“the NHA”). Although its focus is clearly on the public sector, particularly insofar as it deals with the structure of the health system, the NHA deals with access to health care services provided in both public and private health establishments. These matters are considered in further detail in this chapter in the two sections dealing with rights of access to health care services in the public and private health systems respectively.

The right to emergency medical treatment

Section 27(3) of the Constitution provides that no one may be refused emergency medical treatment. According to the Soobramoney judgment of the Constitutional Court, the purpose of section 27(3) is to ensure that treatment is not withheld in an emergency such as when a person suffers a sudden unforeseen health crisis and needs immediate medical attention. This includes, for example, being injured in a car accident, but does not extend to someone needing lifesaving treatment for an ongoing illness such as HIV infection.

A person in need of emergency medical treatment may not be turned away from a health establishment that is able to provide the necessary service if he or she is unable to pay for the service. However, the facility that provided the emergency care may demand payment from the user afterwards. Where a user cannot afford the service of a private health establishment, the facility should at the very least stabilise the user before transferring the person to a public health facility. Unless and until regulations are issued in terms of the NHA (which states that no health care provider, health worker or health establishment may refuse a person emergency medical treatment), facilities will find it very difficult – if not impossible – to claim reimbursement from the state in respect of emergency medical care provided to public sector users.

For a full discussion of the content of the right, see the discussion of Soobramoney in Chapter 2.

According to the Patients’ Rights Charter, users should receive emergency care timeously, regardless of their ability to pay for this service. In terms of the Promotion of Equality and Prohibition of Unfair Discrimination Act 4 of 2000 (“the Equality Act”), the refusal to provide emergency medical treatment to people on the basis of race, sexual orientation or any similar ground constitutes prohibited unfair discrimination.
The public health system consists of health care services that are delivered at preventative, primary, secondary and tertiary levels of care. Essential health services refer to the basic package of services to which everyone is entitled. The Minister of Health must define the content of the essential health services package after consultation with the National Health Council but this has not occurred at the time of writing. The NHA requires that such essential health services must be provided and must at the very least include primary health care services.

Government has committed itself to ensuring that people are able to access at least primary health care services. In particular, the NHA instructs public clinics and community health centres to provide free primary health care services for all except medical scheme members and beneficiaries, and persons receiving compensation for occupational injuries and diseases. Primary health care services refer to those health services prescribed by the Minister of Health as such. At the moment, the Department has released only a set of norms and standards for the provision of primary health care services, which provides some indication of services that can be expected at primary health care level. There is also an essential drug list (EDL) that lists the medicines that should be available to everyone.

To ensure that people are able to access primary health care services, government policy emphasises the management of health services at district level so as to improve access to health care services and health service delivery. Importantly, primary health care includes the following eight essential elements:

- Health education, including education on methods of prevention and control of disease.

CASE STUDY: RIGHT TO BE TAKEN TO HOSPITAL

In September 2004, Simon Mangaliso Radebe, aged 57, died on the street in the Johannesburg inner city after two paramedics, Johan Erasmus and Adriaan Craukamp, refused to take him to a hospital because he was “too dirty” for their ambulance. This violated his right to emergency medical treatment, as well as his rights to life, dignity and equality. The Johannesburg Emergency Management Services Tribunal found the two paramedics guilty of misconduct and dismissed them. The Health Professions Council of South Africa subsequently struck the paramedics off the roll in February 2006 for their failure to assist Mr Radebe.

The rights and duties of users of the health care system

- Promotion of an adequate food supply and nutrition.
- Adequate supply of safe water and sanitation.
- Maternal and child health care, including family planning.
- Immunisation against major infectious diseases.
- Prevention and control of locally endemic diseases.
- Appropriate treatment of common diseases and injuries.
- Provision of essential drugs.


Health services in general are those health services, including reproductive health care and emergency medical treatment, as contemplated in section 27 of the Constitution which are subject to available resources; basic nutrition and basic health care services for children as contemplated in section 28(1)(c) of the Constitution; medical treatment of prisoners as contemplated in section 35(2)(e) of the Constitution; and municipal health services.

Municipal health services include water quality monitoring, food control, waste management, health surveillance of premises, surveillance and prevention of communicable diseases, environmental pollution control, vector control, chemical safety and burials.

GIVING EFFECT TO THE CONSTITUTIONAL RIGHT OF ACCESS

Section 4(3)(a) of the National Health Act places a duty on government to provide free health services for pregnant and lactating women, and children below the age of 6, who are not members or beneficiaries of a medical scheme. This is in line with the general understanding that a child’s right to basic health services places a stronger duty on the state than the general right of access to health care services.

See Chapter 9 for more information on the health rights of children.

Where a public health establishment is not able to provide the necessary care or treatment, it must transfer the user to an appropriate public health facility that can provide the necessary service. In other words, health facilities cannot simply refuse to provide health services without making sure that the patient can receive these services elsewhere.

In addition to the nature of services to be provided in the public health system, the National Health Act also requires all health establishments and health care providers in the public sector to provide health services equitably and without unfair discrimination.
The Batho Pele Principles require all public health establishments to investigate all possible measures to improve access to services for the communities that they serve, especially in respect of those in greatest need. To ensure efficient and quality service delivery, public health establishments are required to develop a mission statement for service delivery and to develop (and display) performance indicators so that users can measure the nature and quality of the services provided.

**Rights of access in the private health system**

The majority of regular users of the private health system are members or beneficiaries of medical schemes. Those who are not medical scheme members or beneficiaries pay for their health care as out-of-pocket expenses, access services directly from their employers (workplace clinics or health care programmes) or make use of the services offered by the not-for-profit private sector (such as faith-based or NGO clinics). Public sector users also make use of the private sector from time to time, for example, by consulting private GPs or buying medicines from the local pharmacy.

This section of the chapter focuses on the rights of medical scheme beneficiaries as users of health care services, as set out in detail in the Medical Schemes Act and given additional force and meaning by the Constitution and the Patients’ Rights Charter. In this section the term “beneficiaries” includes the principal members as well as any dependants. It considers a range of issues that have a significant impact on access to health care services in the private sector:

- Prescribed Minimum Benefits;
- medical scheme membership; and
- waiting periods.

For more on the private health sector, see Chapter 6.

**PRESCRIBED MINIMUM BENEFITS**

Before the introduction of Prescribed Minimum Benefits (PMBs), the law allowed medical schemes to limit benefits. This often resulted in medical scheme beneficiaries running out of cover for certain conditions. If they needed to access health care services for such conditions, they could no longer rely on the medical scheme. Instead, they would have to pay out-of-pocket for the services, or else be “dumped” on the public sector, which was then expected to use its resources to provide health care services.
Regulations under the Medical Schemes Act now set certain PMBs that may not be limited. All medical scheme beneficiaries, irrespective of the benefit option they belong to and when they joined the scheme, are entitled – at the very least – to the benefits listed as PMBs, which cover almost 300 conditions. The introduction of PMBs has thus broadened access to health services by allowing coverage of services that were often previously excluded by medical schemes.

Example: Health care services now covered
- Treatment for HIV-related opportunistic infections (OIs) and sexually transmitted infections (STIs).
- Inpatient psychiatric care for a period of three weeks.
- Substance abuse and drug rehabilitation services.
- Care in attempted suicide cases.
- Infertility treatment.
- Imminent death comfort care.

Key Point: Designated service providers
As PMBs are regarded as an essential service, no monetary limits can be placed by medical schemes on the provision of this service. However, schemes can require that their members use only “designated service providers” when accessing PMBs. The Medical Schemes Act defines a designated service provider as a health care provider or group of providers selected by a medical scheme as the preferred provider(s) to provide to its members diagnosis, treatment and care for a PMB condition. This means that the medical scheme must reimburse – in full – the diagnostic, treatment and care costs of these PMBs in at least one health care establishment, which may include the public health system. But this does not mean that members are forced to use the public health service if the required service is not reasonably available there. The selection of designated service providers must be based on a clearly defined and reasonable policy which furthers the objectives of affordability, cost-effectiveness, quality of care and member access to health services.

