CONSTITUTIONAL COURT OF SOUTH AFRICA

Case CCT 32/97

THIAGRAJ SOOBRAMONEY Appellant

versus

MINSTER OF HEALTH (KWAZULU-NATAL) Respondent

Heard on: 11 November 1997

Decided on: 27 November 1997

JUDGMENT

CHASKALSON P:

[1] The appellant, a 41 year old unemployed man, is a diabetic who suffers from ischaemic heart disease and cerebro-vascular disease which caused him to have a stroke during 1996. In 1996 his kidneys also failed. Sadly his condition is irreversible and he is now in the final stages of chronic renal failure. His life could be prolonged by means of regular renal dialysis. He has sought such treatment from the renal unit of the Addington state hospital in Durban. The hospital can, however, only provide dialysis treatment to a limited number of patients. The renal unit has 20 dialysis machines available to it, and some of these machines are in poor condition. Each treatment takes four hours and a further two hours have to be allowed for the cleaning of a machine,

before it can be used again for other treatment. Because of the limited facilities that are available for kidney dialysis the hospital has been unable to provide the appellant with the treatment he has requested.

[2] The reasons given by the hospital for this are set out in the respondent's answering affidavit deposed to by Doctor Saraladevi Naicker, a specialist physician and nephrologist in the field of renal medicine who has worked at Addington Hospital for 18 years and who is currently the President of the South African Renal Society. In her affidavit Dr Naicker says that Addington Hospital does not have enough resources to provide dialysis treatment for all patients suffering from chronic renal failure. Additional dialysis machines and more trained nursing staff are required to enable it to do this, but the hospital budget does not make provision for such expenditure. The hospital would like to have its budget increased but it has been told by the provincial health department that funds are not available for this purpose.

[3] Because of the shortage of resources the hospital follows a set policy in regard to the use of the dialysis resources. Only patients who suffer from acute renal failure, which can be treated and remedied[1] by renal dialysis are given automatic access to renal dialysis at the hospital. Those patients who, like the appellant, suffer from chronic renal

[1] Where the renal failure can be cured by dialysis this is usually achieved within a period of four to six weeks from the commencement of the treatment.

failure which is irreversible are not admitted automatically to the renal programme. A set of guidelines has been drawn up and adopted to determine which applicants who have chronic renal failure will be given dialysis treatment. According to the guidelines the primary requirement for admission of such persons to the dialysis programme is that the patient must be eligible for a kidney transplant. A patient who is eligible for a transplant will be provided with dialysis treatment until an organ donor is found and a kidney transplant has been completed.

[4] The guidelines provide that an applicant is not eligible for a transplant unless he or she is "[f]ree of significant vascular or cardiac disease." The medical criteria set out in the guidelines also provide that an applicant must be

> "Free of significant disease elsewhere e.g. ischaemic heart disease, cerebro-vascular disease, peripheral vascular disease, chronic liver disease, chronic lung disease."

The appellant suffers from ischaemic heart disease and cerebro-vascular disease and he is therefore not eligible for a kidney transplant.

[5] The appellant has made arrangements to receive dialysis treatment from private hospitals and doctors, but his finances have been depleted and he avers that he is no longer able to afford such treatment. In July 1997 he made an urgent application to the

Durban and Coast Local Division of the High Court for an order directing the Addington Hospital to provide him with ongoing dialysis treatment and interdicting the Respondent from refusing him admission to the renal unit of the hospital. The appellant claimed that in terms of the 1996 Constitution the Addington Hospital is obliged to make dialysis treatment available to him. The respondent opposed the application. The matter came before Combrinck J who dismissed the application.[2]

[6] The appellant applied to the High Court for a certificate in terms of rule 18(e) of the Constitutional Court Rules. The certificate was granted and he applied to this Court in terms of Rule 18 for leave to appeal against the judgment of the High Court. The application for leave to appeal was set down for hearing as a matter of urgency. The respondent did not oppose the application and correctly acknowledged that the matter raised issues of importance on which a decision on the merits of the appeal should be given by this Court. The matter was dealt with on this basis, and counsel were required to deal only with the merits of the appeal, it being accepted by the parties and this Court that the appeal should be heard and decided.

[7] The appellant based his claim on section 27(3) of the 1996 Constitution which provides:

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[2] *Thiagraj Soobramoney v Minister of Health: Province of KwaZulu-Natal* D&CLD 5846/97, 21 August 1997, unreported.

> "No one may be refused emergency medical treatment"

and section 11 which stipulates

> "Everyone has the right to life."