In general, medical schemes are entitled to require that members seek permission from them before accessing treatment (called pre-authorisation). Importantly, authorisation for delivery in a public hospital of standard treatment for a PMB cannot be refused. Medical schemes may also not prohibit the initiation of treatment without pre-authorisation in the case of emergency medical conditions.
Medical schemes can expect beneficiaries to obtain treatment only from designated service providers if they make provision for this in their rules and inform beneficiaries accordingly. Even then, if a medical scheme does not appoint a designated service provider, beneficiaries are entitled to obtain a service listed in the prescribed minimum benefits from any provider, and the scheme must pay. Where beneficiaries do not use a designated service provider prescribed by their scheme, they may have to pay the costs themselves, unless they had to obtain the service involuntarily (in the case of an emergency) because there was no designated service provider nearby.

In addition to setting out the services and conditions covered by the PMBs, the regulations issued in terms of the Medical Schemes Act also deal with the level of care that members are entitled to access. In short, the minimum level of care to be provided for the specific condition is that which forms the current public hospital practice as set out in provincial and/or national clinical protocols.

**EXAMPLE: ANTIRETROVIRAL TREATMENT FOR PEOPLE LIVING WITH HIV/AIDS**

Medical scheme members now have the right to the following PMBs for HIV/AIDS:
- voluntary counselling and HIV testing;
- co-trimoxazole as preventive therapy;
- screening and preventive therapy for TB;
- diagnosis and treatment of sexually transmitted infections;
- pain management in palliative care;
- treatment of opportunistic infections;
- prevention of mother-to-child transmission of HIV;
- post-exposure prophylaxis following occupational HIV exposure or sexual assault; and
- medical management and medication, including the provision of antiretroviral (ARV) therapy and ongoing monitoring for medicine effectiveness and safety to the extent provided in the national guidelines applicable in the public sector. ARV treatment became a PMB only on 1 January 2005, many months after users of the public health system had already started to access it. The Department of Health’s *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* and the *ARV Treatment Guidelines* set out how ARVs should be prescribed in the public sector.

**Chronic conditions**

The Medical Schemes Act does not allow for the rules of a scheme to discriminate unfairly on a range of grounds including health status. This means, for example, that people with chronic conditions cannot be excluded from medical scheme cover, nor can they be charged a higher premium (rate) for cover. To
get around this, most (if not all) schemes made benefits for chronic illnesses available only in options that required higher contributions. They got away with this because they did not exclude such people from scheme membership, nor did they charge them higher premiums for accessing the basic package of services available to all scheme members. The Medical Schemes Act now prohibits benefits structures designed to ring-fence the chronically ill or older people into specific higher cost benefits. Such practices are also contrary to the principles of the Act, which is aimed at cross-subsidisation.

To address much of this problem, which had effectively limited chronic care to those who could afford to pay for it, the PMBs were extended in 2004 to include diagnosis, treatment and care for 25 of the most common chronic conditions, including:

- hypertension;
- cardiac failure;
- glaucoma;
- schizophrenia and bipolar disorder;
- asthma; and
- diabetes.

Treatment protocols for each of these chronic conditions have been published in the *Government Gazette*. The treatment covered by a scheme should be in accordance with – or better than – the standards published in these protocols.

**PMBs for mental health care users**

In terms of the Regulations of the MSA, where medical schemes limit coverage of specific diseases, or its formulary (a list of approved medicines), such limitations must be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability. The Council for Medical Schemes has stated that the failure to base formularies and protocols on evidence-based medicine is unlawful and *prima facie* unfair.

Although some psychiatric illnesses are covered as chronic conditions under the PMBs, benefits available by medical schemes for psychiatric illnesses falling outside of the list of chronic conditions remain limited. It has been argued that these limitations are neither evidence-based nor cost-effective and reflects a lack of understanding of psychiatric illnesses by those who design benefit packages. The same applies with regard to the limitations on medicines available for psychiatric illnesses in the formularies of medical schemes.
Example: Treatment of severe depression

Studies have indicated that effective treatment of patients with severe depression results in reduced visitations to doctors for non-psychiatric conditions.

In this regard, the accepted first line treatment to control symptoms of behavioural and psychological symptoms of dementia is atypical antipsychotics. Despite this, medical schemes will allow the use of only typical antipsychotics, which can also lead to patients developing Parkinson’s syndrome, as well as other side effects.

The Department of Health has released *Standard Treatment Guidelines for Common Mental Health Conditions*.

MEDICAL SCHEME MEMBERSHIP

There are two categories of medical schemes – open and closed. An open medical scheme is open to all members of the public, and must accept every person who wants to join the scheme and who can pay the premiums. Closed (or restricted) medical schemes are linked to a particular company or profession. An employee-based closed medical scheme must accept every applicant in the relevant employee grouping, as defined by the medical scheme’s rules.

Once you join a scheme, you are entitled to be provided with the following:

- written proof of membership, including:
  - your name and details;
  - name of the scheme and applicable benefit option;
  - date of entitlement to benefits, including details of any general and/or condition-specific waiting periods; and
  - details of any limitation on health care providers (such as designated service providers); and
- a free summary of the scheme’s rules.

*Government Employee Medical Scheme (GEMS)*

In January 2005 GEMS started functioning as a restricted public service medical scheme aimed at current and retired government employees. The introduction of GEMS was aimed at providing access to medical cover for all public servants including previously uninsured lower-income government employees. The scheme’s members consist of those public servants who choose to migrate from other medical schemes; public servants who were previously uninsured and can now afford medical cover; and all new public servants.
Example: Unfair medical scheme practices

According to the Council for Medical Schemes, the following are examples of unfair practices:

- complex, legalistic and user-unfriendly information on application forms, rules, and monthly statements;
- misleading, inaccurate or false advertising;
- provision of inaccurate, incomplete or misleading information by a call centre or other agents of the scheme;
- intrusive questions on application forms requiring information which is not material to membership of the scheme;
- insufficient information to beneficiaries on how to utilise the benefit system;
- non-communication of vital information regarding contributions, benefits, rights, pre-authorisation requirements, formularies etc.;
- focus of information provision primarily to urban and electronically literate beneficiaries;
- obtaining beneficiary medical information from providers without the explicit consent of those beneficiaries;
- failure to keep personal information of beneficiaries confidential;
- insufficient information in how to make complaints;
- late or non-payment of valid accounts.

POINTS TO REMEMBER WHEN SELECTING A MEDICAL SCHEME

- Make sure the scheme is registered with the Council for Medical Schemes, which publishes a list of registered schemes online at www.medicalschemes.com.
- Request information about benefits, contributions, limitations and exclusions from your selected schemes so that you can make an informed choice about the scheme that is best suited to your actual and anticipated needs.
- If using the services of an agent or broker, make sure that the person has been accredited by the Council for Medical Schemes – a list of accredited brokers is also available on the Council’s website.
- Contact the Council for Medical Schemes or legal service organisations (like the AIDS Law Project) if you are unclear about your rights in respect of membership.
Unfair discrimination

The Medical Schemes Act expressly states that no medical scheme may be registered if its rules unfairly discriminate against any person on one or more grounds, including race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health. The Council for Medical Schemes has specifically stated that the singling out of a vulnerable grouping belonging to a particular disease group and applying adverse conditions to that group is arbitrary and grossly unfair. For example, a scheme may not exclude a person from membership, change benefit entitlements or charge a higher premium, simply because he or she has HIV. Instead, premiums can be based only on the option or plan chosen, the member’s income and the number of dependants. Schemes may, however, give reduced rates for children.

CASE STUDY: SEXUAL ORIENTATION

In the case of Langemaat v Minister of Safety and Security 1998 (3) SA 312 (T), a police officer had applied to the Police Medical Aid Scheme (Polmed) to register her lesbian life partner as a dependant. Her application was refused on the basis that she and her partner were not married. At the time (as is still the case until 1 December 2006), the law did not allow for two persons of the same sex to be married. In addition, the Medical Schemes Act – which recognises the rights of lesbian and gay people to have their partners registered as dependants – was not yet law.

In its judgment, the Pretoria High Court ruled that parties to a same-sex union that has existed for years in a common home had a duty of support towards each other. It therefore held that a refusal to register the applicant’s partner amounted to unfair discrimination and was therefore unconstitutional. Although the state decided to take the matter on appeal, despite the ruling giving the applicant no more rights than would be recognised in the Medical Schemes Act, it abandoned its appeal shortly before the appeal was to be argued before the SCA in Bloemfontein.

Registering your dependants on your scheme

The Council for Medical Schemes says the following people can be registered as dependants of a member:

- spouse or partner, including same- and opposite-sex partners, and spouses in customary or religious marriages;
- children under 21 who are financially dependent on the member;
- children over 21 who are financially dependent on a member due to mental or physical disability;
- parent or sibling whom a member is legally liable to care for and support (for example where their parents are unable to maintain them); and
any other person recognised as a dependant by the rules of the scheme. Dependants have the right to continue membership after the death of the principal member until they choose to leave the scheme, provided that contributions are paid.

Late joiners
The Medical Schemes Act penalises adults who join medical schemes late in life by the imposition of a “late joiner penalty”. A late joiner is someone over the age of 35 who has never joined a medical scheme and does not include those who change one scheme for another. The later a person over the age of 35 joins a new medical scheme member, the higher the penalty imposed. However, the penalty may be imposed only on that portion of the contribution related to the principal member or adult dependant who is a late joiner.

Because the Medical Schemes Act mandates all schemes to admit any person as a member and to offer PMBs, regardless of health status or age, late-joiner penalties are used as a method to increase the numbers of young members. In general, young people are healthier than old people. If people join medical schemes when they are healthy, their contributions flow into common funds that can be used to cover the medical costs of those who are sick. Late-joiner penalties therefore provide an incentive for people to join schemes earlier in life, when they are more likely to be healthy. In this way, the contributions of healthy people are used to cross-subsidise the medical costs of those who are sick.

Terminating membership
Any member who wants to terminate his or her membership must give the scheme notice. Provided contributions are paid, the member is entitled to access benefits until the last day of membership.

Medical schemes may suspend or cancel membership where the member:

- failed to pay contributions, debts or outstanding accounts;
- submitted fraudulent claims or acted fraudulently (for example by buying toiletries on a medical aid card); or
- did not disclose their health status.

The Council for Medical Schemes has stated that it is unfair for a medical scheme to cancel or suspend membership on the basis of non-disclosure of a pre-existing condition to the extent that the beneficiary had no knowledge thereof at the time of joining.
With a closed or restricted scheme, membership may be terminated (by the scheme) on dismissal (including retrenchments) but not in the case of retirement. In open schemes, the scheme may not terminate membership for as long as the member continues to pay contributions, regardless of employment status.

WAITING PERIODS
There are two types of waiting periods that may ordinarily be imposed upon a new member or beneficiary of any medical scheme: a three-month general waiting period; and a 12-month condition-specific waiting period.

General waiting period
The general waiting period applies to all new applicants, who cannot claim any benefits in the first three months after admission to the scheme, even though they are making monthly contributions. The general waiting period can be avoided if a member makes an extra payment to the medical scheme. While schemes are not obliged to impose general waiting periods, they generally do.

Condition-specific waiting period
A medical scheme may require an applicant to provide the scheme with a medical report of any medical condition present at the time of the application for which medical advice, diagnosis, care or treatment was recommended or received in the previous 12 months. In the case of a pre-existing condition, the scheme may impose a condition-specific waiting period of not more than 12 months. But in the case of costs of confinement due to pregnancy, a scheme may impose a condition-specific waiting period of no more than nine months.

Applicable waiting periods

<table>
<thead>
<tr>
<th>Category</th>
<th>3-month general w/p</th>
<th>12-month conditional w/p</th>
<th>Application to certain PMBs</th>
</tr>
</thead>
<tbody>
<tr>
<td>New applicants or persons not members for preceding 90 days</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</table>


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<table>
<thead>
<tr>
<th>Category</th>
<th>3-month general w/p</th>
<th>12-month conditional w/p</th>
<th>Application to certain PMBs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants who were members for less than 2 years</td>
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<td>Yes</td>
<td>No</td>
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<tr>
<td>Applicants who were members for more than 2 years</td>
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<td>No</td>
</tr>
<tr>
<td>Change of benefits</td>
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<td>No</td>
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<tr>
<td>Child dependant born during period of membership</td>
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<td>No</td>
<td>N/A</td>
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<td>Involuntary transfers due to change of employment or employer changing scheme</td>
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<td>No</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Exceptions

Waiting periods are generally not applicable in respect of the PMBs provided by public hospitals or other designated service providers. Thus a rape survivor without HIV is entitled to access post-exposure prophylaxis within three months of having joined a medical scheme. Similarly, a person with HIV/AIDS is entitled to access ARV treatment whenever medically indicated, even if he or she knew of his HIV status at the time of joining the scheme.

In addition, waiting periods may not be imposed in other situations, including where:

- the applicant was previously a member or dependant of another scheme for a continuous period of at least two years, and he or she applies for membership within three months of the previous membership’s termination;
the applicant was previously a member or dependant of another scheme (for less than two years) and was involuntarily transferred due to a change in employment or where the employer changes the medical scheme of its employees;

- the application is for a change of benefit option within the same scheme; or

- the application is for a child dependant born during the period of membership.

**Rights necessary for accessing health care services**

Before a person is in a position to access the health care services to which he or she is entitled, whether in the public or the private sector, he or she must first know which services are available, obtain all relevant information about such services and be in a position to make an informed choice. In addition, knowledge of one’s health rights is very often a determinant of health care access. Only by guaranteeing these rights in respect of information can people’s rights of access to health care services truly be guaranteed and realised.

**Right to information about health rights and services**

Not only is the right of access to information integral to ensuring a transparent and accountable health system, but it is also an essential tool to be used to access information about the extent and nature of health services provided and one’s rights of access in respect of such services. The right is recognised in various provisions of the Bill of Rights, most obviously in section 32 of the Constitution, which states that everyone has the right of access to any information held by government, and any information that is held by another person and that is required for the exercise or protection of any rights.

In addition to section 32, the right is implicit in other constitutional provisions, such as the right of access to health care services (how can one access services without knowing of their existence?) and the right to bodily and psychological integrity (how can one make an informed choice about medical care without having access to the relevant information?). It has also been given force in a range of statutes, most notably (in the case of public health) in the form of the National Health Act (NHA). To enable people to utilise health services effectively, the NHA instructs the National Department of Health, provincial departments, district health councils and municipalities
to disseminate appropriate, adequate and comprehensive information on the health services that they provide.

In particular, the NHA expressly states that every user (or potential user) has the right to access information on:
- the types and availability of health services;
- the organisation of health services;
- operating schedules and timetables of visits;
- procedures for access to health services;
- procedures for laying complaints; and
- the rights and duties of users and health care providers.

In addition to the NHA, the right of access to information about health care rights and services is also recognised in the Patients' Rights Charter and the Batho Pele Principles. Whilst these are not legally enforceable, they do assist in a proper interpretation of the right and in providing the context within which the NHA is set to operate.

**Patients’ Rights Charter**

The Charter, for example, recognises that information is crucial for people to be able to enforce their other rights and therefore requires that all users of the health system should be informed of their rights. To give effect to the right, the Department of Health (DoH) has issued guidelines to primary health care facilities as the first points of entry for most people into the public health system. In terms of these guidelines, every clinic must display the Patients’ Rights Charter – in the relevant local languages – at its entrance, as well as the name, address and telephone number of the person in charge of the clinic.

**Batho Pele Principles**

The DoH guidelines also require that all health establishments display posters on the Batho Pele Principles. Communities need to be aware of the level and quality of public services they can expect, and should be given full and accurate information about the public services they are entitled to receive. In addition, communities should be informed:
- About the hours during which services are offered and when there are additional activities;
- That openness and transparency is important at national, provincial and local level; and
- About changes in government policy concerning the provision of services.
PROMOTION OF ACCESS TO INFORMATION ACT

Together, the Promotion of Access to Information Act 2 of 2000 (PAIA) – which is supposed to give effect to the constitutional right of access to information – and its regulations set out the various procedures and time periods that have to be followed in order to access information from the public or private sector. While perhaps not the starting point in relation to health care services (given the detailed provisions in the NHA, the Patients’ Rights Charter and the Batho Pele Principles), PAIA is nevertheless an important tool for accessing relevant information. In particular, it says that:

- an individual has the right to request any information in a record, and the public or private body then has a duty to provide the requested information unless there is a valid ground for refusing the request;
- the right to request information includes the right to obtain access to any record containing personal information about the requester;
- where a person requests information from a public body, it does not matter what the reasons are for the request; and
- where information is requested from a private body, it is important to show that the information is required for the exercise or protection of any rights.