[8] We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one in which there will be human dignity, freedom and equality, lies at the heart of our new constitutional order. For as long as these conditions continue to exist that aspiration will have a hollow ring.

[9] The constitutional commitment to address these conditions is expressed in the preamble which, after giving recognition to the injustices of the past, states:

> "We therefore, through our freely elected representatives, adopt this Constitution as the supreme law of the Republic so as to –
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> Heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights;
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> . . . .
>
> Improve the quality of life of all citizens and free the potential of each person".

This commitment is also reflected in various provisions of the bill of rights[3] and in particular in sections 26 and 27 which deal with housing, health care, food, water and social security.

[10] Sections 26 and 27 contain the following provisions:

> "26. Housing
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> (1) Everyone has the right to have access to adequate housing.
>
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.
>
> (3) . . . .
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> 27. Health care, food, water and social security
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> (1) Everyone has the right to have access to–
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> (a) health care services, including reproductive health care;
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> (b) sufficient food and water; and
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> (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
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> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
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> (3) No one may be refused emergency medical treatment."

[11] What is apparent from these provisions is that the obligations imposed on the state by sections 26 and 27 in regard to access to housing, health care, food, water and

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[3] For instance in section 7 where the bill of rights is described as the cornerstone of democracy in South Africa and as affirming "the democratic values of human dignity, equality and freedom", section 28 which deals with childrens' rights, and section 29 which deals with education.

social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled. This is the context within which section 27(3) must be construed.

[12] The appellant urges us to hold that patients who suffer from terminal illnesses and require treatment such as renal dialysis to prolong their lives are entitled in terms of section 27(3) to be provided with such treatment by the state, and that the state is required to provide funding and resources necessary for the discharge of this obligation.

[13] The words "emergency medical treatment" may possibly be open to a broad construction which would include ongoing treatment of chronic illnesses for the purpose of prolonging life. But this is not their ordinary meaning, and if this had been the purpose which section 27(3) was intended to serve, one would have expected that to have been expressed in positive and specific terms.

[14] Counsel for the appellant argued that section 27(3) should be construed consistently with the right to life entrenched in section 11 of the Constitution and that everyone requiring life-saving treatment who is unable to pay for such treatment herself

or himself is entitled to have the treatment provided at a state hospital without charge.

[15] This Court has dealt with the right to life in the context of capital punishment but it has not yet been called upon to decide upon the parameters of the right to life or its relevance to the positive obligations imposed on the state under various provisions of the bill of rights. In India the Supreme Court has developed a jurisprudence around the right to life so as to impose positive obligations on the state in respect of the basic needs of its inhabitants.[4] Whilst the Indian jurisprudence on this subject contains valuable insights it is important to bear in mind that our Constitution is structured differently to the Indian Constitution. Unlike the Indian Constitution ours deals specifically in the bill of rights with certain positive obligations imposed on the state, and where it does so, it is our duty to apply the obligations as formulated in the Constitution and not to draw inferences that would be inconsistent therewith.

[16] This should be done in accordance with the purposive approach to the interpretation of the Constitution which has been adopted by this Court.[5] Consistently

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4 Basing itself on the right to life the Supreme Court of India has made orders requiring the state to provide medical treatment to those needing it, to provide legal aid to those who cannot afford it themselves, and to provide access between isolated areas and more developed areas. See generally in this regard VD Mahajan *Constitutional Law of India* 7 ed (Eastern Book Company, Lucknow 1991) at 230 – 234, and BL Hansaria *Right to Life and Liberty under the Constitution (A Critical Analysis of Article 21)* (NM Tripathi Private Ltd, Bombay 1993) at 24 – 40.

5 *S v Makwanyane and Another* 1995 (3) SA 391 (CC); 1995 (4) BCLR 665 (CC) at para 9.

with this approach the rights which are in issue in the present case must not be construed in isolation

> ". . . but in [their] context, which includes the history and background to the adoption of the Constitution, other provisions of the Constitution itself and, in particular, the provisions of [the bill of rights] of which [they are] part."[6]

[17] The purposive approach will often be one which calls for a generous interpretation to be given to a right to ensure that individuals secure the full protection of the bill of rights, but this is not always the case, and the context may indicate that in order to give effect to the purpose of a particular provision "a narrower or specific meaning" should be given to it.[7]

[18] In developing his argument on the right to life counsel for the appellant relied upon a decision of a two-judge bench of the Supreme Court of India in *Paschim Banga Khet Mazdoor Samity and others v State of West Bengal and another*,[8] where it was said:

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6 Id at para 10.