To request a record from a public body, one must follow the procedural requirements set out in PAIA. Requests are made to the designated information officer of the public or private body by filling out a standard form setting out the requestor’s details and sufficient information to identify the records requested, as well as paying the required fee. There is a general duty on information officers to assist a requester to make a request for records, with PAIA setting out various time periods that public or private bodies must follow in replying to the request.

See Chapter 2 for more on PAIA and the general right of access to information.

Right to make choices about health care

Part of the right of access to health care services includes a right to make choices about health care. The right of access to information allows a person to properly exercise her right to make choices. Supporting this is section 12(2) of the Constitution, which states that everyone has the right to bodily and psychological integrity, which includes:

- the right to make decisions regarding reproduction;
- the right to security in and control over the body; and
- the right not to be subjected to medical or scientific experiments without informed consent.
For more information on the right to reproductive choice, see Chapter 10 on gender and health.

For more on informed consent and “experiments”, see Chapter 12 on rights, ethics and health research.

The central pillar of the right to make choices is the concept of informed consent, which our law has recognised for many years. In particular, the landmark 1923 case of *Stoffberg v Elliott* 1923 CPD 128 emphasised that any interference with a person’s body – such as a medical operation – that is not permitted by law or consented to is a violation of that person’s rights. A user does not waive his or her right to security of the person simply by going into hospital – express informed consent must still be obtained.

### CASE STUDY: *STOFFBERG v ELLIOTT*

In *Stoffberg*, the court considered an action for damages for assault after surgical treatment was performed on a user without specific consent. During a surgical procedure, for which informed consent had been obtained, the surgeon uncovered previously undiagnosed cancer of the penis. Knowing that the cancer could mean a life expectancy of only two years, the doctor amputated the patient’s penis to prevent the cancer from spreading. The patient brought an action for damages.

*Stoffberg* also makes the following points:

- By entering a hospital, a patient does not submit to any surgical treatment that the doctors consider necessary. Any surgical procedure performed without informed consent is an unlawful infringement of the right to personal security and entitles the patient to compensation.
- Informed consent must always be obtained, except in cases of extreme urgency where it is not possible to obtain consent because the patient is unconscious or otherwise unable to give consent, and the operation is necessary to save his or her life.
- The person performing the operation must confirm whether consent had been obtained. In this case, the doctor who performed the operation had assumed that consent had been obtained by the hospital.

In addition to *Stoffberg*, the right to informed consent has been given further content through the following:

- 1994 case of *Castell v de Greef*;
- 1996 case of *C v Minister of Correctional Services*;
- Patients’ Rights Charter;
- Health Professions Council Guidelines; and
- National Health Act.
CASTELL V DE GREEF

In Castell, a woman with a family history of breast cancer sued a doctor for medical negligence after performing surgery on her breasts. After discovering lumps in her breasts, the doctor recommended the removal of breast tissue to reduce the risk of cancer. Various complications occurred after the surgery that caused the patient pain and suffering, as well as additional medical expenses as a result of the need for further operations. The woman claimed that the doctor had failed to advise her of the 50% risk of complications in such procedures; that necrosis of the tissue was a recognised complication arising from such surgery which is difficult to treat; and that an alternative surgical procedure existed which would have reduced the risk of infection and necrosis. In the absence of this information, the woman consented to the treatment proposed by the doctor.

In this case, the court considered circumstances where a user’s right to informed consent has to be balanced against the health care provider’s interest in deciding what information is necessary to disclose. Emphasising the need for a user-orientated approach, which respects the user’s right to make informed decisions, the court held that even in situations where the doctor knows that a user would not consent to a life-saving operation if told about certain risks, it is nevertheless his or her duty to inform the user of these risks.

According to Castell v de Greef, the following must be satisfied before the requirements regarding informed consent have been satisfied:

- the consenting patient must be made aware of the nature and extent of the harm or risk that accompanies the particular surgical procedure;
- he or she must understand the nature of and consent to the possibility of the harm or risk; and
- the consent must be detailed, and apply both to the procedure and its possible consequences.

In other words, the health care provider must warn the patient of any material risk in the proposed treatment. A risk can be seen as material if, in the circumstances:

- a reasonable person in the patient’s position – if warned of the risk – would feel that it is important to have known about it; or
- the doctor is (or should reasonably be) aware that the patient – if aware of the risk – would think that it is important.
C V MINISTER OF CORRECTIONAL SERVICES

In this case, a prisoner (C) stood in a row of prisoners in the hospital passage. They were informed that a blood sample would be taken from them, which was to be tested for HIV and other sexually transmitted infections, and that they had the right to refuse to be tested. The court had to determine whether C’s informed consent had been obtained before the test. The court held that informed consent for an HIV test requires adequate pre-test counselling which includes providing the patient with information on the meaning of HIV infection; the manner in which HIV is transmitted; the nature of the test and the consent required; the social, psychological and legal implications of the test; and what was expected if the test result is positive. The patient had to be given time to consider the information before consenting to the test. In this case the court held that informed consent had not been obtained.

Key Point: National Policy on testing for HIV

In 2000 the Department of Health confirmed and elaborated on these guidelines in its National Policy on Testing for HIV. The notion of routine testing for HIV gained ground in South Africa in 2006. However, informed consent is still a requirement for testing.

PATIENTS’ RIGHTS CHARTER

The Patients’ Rights Charter gives further content to the concept of informed consent. In particular it provides as follows:

- a patient has the right to be given full and accurate information in order to be able to make a decision on testing or treatment;
- all necessary health information must be given to a patient in a language understood by the patient and any proposed treatment must be explained to the patient;
- patients are entitled to refuse treatment as long as this refusal does not endanger the health of others; and
- if a patient is unhappy with the medical opinion of a health care provider, the patient has the right on request to be referred to another health care provider for a second opinion.
HEALTH PROFESSIONS COUNCIL GUIDELINES

The ethical duties of health care providers when seeking informed consent are explained in detail in the *Health Professions Council Guideline for Good Practice in Medicine, Dentistry and Medical Sciences*, which states that:

- Health care providers should provide patients with sufficient information about their condition and the available treatment options, answer patients’ questions honestly and not withhold information.

- Obtaining informed consent is not an isolated event, but involves a continuing dialogue between the health care provider and patient that keeps the patient updated on changes in his/her condition, and the treatment or investigation proposed.

- Where a health care provider decides to withhold treatment, the reasons for doing this must be recorded in the patient’s medical record.

In addition, the *Health Professions Council Guideline on Seeking Patients’ Consent* states that:

- The health care provider who will provide the treatment or do the investigation has the responsibility to discuss it with the patient and obtain consent.

- Where this is not practically possible, the health care provider can delegate this task to a person who is suitably educated, trained and qualified, has sufficient knowledge of the proposed treatment or investigation and understands the risks involved.

- The principal health care provider (such as the surgeon in an operative procedure) must still ensure that – before starting any treatment – the patient was given enough time and information to make an informed decision, and that he or she has in fact given consent for the investigation or procedure.

NATIONAL HEALTH ACT

The requirements for informed consent, as set out in *Stoffberg, Castell and C v Minister of Correctional Services* (and as given further content in the Patients’ Rights Charter), have now been included in the National Health Act (NHA), which defines informed consent as:

- consent for the provision of a specified health service
- given by a person with legal capacity to consent
- who has been adequately informed.

Where a person other than the user him- or herself gives informed consent, the user must – if possible – be consulted before the consent is given on his
or her behalf. This is because all users have the right to participate in any
decisions affecting their health and treatment, even if they are not legally
capable of consenting.

In addition, the NHA states that users have the right to be informed by
a health care provider, in a language and manner that they understand, of
the following:

- their health status;
- the range of diagnostic procedures and treatment options generally
  available to them;
- the benefits, risks, costs and consequences of each option; and
- the right to refuse health services and the implications of refusing.

A user’s right to informed consent thus places a duty on a health care provider
to place the patient in a position where he or she is able to make an informed
choice.

In general, this information must be provided to every user who is capable
of understanding, even if he or she lacks legal capacity to give informed
consent. In certain exceptional circumstances, however, users do not have
to be informed of their health status. But this can occur only when there is
substantial evidence that this would not be in the user’s best interests. It would
not be justified to withhold information merely because a patient might get
upset or refuse medical treatment.