7 Id at para 325. See also the analysis of the right to freedom and security of the person by the majority of the Court in *Ferreira v Levin NO and Others; Vryenhoek and Others v Powell NO and Others* 1996 (1) SA 984 (CC); 1996 (1) BCLR 1 (CC), and Hogg *Constitutional Law of Canada* 3 ed (Carswell, Scarborough 1992) at para 33.7(c).

8 (1996) AIR SC 2426.

> "The Constitution envisages the establishment of a welfare State at the federal level as well as at the State level. In a welfare State the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare State. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21."[9]

These comments must be seen in the context of the facts of that case which are materially different to those of the present case. It was a case in which constitutional damages were claimed. The claimant had suffered serious head injuries and brain haemorrhage as a result of having fallen off a train. He was taken to various hospitals and turned away, either because the hospital did not have the necessary facilities for treatment, or on the grounds that it did not have room to accommodate him. As a result he had been obliged to secure the necessary treatment at a private hospital. It appeared from the judgment that the claimant could in fact have been accommodated in more than one of the hospitals which turned him away and that the persons responsible for that decision had been guilty of misconduct. This is precisely the sort of case which would fall within section 27(3). It is one in which emergency treatment was clearly necessary.

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9 Id at 2429.

The occurrence was sudden, the patient had no opportunity of making arrangements in advance for the treatment that was required, and there was urgency in securing the treatment in order to stabilise his condition. The treatment was available but denied.

[19] In our Constitution the right to medical treatment does not have to be inferred from the nature of the state established by the Constitution or from the right to life which it guarantees. It is dealt with directly in section 27. If section 27(3) were to be construed in accordance with the appellant's contention it would make it substantially more difficult for the state to fulfill its primary obligations under sections 27(1) and (2) to provide health care services to "everyone" within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities which are not life threatening. In my view much clearer language than that used in section 27(3) would be required to justify such a conclusion.

[20] Section 27(3) itself is couched in negative terms – it is a right not to be refused emergency treatment. The purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate

medical attention, such as the injured person in *Paschim Banga Khet Mazdoor Samity v State of West Bengal*, should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment.[10] What the section requires is that remedial treatment that is necessary and available be given immediately to avert that harm.

[21] The applicant suffers from chronic renal failure. To be kept alive by dialysis he would require such treatment two to three times a week. This is not an emergency which calls for immediate remedial treatment. It is an ongoing state of affairs resulting from a deterioration of the applicant's renal function which is incurable. In my view section 27(3) does not apply to these facts.

[22] The appellant's demand to receive dialysis treatment at a state hospital must be determined in accordance with the provisions of sections 27(1) and (2) and not section 27(3). These sections entitle everyone to have access to health care services provided by the state "within its available resources".

[23] In the Court a quo Combrinck J held that "[i]n this case the respondent has

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[10] We have only recently emerged from a system of government in which the provision of health services depended on race. On occasions seriously injured persons were refused access to ambulance services or admission to the nearest or best equipped hospital on racial grounds.

conclusively proved that there are no funds available to provide patients such as the applicant with the necessary treatment."[11] This finding was not disputed by the appellant, but it was argued that the state could make additional funds available to the renal clinic and that it was obliged to do so to enable the clinic to provide life saving treatment to the appellant and others suffering from chronic renal failure.

[24] At present the Department of Health in KwaZulu-Natal does not have sufficient funds to cover the cost of the services which are being provided to the public. In 1996–1997 it overspent its budget by R152 million, and in the current year it is anticipated that the overspending will be R700 million rand unless a serious cutback is made in the services which it provides. The renal unit at the Addington Hospital has to serve the whole of KwaZulu-Natal and also takes patients from parts of the Eastern Cape. There are many more patients suffering from chronic renal failure than there are dialysis machines to treat such patients. This is a nation-wide problem and resources are stretched in all renal clinics throughout the land. Guidelines have therefore been established to assist the persons working in these clinics to make the agonising choices which have to be made in deciding who should receive treatment, and who not. These guidelines were applied in the present case.

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11 Above n 2 at 17.

[25] By using the available dialysis machines in accordance with the guidelines more patients are benefited than would be the case if they were used to keep alive persons with chronic renal failure, and the outcome of the treatment is also likely to be more beneficial because it is directed to curing patients, and not simply to maintaining them in a chronically ill condition. It has not been suggested that these guidelines are unreasonable or that they were not applied fairly and rationally when the decision was taken by the Addington Hospital that the appellant did not qualify for dialysis.