WHERE INFORMED CONSENT MAY NOT BE NEEDED

While health care providers must take all reasonable steps to obtain the user’s
informed consent, our law recognises that health care services may be provided
without the user’s informed consent in the following limited circumstances:

- the user is unable to give informed consent, with consent being given on
  his or her behalf by –
  - a mandated person – usually stipulated in what is often called a "living
    will" – a sworn affidavit which gives the authority to a named person
    to make decisions regarding the medical care of someone in case he or
    she is ever unable to make decisions on his or her own;
  - someone authorised to give consent by a court order or law; or
  - a spouse, partner, parent, grandparent, adult child or sibling;
- the provision of a health service without informed consent is expressly
  permitted under a law or court order – such as what is proposed in the
  Sexual Offences Bill (2006);
failure to treat the user (or a group of people that includes the user) will result in a serious risk to public health, for example, where the user is diagnosed with a serious infectious disease such as Ebola, SARS or Marburg; and

a delay in the provision of a health service to the user might result in death or irreversible damage to health, and the user has not indicated in some way that he or she does not wish to undergo that health service.

How to treat users who access health care services

When a user attempts to access health care – or is already in the health care system – he or she has a right to be treated with decency and equal respect. This is essential. Without it, people may be dissuaded from seeking necessary care.

In general, there are three key aspects to this right:

- the right to privacy (which includes rights to autonomy and confidentiality);
- the right to dignity; and
- the right to equality.

RIGHT TO PRIVACY

The right to privacy – which predates the Constitution – has existed in our law for some time. In relation to health care, an important breakthrough regarding the duty of health care providers to keep a person’s medical information confidential was achieved in *Jansen van Vuuren NNO v Kruger* 1993 (4) SA 842 (A). In that case, decided before the adoption of a Bill of Rights, the then Appellate Division of the Supreme Court (now the Supreme Court of Appeals) held that –

- a health care provider has an ethical and legal duty to respect a patient’s confidentiality; and
- the ethical guidelines for health care providers are legally enforceable, providing patients with a legal remedy when guidelines are breached.

If you think that your constitutional right to privacy has been violated by the disclosure of your private medical facts, courts will consider a range of issues in determining whether the disclosure was in fact unlawful, including whether:

- the information was obtained in an intrusive manner;
- the information was about intimate aspects of your personal life;
- the disclosure involved information that was provided for one purpose but used for another; and
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In addition to the common law and the Constitution, the right to privacy is given further content in a range of legal and policy instruments, such as the National Health Act; Health Professions Council Guideline on Confidentiality; and Promotion of Access to Information Act.

**National Health Act**

The National Health Act (NHA), which regulates access to health records held by clinics, hospitals and all other health facilities, states that all information concerning a user – including information relating to his or her health status, treatment or stay in a health facility – is confidential and should not be made available to third parties. This is important because without confidentiality, users may be reluctant to make use of health facilities and disclose all information necessary for diagnosis and treatment. By encouraging a relationship of trust between users and health care providers, confidentiality of medical information has the potential to contribute significantly towards better health outcomes.

While health facilities are obliged to put in place control measures to prevent unauthorised access to records, and – as already discussed – health care personnel have a legal duty to ensure that patients’ personal information is kept

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**CASE STUDY: JANSEN VAN VUUREN NNO v KRUGER 1993 (4) SA 842 (A)**

_Jansen van Vuuren_ dealt with the unlawful disclosure of private medical facts. It involved a patient who had requested an HIV test. After being informed that he had tested positive, he was assured that his confidentiality would be maintained. Yet not long after, the doctor disclosed his patient’s status to another doctor and dentist who knew the patient, had treated him in the past and had not been – nor were they then – at risk of infection by him. This took place during a game of golf. It did not take long for the whole town to know the patient’s HIV status.

The application in the then Supreme Court (now the High Court) was initially dismissed. On appeal, however, the patient’s right to medical confidentiality was upheld. Tragically, the decision came too late. By the time the matter got to the appeal court, the patient had already died of an AIDS-related illness. It is widely believed that the stress of the trial contributed towards his rapid decline in health.
In other words, the disclosure can generally only take place if it is a part of the user's health care. This would include discussions with a specialist regarding diagnosis, as well as talks with other health care providers involved in the patient's care as to the appropriate treatment regimen. Outside of the patient's health care needs, the rules are stricter. In the absence of consent, personal information cannot be used, for example, to educate students. Instead, the private medical facts of the user will have to be presented in a manner that does not link them directly to the person.

Example: Disclosure in suspected child abuse cases

Disclosure without consent may take place, for example, when a child has been hospitalised with serious physical injuries and the father has been charged with abuse. A health care provider who treated the child can provide information about the child and his or her family to a Children's Court inquiry even if the family does not consent to the release of the relevant information. In fact, health care providers have a legal duty to report all suspected child abuse cases. Health care providers must, however, be able to explain their actions and must record the reasons for their decision to disclose information without consent.
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Health Professions Council Guideline on Confidentiality

In addition to the requirements of the NHA, health care providers also have ethical duties – as set out in the Health Professions Council Guideline on Confidentiality. These duties, which according to Jansen van Vuuren are in fact legally enforceable, require a health care provider to act as follows when asked to provide information about patients:

- wherever possible, ask the patient for consent to disclose information, even in circumstances where the health care provider believes that the patient will not be identified by the disclosure;
- where unidentifiable data will serve the purpose, make the data anonymous (known as anonymised data); and
- keep disclosures to a minimum.

The Guideline also emphasises the importance of explaining to patients that their personal information will be shared within the health care team. This can happen only where a patient has consented to a particular treatment and the involvement of others is necessary to provide the requested treatment.

What about disclosure after a patient's death? The Health Professions Council Guideline on Confidentiality states that the duty to maintain confidentiality continues after a patient dies. But once again this is not an absolute bar on disclosure. The extent to which confidential information can be disclosed after a patient’s death depends, as always, on the circumstances. In deciding whether to disclose, health care providers must consider:

- the nature of the information;
- whether the information is already public knowledge or can be made anonymous;
- the intended use of the information; and
- whether the disclosure may cause distress, or be a benefit, to the patient’s spouse, partner and/or family.

Thus a parent’s request for confidential medical information about a deceased son may be denied if the release of such records may cause distress to the surviving wife. This may occur in a case, for example, where the son died of an AIDS-related illness and the surviving spouse does not want her in-laws to know that she is living with HIV. Where a health care provider refuses access to such information, the deceased’s next-of-kin may make use of the Promotion of Access to Information Act to request the information from the health facility’s information officer.
Promotion of Access to Information Act

The Promotion of Access to Information Act (PAIA) allows for third parties to request personal information, which includes information about a person’s physical and mental health and medical history. However, such information must be required for the exercise of the requester’s own rights. But even where this is indeed the case, access to the information may still be denied. A request for personal information may be refused on the grounds of privacy, confidentiality, the safety of individuals and privilege. Where the request involves the unreasonable disclosure of personal information about a person (including a deceased person), it must be denied.

In some cases, however, PAIA requires personal information to be handed over. If, for example, the information requested deals with the physical or mental health of a person who is either under the age of 18 years or incapable of understanding the nature of the request, such information must be disclosed if –

- the requester is caring for the person; and
- the person’s best interests are served by providing access to the requested information.

In addition, a request for a record containing personal medical information may not be refused if –

- the individual concerned –
  - consented in writing to the disclosure; or
  - was informed, before giving the information, that it would or might be made available to the public;
- the information is already publicly available; or
- the request relates to a person who has been dead for less than 20 years, and is made by or on behalf of that person’s next-of-kin. Where a person has been dead for more than 20 years, their information is no longer regarded as personal information and is therefore freely available.