[26] Ideally the dialysis machines available at the Addington Hospital should handle no more than about 60 patients. At present they are being used to treat 85 patients and the hospital can barely accommodate those who meet its guidelines. The nurse-patient ratio in the renal unit is 1:4.5 instead of the recommended ratio of 1:2.5. According to Dr Naicker, if the hospital were required to treat all persons who, like the appellant, are suffering from chronic renal failure, it would be unable to do so. She says that if the appellant were to be admitted to the programme it would result in other patients who comply with the guidelines being put at risk. Only about 30% of the patients suffering from chronic renal failure meet the guidelines for admission to the dialysis programme. If everyone in the same condition as the appellant were to be admitted the carefully tailored programme would collapse and no one would benefit from that.

[27] The appellant avers in his affidavits that better use could be made of the dialysis machines at the Addington Hospital by keeping the clinic open for longer hours. He says that some of the nurses "moonlight" at other hospitals after their normal working hours in order to earn extra income, and that if they were given overtime opportunities at the Addington Hospital more people could be treated.

[28] The appellant's case must be seen in the context of the needs which the health services have to meet, for if treatment has to be provided to the appellant it would also have to be provided to all other persons similarly placed. Although the renal clinic could be kept open for longer hours, it would involve additional expense in having to pay the clinic personnel at overtime rates, or in having to employ additional personnel working on a shift basis. It would also put a great strain on the existing dialysis machines which are already showing signs of wear. It is estimated that the cost to the state of treating one chronically ill patient by means of renal dialysis provided twice a week at a state hospital is approximately R60 000 per annum. If all the persons in South Africa who suffer from chronic renal failure were to be provided with dialysis treatment – and many of them, as the appellant does, would require treatment three times a week – the cost of doing so would make substantial inroads into the health budget. And if this principle were to be applied to all patients claiming access to expensive medical treatment or expensive drugs, the health budget would have to be dramatically increased

to the prejudice of other needs which the state has to meet.

[29] The provincial administration which is responsible for health services in KwaZulu-Natal has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters.

[30] Although the problem of scarce resources is particularly acute in South Africa this is not a peculiarly South African problem. It is a problem which hospital administrators and doctors have had to confront in other parts of the world, and in which they have had to take similar decisions. In his judgment in this case Combrinck J refers to decisions of the English courts in which it has been held to be undesirable for a court to make an order as to how scarce medical resources should be applied, and to the danger of making any order that the resources be used for a particular patient, which might have the effect of denying those resources to other patients to whom they might more advantageously be devoted.[12] The dilemma confronting health authorities faced

[12] *Re J (a minor)* [1992] 4 All ER 614 (CA) at 625g; *Airedale NHS Trust v Bland* [1993] 1 All ER 821 (CA) at 857b.

with such cases was described by Sir Thomas Bingham MR in a passage cited by Combrinck J from the judgment in *R v Cambridge Health Authority, ex parte B*:[13]

> "I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make."

[31] One cannot but have sympathy for the appellant and his family, who face the cruel dilemma of having to impoverish themselves in order to secure the treatment that the appellant seeks in order to prolong his life. The hard and unpalatable fact is that if the appellant were a wealthy man he would be able to procure such treatment from private sources; he is not and has to look to the state to provide him with the treatment. But the state's resources are limited and the appellant does not meet the criteria for admission to the renal dialysis programme. Unfortunately, this is true not only of the appellant but of many others who need access to renal dialysis units or to other health services. There

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13 [1995] 2 All ER 129 (CA) at 137d–f.

are also those who need access to housing, food and water, employment opportunities, and social security. These too are aspects of the right to

> ". . . human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity."[14]

The state has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society.

[32] In his concurring judgment in this matter Madala J refers to the possibility of the appellant being treated by Continuing Ambulatory Peritoneal Dialysis (CAPD). This treatment is dealt with fully by Dr Naicker in a supplementary affidavit lodged by her in response to an averment made by the appellant in his replying affidavit that there is treatment, other than renal dialysis, which would be of benefit to him, but had not been offered to him by the Addington Hospital.

[33] Dr Naicker explains that CAPD treatment makes patients vulnerable to infections and leads to patients having to be put on dialysis for two to three months when such infections occur. If an infection occurs frequently or is severe the patient has to be put

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[14] Per O'Regan J in *S v Makwanyane* above n 5 at para 326.

onto dialysis permanently. A study undertaken at the hospital shows that over 60% of the patients treated at the hospital by CAPD have had to be placed on dialysis permanently. The cost of the treatment is high – the fluids used in the treatment call for an expenditure of approximately R4000 per month – and there is the additional cost of having to accommodate the patient at the hospital and treat him or her in the surgery. Because of the high cost of the treatment and the demands that it makes on hospital resources including dialysis facilities, the hospital has also set criteria for treating patients by CAPD. Only patients who are candidates for transplant are placed on CAPD and approximately 130 such patients are being treated in this way at the hospital. The appellant is not a candidate for a transplant and accordingly does not meet the criteria for CAPD treatment.