RIGHT TO DIGNITY

Section 10 of the Constitution recognises that everyone has inherent dignity and has a right to have their dignity respected and protected. Its centrality to our constitutional scheme has repeatedly been recognised by the Constitutional Court. In *S v Makwanyane* 1995 (3) SA 391 (CC) (the death penalty decision), for example, the following was said:
"Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern. This right therefore is the foundation of many of the other rights that are specifically entrenched in the Bill of Rights."
(paragraph 328)

The rights to dignity, equality and access to health care services should always be considered together. For example, a woman who faces domestic violence or rape and needs to access health care services, might be deterred from doing so because she fears further violation of her rights by health care workers, including her right to dignity. Similarly, a person living with HIV/AIDS may be deterred from accessing health care services in her area because she fears insults or a breach of confidentiality; she may be denied access to health care services or adequate treatment at health facilities because of her HIV status; or she may face an early death because she cannot afford life-saving ARV treatment and this is not available at her local public health facility. The way in which health services are provided impacts directly on the right of users to be treated with dignity.

Various aspects of the right to dignity, insofar as it concerns the rights of users of the health system, are dealt with in a number of laws and policies, including:
- the National Health Act;
- the Patients’ Rights Charter; and
- the Batho Pele Principles.

**National Health Act**

In line with the Constitution, the preamble to the NHA recognises:
- the socio-economic injustices, imbalances and inequities of health services in the past;
- the need to heal the divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights;
- the need to improve the quality of life of all citizens and to free the potential of each person.

The NHA therefore envisages health service provision which is in line with this recognition. In addition, the NHA gives content to the right to dignity through its provisions on equitable treatment, informed consent and confidentiality and the recognition of users’ right to make decisions concerning their health.
Patients’ Rights Charter and the Batho Pele Principles

According to the Patients’ Rights Charter, users have the right to a positive attitude from health care workers that demonstrates courtesy, human dignity, patience, empathy and tolerance. The Batho Pele Principles, on the other hand, instruct health care personnel to provide health care services that are customer-friendly and confidential. They expressly provide that everyone who accesses services must be treated with courtesy and consideration.

But how does one move from policy to practice? How can these principles be given real force? To put Batho Pele into practice requires – at minimum – the following:

- health care workers and providers should receive training on how to practise the Batho Pele Principles; and
- users should be surveyed on their experiences in health establishments.

RIGHT TO EQUALITY

The health profession came under the spotlight during the Truth and Reconciliation Commission (TRC) hearings into human rights abuses conducted under Apartheid. Recognising the role that the profession and health establishments played in contributing towards discriminatory practices, which often had the effect of denying poor and black people access to appropriate health care services, the TRC emphasised the need to eliminate racial discrimination in the health sector, to adopt human rights standards for health professionals and to reform health profession bodies.

In recognition of past human rights abuses and the deep inequalities that exist in our society, section 9 of the Constitution makes it plain that equality includes the full and equal enjoyment of all rights and freedoms, outlawing unfair discrimination on the basis of an attribute or characteristic that can impair a person’s human dignity. In particular, it expressly prohibits unfair discrimination on the basis of race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language or birth. To date, the Constitutional Court has held that the protection extends to a number of unlisted grounds, such as nationality (Larbi Odam case) and HIV status (Hoffmann case).

The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (also simply known as the “Equality Act”), the central piece of legislation dealing with equality, is required by section 9 of the Constitution. It aims to prevent, prohibit and eliminate unfair discrimination and harassment, as well as to promote equality. It does so by:
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- giving content to the constitutional right to equality;
- providing people with procedures and forums to enforce the right; and
- forbidding unfair discrimination on the prohibited grounds listed in the Constitution, as well as a range of unlisted grounds that reinforce disadvantage, undermine human dignity or negatively affect equal enjoyment of rights and freedoms.

What is “fair” discrimination?

The prohibition against unfair discrimination does not mean that everyone should be treated the same, or in the case of health care, receive the same treatment. In essence, a right to equality means a right to be treated with equal respect and dignity. Denying access to health care on the basis of race violates this right. But the National Health Act’s guarantee of free public health services for pregnant and lactating women, as well as children under the age of 6 years, is not unfair discrimination. Instead it is simply an acknowledgement that many of these women and children face additional burdens that give rise to the need for additional assistance just to enable them to enjoy their rights to the same extent as others.

In terms of the Act, an Equality Review Committee was established to, among its other duties, investigate whether discrimination on the grounds of HIV/AIDS status, socio-economic status, nationality, family responsibility and family status should be included in the list of prohibited grounds in the Act. This was done in recognition of these grounds’ importance, impact on society and link to systemic disadvantage and discrimination. However, although the Committee has made recommendations to the Minister, by September 2006 they had not been published or acted upon.

Despite the above process, our courts regularly consider the fairness of discrimination on grounds other than those listed in the Constitution. For example, in the case of Hoffmann v SAA, the Constitutional Court held that the denial of employment to the appellant because he was living with HIV impaired his dignity and constituted unfair discrimination.

Health system rights

In addition to the health service rights already discussed in this chapter, users have certain rights in respect of the health system itself. In essence, a broad right to an open, accountable and inclusive health system arises when one considers a range of rights already recognised in the Constitution and elsewhere, including:
- the right of access to information;
the right to just administrative action; and
the rights entrenched in the National Health Act regarding civil society
and user participation in decisions about the health care system.
This chapter has already considered the right of access to information in some
detail, particularly insofar as information about health services is concerned.
As highlighted in chapter 2, this right is very useful in holding government to
account and in ensuring that those who have public power are kept in check.
The same can be said for the right to just administrative action, discussed
in some detail in chapter 2 and given force and effect in the Promotion of
Administrative Justice Act 3 of 2000, which was enacted to provide people
with mechanisms to enforce their rights.
This part of the chapter therefore focuses on the third leg of the right to an
open, accountable and inclusive health system – the right of health care users
and civil society groupings (often acting on behalf – or in the interests – of
users) to participate in decisions about the health care system.

Participation in decisions about
the health care system
Implicit in the right of access to health care services, which imposes an obligation
on the state to take reasonable measures to realise the right progressively, is a
duty on the part of policy makers and implementers to consult – particularly
with those who are directly affected by the health care policies adopted. If
peoples’ needs – as identified by them and those who act on their behalf – are
not known to policy makers and implementers, access to health care services
may very well be undermined.

National Health Act
With this apparently in mind, the National Health Act (NHA) expressly
recognises the importance of community participation, placing an obligation
– for example – on provincial health departments to promote community
participation in the planning, provision and evaluation of health services.
Thus provincial departments must consult with communities on health issues,
and members of communities must form part of the management structures
of the relevant health establishments. In particular:
- hospital boards must include three representatives of the communities
  served by the hospital, including special interest groups;
- clinic and community health centre committees must include one or
  more members of the community served by the health facility;
the Forum of Statutory Health Professional Councils should include three community representatives who have been appointed to any of the statutory health professional councils; and

the National Health Consultative Forum as well as provincial consultative bodies must include relevant stakeholders.

Despite the move towards more community representation, structures such as the National Health Council and Provincial Health Councils are not required to include community representatives.

Patients’ Rights Charter and the Batho Pele Principles

The Patients’ Rights Charter recognises that every citizen has the right to participate in decision-making on health policies and issues affecting his or her health. Similarly, the Batho Pele Principles require that communities be consulted about the level and quality of public services they receive. An important aspect of consultation is that communities’ recommendations should be incorporated into planning and service delivery. Where possible, communities should be given a choice about the services offered.

According to the Batho Pele Principles, communities should be informed about health services in their area and be able to participate in decisions affecting this service. If this is indeed done, it will allow communities to:

- provide input – based on actual experience – on the quality and standard of health services provided;
- hold health establishments accountable to the communities that they are serving; and
- assist in disseminating information on the types of health services available and practices in the community that affect health, thereby helping to advise community members of their health service rights.

EXAMPLE: NEGOTIATING CLINIC HOURS

The Department of Health’s User’s Guide to Primary Health Services says that clinics should be open eight hours a day, five days a week. If this is not possible, owing to limited human resources or another real concern, communities have at least two options. They can either mobilise for the required resources so that the clinic provides the services as required, or they can negotiate with the clinic on what the operating hours should be. In practice, they may decide to do both – reaching agreement on a temporary solution (regarding hours of operation) as well as pushing for the resources necessary to ensure that the clinic stays open as promised by the department.
8.3 What duties do users of the health care system have?

While this chapter focuses on the rights of users of the health care system, it is nevertheless important to remember that such rights can only be realised in an environment in which the rights of health care workers are respected and the functioning of the health system is not subject to undue pressure. For this to happen, users of the health care system must comply with certain duties, as set out in the National Health Act and the Patients’ Rights Charter.

National Health Act

The NHA, which in many respects codifies certain aspects of the Patients’ Rights Charter, sets out the duties of users in some detail. When accessing health care services, users are – in general – obliged by the NHA to:

- stick to the rules of the health establishment;
- co-operate with and give health care providers accurate information on their health status; and
- sign a discharge certificate releasing the health care establishment from liability if a user refuses to accept the recommended treatment.

These requirements assume that the rules of health facilities are fair and lawful, that health care providers do not demand information that a user is unwilling to provide, and that the recommended treatment complies with accepted standards and treatment protocols. Where this is not so, such as would be the case where a doctor insisted on providing dual antiretroviral therapy as HIV treatment instead of the accepted three-drug regimen, a user cannot be required to sign a discharge certificate releasing the health care establishment from liability. Similarly, where the rules of a health facility unfairly discriminate against a user, or where health care workers demand that a user be tested for HIV, the user is entitled to refuse to comply with the rules or to co-operate.

The NHA also protects the rights of health care providers and workers, as enshrined in the Constitution, by imposing certain duties on users. For example, users are required to treat health care workers with dignity and respect. Furthermore, a health care worker may refuse to treat a user who is physically or verbally abusive or who sexually harasses her.

See Chapter 10 for more on the rights of health care workers.
Patients’ Rights Charter
The Charter attempts to create awareness and a culture of responsibility for our own health. When users access health facilities, they can be assisted only to the extent that they are co-operative and provide health care personnel with adequate information. While a user cannot be refused medical care if he or she does not take responsibility for his or her own health, which includes proper co-operation with health care workers, the quality of care may be compromised because the health care worker may not have sufficient information to do his or her job properly.

8.4 Getting help when your rights are not respected
Rights would be meaningless if there was no accessible way to ensure that those who do not respect them are held to account. But the actions of many different people at various levels within the health system may work together to violate a user’s health care rights. For example, poor administration by a state pharmacist, coupled with poor managerial oversight, may result in some essential medicines simply not being available in a hospital dispensary. For this reason, it is important to understand the various ways of enforcing one’s health care rights. In this part of the chapter, therefore, we consider three ways of enforcing a user’s rights:

- complaints against health establishments;
- complaints against health care providers; and
- complaints against medical schemes.

Most of these mechanisms, at least insofar as the initial complaints are concerned, do not require legal representation. But getting final legal redress – including a vindication of your rights – may still require costly court action. Public interest law groups – such as the AIDS Law Project and the Legal Resources Centre – may be able to assist on selected matters of public importance. Another option may be to approach the Legal Aid Board (LAB), which aims to ensure the protection of human rights by offering free quality legal services in both criminal and civil cases to indigent South Africans. However, the LAB’s capacity to take on civil cases is limited.

In addition, an increasing number of private law firms have set up public interest and pro bono departments that provide free legal services on a limited
basis. It may also be possible to make a contingency fee arrangement with an attorney, meaning that he or she will take the case on for free, provided that in the event of a successful outcome, they will receive a certain percentage of any money awarded to the client.

Complaints against health establishments
Health establishments may be held to account in a number of ways, as set out in the key legal documents that have already been discussed in this chapter:

- the Patients’ Rights Charter;
- the Batho Pele Principles;
- the National Health Act; and
- the Equality Act.

Patients’ Rights Charter
The Patients’ Rights Charter says that everyone has the right to complain about health care services, to have these complaints investigated and to receive a full report of the investigation. In terms of the Charter, the following complaint procedures should be followed by all health facilities:

- The facility should have a formal, clear, structured complaint procedure.
- Users who are illiterate and people with disabilities must be assisted in making complaints.
- All complaints should be forwarded to the appropriate authority if they cannot be dealt with at the facility concerned.
- A register of complaints and how they were addressed must be maintained.

Batho Pele Principles
The Batho Pele Principles explain that, if the promised standard of service is not delivered, users should be offered an apology, an explanation and an effective remedy. In addition:

- Users should be given a clear explanation of complaint procedures and possible time frames for resolving complaints.
- Health establishments should ensure that complaint procedures are easily accessible and that complaints are dealt with effectively and speedily.
- When complaints are made, users should receive a sympathetic, positive response.
The rights and duties of users of the health care system

National Health Act

While the Patients’ Rights Charter and the Batho Pele Principles set out the way in which health establishments are expected to deal with complaints, it is the National Health Act (NHA) that creates a binding legal framework for users to lay complaints when their rights have been violated. It gives users of the health care system the right to make complaints about how they were treated at a health establishment and to have the complaints investigated. Regulations, which have yet to be finalised, are expected to explain the structures in more detail and to set out clear guidelines for how complaints should be made and investigated.

PUBLIC HEALTH ESTABLISHMENTS

The procedure for laying a complaint against a public health establishment is usually established by the provincial or local government, depending on the jurisdiction under which the particular facility falls. In general:

- the procedure must be displayed by all health establishments and must be communicated to users on a regular basis;
- health establishments must acknowledge receipt of all complaints received; and
- if complaints should have been directed elsewhere, the health establishment must take responsibility for referring the complaint to the appropriate body or authority.

All health establishments must have their own complaints procedures in place. The procedures usually require that complaints regarding health care services in clinics or hospitals – including allegations of rights violations – should first be taken to the most senior person in charge of the facility, telephonically, in person or in writing. All clinic and hospital managers are obliged to hear and address complaints to the satisfaction of the person who complained. This may include holding a formal inquiry and referring the complaint to the relevant statutory health professional council.

If the clinic or hospital's response is unsatisfactory, you may take the complaint to the provincial Department of Health or to the professional body to which the specific health care provider belongs (such as the Hospital Association of South Africa).

If you have followed the complaints procedure and your complaint has not been addressed, you may also sue the health facility in the High Court, depending on the nature of the complaint and its severity. Access to legal
advice and representation would be necessary and, where cost is an issue, you should approach the Legal Aid Board for an attorney.

Aside from the standard complaint process, our law recognises a range of options that can be used to hold health establishments to account. For example, complaints dealing with allegations of rights violations may be lodged with the South African Human Rights Commission or the Commission on Gender Equality (in the specific case of rights violations based on gender or sex). If the complaint is against a public sector health establishment, it may be lodged with the Public Service Commission or the Public Protector.

### PRIVATE HOSPITALS

In respect of private health establishments, the NHA requires that complaint procedures allow for the making of complaints to the head of the relevant facility. Complaints against private hospitals can also be lodged with the Hospital Association of South Africa (HASA), in its role as a mediator that investigates the complaint on behalf of the user. HASA recommends that complaints be dealt with by first complaining to the nurse in charge, then the hospital public relations officer and finally the hospital manager.

For more on the role of HASA, refer to Chapter 6 which deals with private health care.
RELEVANT STATUTORY FORUMS

In future, all health establishments will have to comply with the quality requirements and standards that are to be prescribed by the Minister of Health after consultation with the National Health Council. Compliance with these quality requirements and standards will be monitored and enforced by two statutory forums established by the NHA – the National Office of Standards Compliance and the Provincial Inspectorate for Health Establishments. According to the NHA, the Office of Standards Compliance must include a person who acts as an ombudsperson for complaints made in terms of the Act. At the time of writing in September 2006 chapter 10 of the National Health Act, which deals with ‘Health Officers and Compliance Procedures’ had not been enacted.

Equality Act

If a complaint against a health establishment deals with a matter of unfair discrimination, it may be pursued through the Equality Courts. According to the Equality Act, every High Court also serves as an Equality Court. In addition, the Minister of Justice and Constitutional Affairs has the power to designate certain Magistrates’ Courts as Equality Courts, which she has already done.

WHO CAN TAKE CASES TO THE EQUALITY COURT?

The following persons are recognised by the Equality Act as having the necessary standing to bring a case before an Equality Court:
- any person acting in his or her own interest;
- any person acting on behalf of someone who cannot act in his or her own name, such as a child;
- any person acting as a member of, or in the interest of, a group or class of persons (such as persons living with HIV/AIDS);
- any person acting in the public interest;
- any association acting in the interests of its members; and
- the South African Human Rights Commission and the Commission for Gender Equality (acting on behalf of individuals who have approached them for assistance).

HOW DOES ONE TAKE A COMPLAINT TO THE EQUALITY COURT?