[34] Counsel for the appellant, correctly in my view, appreciated that there was no material difference between the appellant's claim to be placed on dialysis (which is his preferred option) and the alternative of being treated by CAPD. Neither form of treatment is "emergency treatment", neither is accessible to all patients suffering from chronic renal failure and because of the limited resources both are subject to criteria which the appellant does not meet.

[35] I should add that I do not consider it appropriate to comment on the attitude of the

private medical sector to CAPD treatment. No evidence was placed before us in that regard and there is nothing on the papers to show that patients treated privately do not receive proper advice in regard to the availability, risks and costs of such treatment.

[36] The state has a constitutional duty to comply with the obligations imposed on it by section 27 of the Constitution. It has not been shown in the present case, however, that the state's failure to provide renal dialysis facilities for all persons suffering from chronic renal failure constitutes a breach of those obligations. In the circumstances the appellant is not entitled to the relief that he seeks in these proceedings and his appeal against the decision of Combrinck J must fail. This is not an appropriate case for an order for costs to be made and the respondent correctly does not seek such an order.

[37] The following order is made. The appeal against the order made by Combrinck J is dismissed. No order is made as to costs.

Langa DP, Ackermann J, Didcott J, Goldstone J, Kriegler J, Mokgoro J, O'Regan J, and Sachs J concur in the judgment of Chaskalson P

MADALA J:

[38] I have had the benefit of reading the judgment prepared by Chaskalson P and the concurring judgment of Sachs J in this matter. I am in agreement with Chaskalson P's very incisive analysis of the provisions of section 27 and in particular his conclusion that section 27(3) envisages a dramatic, sudden situation or event which is of a passing nature in terms of time. There is some suddenness and at times even an element of unexpectedness in the concept "emergency medical treatment". I accordingly also agree that on that score the appellant's case must fail since he has not persuaded us that section 27(3) applies. I, however, seek to make my own further observations about this case and now do so briefly. It is not necessary for me to restate the facts of the case as they have been set out succinctly in the judgment of Chaskalson P. Nor do I see the need to repeat in any detail the arguments that were advanced in the appeal.

[39] In the oral submissions addressed to us, Mr Jacobs, who appeared on behalf of the appellant, placed reliance, among others, on the provisions of section 11 of the Constitution – the right to life. In this case life is indeed potentially at stake and this Court is enjoined therefore not only to find a humane and morally justified solution to the problem at hand, but also to examine assiduously the process by which the solution is reached and the legal foundation on which it rests. The state undoubtedly has a strong

interest in protecting and preserving the life and health of its citizens and to that end must do all in its power to protect and preserve life.

[40] In another sense the appeal before us brings into sharp focus the dichotomy in which a changing society finds itself and in particular the problems attendant upon trying to distribute scarce resources on the one hand, and satisfying the designs of the Constitution with regard to the provision of health services on the other. It puts us in the very painful situation in which medical practitioners must find themselves daily when the question arises: "Should a doctor ever allow a patient to die when that patient has a treatable condition?" In the context of this case, the question to be answered is whether everybody has the right of access to kidney dialysis machines even where resources are scarce or limited.

[41] Chapter 2 of the Constitution sets out the fundamental rights to which every person is entitled and also contains provisions dealing with the manner in which the chapter is to be interpreted by the courts. Kentridge AJ, who delivered the judgment of the Court in *S v Zuma and Others*,[1] referred with approval[2] to the judgment of Dickson J (later CJC) in *R v Big M Drug Mart Ltd* [3] and to the following passage in particular:

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1 *S v Zuma and Others* 1995 (2) SA 642 (CC); 1995 (4) BCLR 401 (CC).

2 Id at para 15.

3 (1985) 18 DLR (4th) 321 at 359–60.

> "The meaning of a right or freedom guaranteed by the Charter was to be ascertained by an analysis of the *purpose* of such a guarantee; it was to be understood, in other words, in the light of the interests it was meant to protect.
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> In my view, this analysis is to be undertaken, and the purpose of the right or freedom in question is to be sought by reference to the character and the larger objects of the Charter itself, to the language chosen to articulate the specific right or freedom, to the historical origins of the concept enshrined, and where applicable, to the meaning and purpose of the other specific rights and freedoms with which it is associated within the text of the Charter. The interpretation should be . . . a generous rather than a legalistic one, aimed at fulfilling the purpose of the guarantee and securing for individuals the full benefit of the Charter's protection."