If you wish to take a complaint to the Equality Court, you must inform the clerk of the Equality Court. The clerk will then refer your case to the presiding
Complaints against health care providers

Various statutory health professional councils regulate the conduct of health care providers in the public and private sector. These include:

- the Health Professions Council of South Africa (HPCSA);
- the South African Nursing Council (SANC);
- the South African Pharmacy Council; and
- the South African Dental Technicians Council.

Users may lodge complaints against health care providers at these councils. Ideally, complaints against health care providers should first be raised at institutional or facility level. Depending on the nature of the complaint, a complainant may decide instead to take ordinary civil action in the courts, or to lay criminal charges.

In addition, the National Health Act establishes a Forum of Statutory Health Professional Councils that is made up of representatives from all the statutory health professional councils. The forum is intended to:

- protect the interests of the public, including users of the health care system;
- ensure consistency in the actions and decisions of the statutory professional councils;
- hold the councils directly accountable for their performance as competent public authorities; and
- act as ombudsperson for complaints by members of the public and other persons relating to the councils.

Thus if the HPCSA, for example, does not investigate a complaint properly, the complainant will be entitled to lodge a complaint against it with the Forum of Statutory Health Professional Councils.

Health Professions Council of South Africa

Established in terms of the Health Professions Act, 56 of 1974, the Health Professions Council of South Africa (HPCSA) is a co-ordinating body for a
range of health professions. Various professional boards (such as the Medical and Dental Professions Board dealing with dentists, medical practitioners and medical students), fall under the HPCSA and can be contacted through it. The HPCSA regulates the registration, training and conduct of all registered health care providers. It is an offence to practice as a health professional if unregistered.

See chapters 9 and 12 for more information on the HPCSA.

LODGING A COMPLAINT WITH THE HPCSA

These are the steps for lodging a written complaint of professional misconduct with the HPCSA, either against a health professional or a student studying to become a professional:

- give details of the name of the person complaining;
- provide the name of the health professional (or student) against whom the complaint is being lodged; and
- set out the date and place of the incident of alleged misconduct, and how it happened.

After receiving a complaint, the HPCSA may request further information from you as the complainant. It will then request the person against whom the complaint was lodged to provide a written explanation. A Committee of Preliminary Inquiry will then consider the complaint and the explanation, and will decide whether there are any grounds for a professional conduct inquiry to be held.

If the committee decides that an inquiry should be held, this will be arranged and conducted by the HPCSA’s Legal Section. If, as the complainant, you are unhappy with the outcome of a complaint, you can appeal to the Special Appeal Committee and thereafter take its decision (if unacceptable to you) to the High Court on review.

CASE STUDY: TAKING THE HPCSA ON REVIEW TO THE HIGH COURT

In the 2002 case of VRM v Health Professions Council of South Africa [unreported judgment of the High Court, TPD case no 1679/2000, 10 October 2003], the High Court was approached to overturn a decision of the HPCSA’s Committee of Preliminary Inquiry holding that a particular doctor had not acted improperly or disgracefully. The complaint, lodged by a woman who had been in the care of the doctor when she was pregnant, alleged that the doctor had tested her for HIV without her consent, and had failed to –
South African Nursing Council

The South African Nursing Council (SANC) is set up in terms of the Nursing Act 33 of 2005, which – amongst other things – provides for the registration of nurses. The Act says that no person may practise as a registered nurse, a midwife, an enrolled nurse, a nursing auxiliary or student if not properly registered. The job of registering nurses is performed by the SANC, which can refuse to register any person that it regards as not fit to practise, for example because of a previous criminal conviction.

The SANC has the statutory power to hold an inquiry into any complaint, charge or allegation of improper conduct against any registered or enrolled nurse. If guilty, a nurse may be warned, suspended (for a period) or fined. In serious cases, the nurse’s name may be removed from the roll, meaning that he or she would not be able to practice nursing. These important controls impose a duty on nurses to carry out their duties in a professional and respectful manner, and thus protect patients from abuse.
In addition the Act specifically states that the SANC must ensure that its members behave towards users in a manner that recognises their constitutional rights to human dignity, bodily and psychological integrity and equality and that disciplinary action be taken against those who fail to do so.

Complaints against medical schemes

The Council for Medical Schemes (CMS), established in terms of the Medical Schemes Act, plays a central role in regulating the medical scheme “industry”. One of its core functions is to protect the rights of medical scheme members or beneficiaries. It can do this in a number of ways. The CMS, which is responsible for the registrations of schemes, may suspend the registration of any particular scheme if and when it becomes aware of any conduct of the scheme that violates any material provisions of the Act.

For more about the CMS, see Chapter 6 dealing with private health care.

Complaining to the CMS

A member of a medical scheme can complain to the CMS about a broker, scheme administrator or anyone else who renders a service to the scheme’s members and is accredited by the CMS regarding unpaid accounts, rejection of membership applications, unfair imposition of waiting periods, poor service, unauthorised deductions or unfair discrimination on the basis of, for example, ill health, age, race or gender.

Before complaining to the CMS, a medical scheme member must exhaust the internal complaints procedures set out in the rules of the medical scheme. This means that the member must:

- Phone the toll-free line of the medical scheme and lodge a complaint.
- If the member is unsatisfied with the response, he or she can complain to the Principal Officer of the scheme in writing, providing his or her full details and details of the complaint. The Principal Officer must investigate the complaint.
- If the member is unhappy with the response, he or she can ask the Principal Officer to refer the complaint to the scheme’s Disputes Committee. The member must be given 14 days’ notice of the meeting of the Disputes Committee.

Thereafter, he or she must follow the provisions of the Act that set out – in detail – how a complaint against a scheme is to be lodged with the CMS. Members may submit a complaint online (using the CMS’s website), or
they may write to, phone, fax or e-mail the Registrar of Medical Schemes. The appeal of the Disputes Committee’s decision must be made within 3 months of its decision and must be reported in writing to the Registrar with sufficient information about the member and the complaint, as well as supporting documentation.

Once a complaint against a medical scheme has been submitted, the following procedure is to be followed:

- The Complaints Unit within the Registrar’s Office must send a written acknowledgement of a complaint within five working days of receiving it, and must provide the complainant with the name and contact details of the person dealing with the complaint.
- The Registrar must analyse a complaint within three days of receiving it and must send the complaint to the medical scheme if the complaint has merit.
- Within 30 days of receiving a complaint, the Registrar’s Office must send the complainant a final response, or explain why the complaint has not yet been resolved and when further contact will be made (which must be within 60 days of receiving the complaint).
- The final response must inform the complainant of the right to appeal against the Registrar’s decision to the Council within 30 days. The complainant must appear in person or through a representative and provide evidence or submit an explanation or argument to the Council in support of her case.
- If the complainant remains unsatisfied, he or she can appeal to the Appeal Board which consists of 3 persons appointed by the Minister. Anyone who lodges an appeal with the CMS’s Appeal Board is required to pay a prescribed fee.
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CASE STUDY: NON-DISCLOSURE OF HIV STATUS

The issue of non-disclosure of a pre-existing condition was discussed in the 2002 complaint to the Council for Medical Schemes, *Compcare Medical Scheme v FH*. In that case, FH’s membership of the medical scheme had been terminated because he did not disclose his HIV status at the time of applying for membership. FH objected to the termination of his membership as he said that he did not know his HIV status at the time of the application. He requested that the case be referred to the dispute committee of the scheme. The medical scheme denied his request on the basis that, since he was no longer a member of the scheme, he could not use the scheme’s dispute committee process.

The CMS upheld the complaint. It ruled that Compcare had failed to prove that FH knew of his HIV-positive status at the time that he applied for medical scheme membership. The CMS also held that the decision of the medical scheme not to refer the matter to the dispute committee was unfair. The scheme was therefore ordered to reinstate FH’s membership and honour all his claims.

Other complaints

The Medical Schemes Act does not regulate certain benefit type insurance products such as hospital plans. Any complaints against these products should be made to the Financial Services Board. Where a broker has provided fraudulent or misleading advice about a medical scheme, hospital plan or other health service benefits, it is also possible to lay a complaint with the Ombud for Financial Services Providers. Health brokers are subject to the licensing regulations and code of conduct established by the Financial Advisory and Intermediary Services Act 37 of 2002, but must at the same time also be accredited by the Council for Medical Schemes.