[42] The Constitution is forward-looking and guarantees to every citizen fundamental rights in such a manner that the ordinary person-in-the-street, who is aware of these guarantees, immediately claims them without further ado – and assumes that every right so guaranteed is available to him or her on demand. Some rights in the Constitution are the ideal and something to be strived for. They amount to a promise, in some cases, and an indication of what a democratic society aiming to salvage lost dignity, freedom and equality should embark upon. They are values which the Constitution seeks to provide, nurture and protect for a future South Africa.

[43] However, the guarantees of the Constitution are not absolute but may be limited in one way or another. In some instances, the Constitution states in so many words that the state must take reasonable legislative and other measures, within its available

resources "to achieve the progressive realisation of each of these rights."[4] In its language, the Constitution accepts that it cannot solve all of our society's woes overnight, but must go on trying to resolve these problems. One of the limiting factors to the attainment of the Constitution's guarantees is that of limited or scarce resources. In the present case the limited haemodialysis facilities, inclusive of haemodialysis machines, beds and trained staff constitute the limited or scarce facilities.

[44] The applicant, aware of his rights under the Constitution, sought to claim in the court a quo, his right to emergency medical treatment under section 27(3). He averred that with haemodialysis he could live for a long time, without it his life would be brief. The application was turned down by Combrink J. It is that refusal to grant an order directing the respondent to cause the rendering of on-going dialysis which has precipitated this appeal. The appellant contended that the refusal by the renal unit to give him the dialysis treatment he requires in order to keep alive was unreasonable, unjust and not equitable in a just and open democratic society and was a flagrant violation of his rights. He also averred in his papers that by refusing him this treatment, the respondent was discriminating against him. This latter averment was not followed up in argument at the hearing, and I accordingly take it no further. Suffice to observe that in the light of this Court's approach to equality, the appellant's argument in that

[4] Section 27(2). See also sections 25, 26, 29 and 32.

regard could not stand.[5]

[45] The fundamental issue is whether this Court, as the guardian of the Constitution, as the protector of human rights and as the upholder of democracy, should in this case require a health authority, acting through its authorised medical practitioner, to adopt a course of treatment which in the bona fide clinical and incisive judgment of the practitioner will not cure the patient but merely prolong his life for some time. Dr Naicker's qualifications as head of the Renal Unit at Addington Hospital are undoubted and her 18 years experience as a specialist physician in the field of renal medicine puts her in a singular position when it comes to the exercise by her of her own professional judgment on renal matters. She states in her affidavit in the present matter that patients who suffer from chronic renal failure, the condition which has afflicted the appellant, have as their only hope, either an organ transplant or long-term dialysis. It is always envisaged when such patients are put on the dialysis programme, that in due course a suitable cadaver transplant may be carried out or that organ donation may be made by a suitable living person. The appellant is not a suitable candidate for renal transplant; also he does not qualify for long-term dialysis because of the scarcity of facilities and his state of health.

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5 *Harksen v Lane NO and Others* CCT 9/97, 7 October 1997, as yet unreported; *President of the Republic of South Africa and another v Hugo* 1997 (4) SA 1 (CC); 1997 (6) BCLR 708 (CC); *Prinsloo v Van der Linde and another* 1997 (3) SA 1012 (CC); 1997 (6) BCLR 759 (CC); and *Brink v Kitshoff NO* 1996 (4) SA 197 (CC); 1996 (6) BCLR 752 (CC).

[46] It appears that because the appellant is suffering from, inter alia, coronary artery disease, ischaemic heart disease which caused him to have a stroke in 1996, hypertension and diabetes, he is not a suitable candidate for kidney transplant. The results of the angiogram indicated that he has to be excluded from the dialysis programme. It appears that barring a kidney transplant, haemodialysis is the most efficacious treatment of end-stage renal failure. It appears also that the renal unit at the said hospital cannot render treatment to all end-stage renal failure patients, including the appellant, unless they satisfy the guidelines which are accepted throughout South Africa as the minimum standards to be met for admission to the dialysis programme, the main criterion of which is the patient's suitability for a renal transplant. It was not suggested on the papers before us nor in argument at the hearing that the applicant has ever considered seeking the less expensive treatment known as Continuing Ambulatory Peritoneal Dialysis (CAPD) or indeed that he was not eligible for that treatment as well. It appears that this form of treatment has been resorted to by many patients as a result of the lack of haemodialysis facilities and that while it cannot be equated to renal transplant or haemodialysis, it nonetheless prolongs life expectancy to some extent. In countries like the United Kingdom the prevalence of renal failure and the scarcity of resources has resulted in an increase in the number of patients who resort to CAPD.

[47] The appellant was initially dialysed in the private sector at the rate of

approximately R1 000 per treatment and required two or three treatments per week but could not continue with this treatment when his funds ran out and he found himself owing the private clinic approximately R25 000.

[48] Private hospitals and clinics which offer haemodialysis programmes play an important role in cases such as the present. They do afford end-stage renal failure patients with haemodialysis treatment where the public sector cannot. The private sector criteria for acceptance onto a dialysis programme are not as strict, but naturally the patient must have the funds in order to sustain treatment. It seems to me that it would alleviate the problem of the public sector if more patients were given by the private sector alternative possible treatment of providing catheters and bags which go with CAPD. The appellant in this case alleges that he was never advised about this option. If this were so, it would, in my view, be a serious indictment for the private sector which offers private renal dialysis programmes. However, the private sector is not before us and we cannot condemn it without hearing it.

[49] Perhaps a solution might be to embark upon a massive education campaign to inform the citizens generally about the causes of renal failure, hypertension and diabetes and the diet which persons afflicted by renal failure could resort to in order to prolong their life expectancy.

SACHS J:

[50] I am in full agreement with the eloquent, forceful and well-focused judgment of Chaskalson P and wish merely to add certain considerations which I regard as relevant.

[51] The special attention given by section 27(3) to non-refusal of emergency medical treatment relates to the particular sense of shock to our notions of human solidarity occasioned by the turning away from hospital of people battered and bleeding or of those who fall victim to sudden and unexpected collapse. It provides reassurance to all members of society that accident and emergency departments will be available to deal with the unforeseeable catastrophes which could befall any person, anywhere and at any time.[1] The values protected by section 27(3) would, accordingly, be undermined rather than reinforced by any unwarranted conflation of emergency and non-emergency treatment such as that argued for by the appellant.

[52] In a case such as the present which engages our compassion to the full, I feel it necessary to underline the fact that Chaskalson P's judgment, as I understand it, does not

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1 See B New *The Rationing Agenda in the NHS* (King's Fund Policy Institute, London 1996) at 9.

merely "toll the bell of lack of resources".[2] In all the open and democratic societies based upon dignity, freedom and equality with which I am familiar,[3] the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care.

[53] Indeed, while each claimant seeking access to public medical resources is entitled to individualised consideration, the lack of principled criteria for regulating such access could be more open to challenge than the existence and application of such criteria. As a UNESCO publication put it:

> "Even in the industrialized nations where public tax-supported research has made a private biomedical technology industry possible, the literal provision of equal access to high-technology care, utilized most often by the elderly, would inevitably raise the level of spending to a point which would preclude investment in preventive care for the young, and maintenance care for working adults. That is why most national health systems do not offer, or severely ration (under a variety of disguises), expensive technological care such as renal dialysis or organ transplants."[4]

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2 Quoted in *R v Cambridge Health Authority, ex parte B* [1995] 2 All ER 129 (CA) at 137c–d. In that case the judge in the Court a quo quashed the decision of a local health authority refusing to provide expensive treatment for a seriously ill child saying that ". . . the responsible authority . . . must do more than toll the bell of tight resources". The appeal Court overturned his decision.

3 Section 39(1)(a) of the Constitution requires us, when interpreting the bill of rights, to "promote the values that underlie an open and democratic society based on human dignity, equality and freedom".

4 Brody *Biomedical Technology and Human Rights* (UNESCO, Paris 1993) at 233. South Africa is a middle income country where "despite their high profile, modern lifesaving medical treatments are only available on a limited scale", Benatar "History of Medical Ethics: Africa" *Encyclopaedia of Bioethics Vol 3* Revised ed (Macmillan, New York 1995) 1465 at 1467.

The inescapable fact is that if governments were unable to confer any benefit on any person unless it conferred an identical benefit on all, the only viable option would be to confer no benefit on anybody.[5]

[54] Health care rights by their very nature have to be considered not only in a traditional legal context structured around the ideas of human autonomy but in a new analytical framework based on the notion of human interdependence. A healthy life depends upon social interdependence: the quality of air, water, and sanitation which the state maintains for the public good; the quality of one's caring relationships, which are highly correlated to health; as well as the quality of health care and support furnished officially by medical institutions and provided informally by family, friends, and the community.[6] As Minow put it:

> "Interdependence is not a social ideal, but an inescapable fact; the scarcity of resources forces it on us. Who gets to use dialysis equipment? Who goes to the front of the line for the kidney transplant?"[7]

Traditional rights analyses accordingly have to be adapted so as to take account of the

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5 See *Brown v British Columbia (Minister of Health)* (1990) 48 CRR 137 at 157–8.

6 Minow, participating in an interdisciplinary discussion held at Harvard Law School in 1993, "Session I: Applying Rights Rhetoric to Economic and Social Claims" *Economic and Social Rights and the Right to Health* (Harvard Law School Human Rights Program, Cambridge MA 1995) 1 at 3.

7 Id.

special problems created by the need to provide a broad framework of constitutional principles governing the right of access to scarce resources and to adjudicate between competing rights bearers. When rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as imposing limits on those rights (which would then have to be justified in terms of section 36), but as defining the circumstances in which the rights may most fairly and effectively be enjoyed.

[55] I conclude with some observations on the questions raised relating to section 11 of the Constitution which states that "[e]veryone has the right to life." The present case does not necessitate any attempt to give a definitive answer to all these questions. Yet it does point to the need to establish what Dworkin has in his book *Life's Dominion,* called the "relative importance of the natural and human contributions to the sanctity of life".[8] He concludes his study with the eloquent reminder that if people are to

> "retain the self consciousness and self respect that is the greatest achievement of our species, they will let neither science nor nature simply take its course, but will struggle to express, in the laws they make as citizens and the choices they make as people, the best understanding they can reach of why human life is sacred, and of the proper place of freedom in its dominion."[9]

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8 Dworkin *Life's Dominion: An Argument about Abortion and Euthanasia* (Harper Collins, London 1993) at 240.

9 Id at 241.

[56] "[T]he timing of death – once solely a matter of fate – is now increasingly becoming a matter of human choice."[10] In the United States, eighty percent of the two million people who die each year, die in hospitals and long term care institutions, and approximately seventy percent of those after a decision to forego life sustaining treatment has been made.[11] The words of Brennan J of the US Supreme Court, writing in a different context, have resonance:

> "Nearly every death involves a decision whether to undertake some medical procedure that could prolong the process of dying. Such decisions are difficult and personal. They must be made on the basis of individual values, informed by medical realities, yet within a framework governed by law. *The role of the courts is confined to defining that framework, delineating the ways in which government may and may not participate in such decisions.*"[12] (My emphasis.)

[57] However the right to life may come to be defined in South Africa, there is in reality no meaningful way in which it can constitutionally be extended to encompass the right indefinitely to evade death. As Stevens J put it: dying is part of life, its completion rather than its opposite.[13] We can, however, influence the manner in which we come to

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10 Office of Technology Assessment Task Force, Life Sustaining Technologies and the Elderly 41 (1988), quoted by Brennan J (dissenting) in *Cruzan v Director, Missouri Department of Health, et al* 497 US 261, 302 (1990). That case involved terminating rather than having access to expensive equipment.

11 Id at 302–3.

12 Id at 303.

13 Id at 343.

terms with our mortality. It is precisely here, where scarce artificial life-prolonging resources have to be called upon, that tragic medical choices have to be made.

[58] Courts are not the proper place to resolve the agonising personal and medical problems that underlie these choices. Important though our review functions are, there are areas where institutional incapacity and appropriate constitutional modesty require us to be especially cautious. Our country's legal system simply "cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient, and those who care about the patient."[14] The provisions of the bill of rights should furthermore not be interpreted in a way which results in courts feeling themselves unduly pressurised by the fear of gambling with the lives of claimants into ordering hospitals to furnish the most expensive and improbable procedures, thereby diverting scarce medical resources and prejudicing the claims of others.[15]

[59] The applicant in this case presented his claim in a most dignified manner and showed manifest appreciation for the situation of the many other persons in the same harsh circumstances as himself. If resources were co-extensive with compassion, I have

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14 *In re Jobes* 529 A2d 434 at 451 (NJ SCt, 1987). And see Lo et al "Family Decision-making on Trial: Who Decides for Incompetent Patients?" (1990) 322 *New England Journal of Medicine* 1228 at 1231.

15 Gostin commenting in "Session II Defining the Right to Adequate Health" *Economic and Social Rights and the Right to Health: An Interdisciplinary Discussion Held at Harvard Law School in September, 1993* (Harvard Law School Human Rights Program, Cambridge MA 1995) 17 at 20.

no doubt as to what my decision would have been. Unfortunately, the resources are limited, and I can find no reason to interfere with the allocation undertaken by those better equipped than I to deal with the agonising choices that had to be made.

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Counsel for the Respondent	:	CJ Pammenter SC and JS Moodley instructed by the State Attorney, KwaZulu-Natal.