MIGRANT HEALTH FORUM SUBMISSION ON THE WHITE PAPER ON NATIONAL HEALTH INSURANCE

7 June 2016

INTRODUCTION

1. The Migrant Health Forum (MHF) is a coalition of civil society organisations concerned with migrant health and access to health care services for migrants, including refugees, asylum-seekers and undocumented migrants. The submission is supported by the following MHF member organisations: Consortium for Refugees and Migrants in South Africa (CoRMSA), Jesuit Refugee Service (JRS), the International Organisation for Migration (IOM), the African Centre for Migration and Society (ACMS), SECTION27, Sonke Gender Justice, Nazareth House, Amnesty International SA, Solidarity Centre, Lawyers for Human Rights (LHR), MIWUSA and concerned academics from the Faculty of Health Sciences at Wits university.

2. We write regarding the National Health Insurance White Paper (White Paper), which was released on Thursday, 10 December 2015.

3. The Migrant Health Forum welcomes the release of the White Paper for public comment. As a forum that is committed to the realisation of the right of everyone, including migrants, to have

access to health care services, as guaranteed in section 27 of the Constitution (the Constitution)[1], we value the opportunity to participate in this policy development and implementation process. We moreover commend the National Department of Health for giving credence to the ethos of a participatory democracy and we trust that the principles of meaningful engagement as laid down in the Constitutional Court's jurisprudence[2] will be a mark of this process.

4. It is important to note that we do not seek to exceptionalise migrants. We do not suggest that migrants should have better access to health care services than South Africans. Nonetheless, this is far from the case at present. While the current law and policy provide equal access to health care services for some migrants, as will be discussed below, in practice migrants continue to experience a range of unfair discriminatory practices in the health care system. In this submission we seek to draw the attention of the Department of Health to its obligations to migrants and to ensure that NHI does not constitute a policy regression in access by different categories of migrants to health care services. We seek also to encourage the Department of Health to ensure that its practices are in line with policy when it comes to access by migrants to health care services.

5. This submission is structured as follows:

5.1. We first lay out the socio-economic position of migrants in South Africa.

5.2. Second, we consider the public health consequences of the non-provision of health care services to some populations.

[1] Constitution of the Republic of South Africa, Act 108 of 1996.

[2] *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street Johannesburg v City of Johannesburg and Others* 2008 (3) SA 208 (CC) ; 2008 (5) BCLR 475 (CC) at para 13 – 16.

5.3. Third, we discuss the marginalisation of migrants in the White Paper under the following headings:

5.3.1. The law

5.3.2. Regression

5.3.3. Equal treatment and the limitation of rights

5.4. Fourth, we discuss the variation in the treatment of migrants across provinces and the need for consistency.

5.5. Finally, and in conclusion, we propose an approach to migrants under NHI.

SOCIO-ECONOMIC POSITION OF MIGRANTS IN SOUTH AFRICA

6. In formulating any policy that affects them, it is important to locate the social and economic position of migrants within the often violent and stratified society of South Africa.

7. First, the various categories of migrants in South Africa are often misunderstood. It is important to recognise that migrants in South Africa are heterogeneous; they include internal migrants, cross-border migrants, men, women, young, old, families and individuals. Within this broad mix of people who move are a number of different categories of migrant including: Asylum seekers (on a Section 22 permit), Refugees (on a Section 24 permit), those on study, work and visitors permits, undocumented migrants and unaccompanied minors. While some migrants are new arrivals in South Africa, others have been in the country for many years. Some have been born here and see South Africa very much as home. In addition to these distinctions it is also important to remain cognisant of the fact that of South Africa's total population, only 3.4 per cent are non-nationals, which reflects a global norm.[3] Moreover, the numbers of internal

[3] http://esa.un.org/migration/p2k0data.asp.

migrants are three times higher than cross-border migrants, demonstrating that migration and mobility is very much a part of everyday life in South Africa.[4]

8. Many refugees, asylum-seekers and undocumented migrants are particularly vulnerable in South Africa. Many migrants in the country have escaped unspeakable horrors in their home countries. Often with little but the clothes on their backs, they endure long journeys through unknown territories and may become ill. Some migrants do not speak English or any South African language, which makes it almost impossible for them to navigate and have meaningful relations with other people in the country. Others are separated from friends and family. Migrants are often unfamiliar with South African law (as are many South African citizens) and have significant difficulty accessing the health care and other systems. All of these challenges are compounded by the fact that migrants struggle to find employment or any reliable source of income to support their families including children, the elderly and women.

9. Many migrants are faced with a Home Affairs office, department or officials that are bureaucratic, understaffed, and sometimes xenophobic[5] or corrupt. As a consequence, many migrants are unable to regularise their immigration status or maintain a regularised status because they are unable to pay the bribes that are demanded of them. The period when migrants are waiting for papers provides an ideal opportunity to those who seek to harass and victimise migrants.

[4] Moultrie, T. et Al, 2016. Migration in South Africa an analysis of the 2011 South African census data. African Centre for Migration & Society, University of the Witwatersrand, Johannesburg.

[5] For a detailed account of the xenophobia faced by migrants see: http://www.sahistory.org.za/article/xenophobic-violence-democratic-south-africa accessed on 10 May 2016.

10. In conclusion, the vulnerability of migrants in South Africa makes them candidates for a corrupt employer/official to exploit them. For an abusive spouse or partner to beat or rape them. For an assailant to rob them. For illnesses to come upon them.

11. At the same time, it is important to recognise the positive contribution to the South African economy and society made by many refugees and asylum-seekers and other categories of migrants in South Africa. Migration is a positive driver of development and South Africa has benefitted and continues to benefit in many ways from the multiplicity of people who live in the country. Therefore, the assumption that migrants are always a drain on the state is incorrect.

12. For the above reasons, it is important that any policy based on human dignity, equality, and freedom and that seeks to create a society of social justice and fundamental freedoms must appreciate the vulnerability of migrants in its conception, formulation and in implementation together with the important role that many migrants play in South Africa's economy and society.

PUBLIC HEALTH CONSEQUENCES OF THE EXCLUSION OF MIGRANTS

13. The need to make provision for the health care needs of asylum-seekers, refugees and undocumented migrants supports the public health interest in ensuring the health of everyone in the country.

14. Evidence suggests that there is globally a phenomenon known as the 'healthy migrant effect'.[6] This effect shows that there is a positive selection of those who move: to migrate, you need to be healthy. The majority who move are not moving in search of healthcare and are likely to be healthier than the population to which they move into. They may – once in a new country or place – need healthcare from time-to-time, including maternal and child healthcare.

[6] Malmusi D. et al, Migration-related health inequalities: Showing the complex interactions between gender, social class and place of origin. Soc Sci Med 2010;71(9):1610-1619.

In addition, those who find themselves sick once they have settled in a new place tend to return home for treatment or to be with family. However, in spite of the available data that supports these findings, it is often assumed that people move to South Africa in order to access public healthcare services. This assumption can lead to a misunderstanding of the reasons why non-nationals may need to make use of the South African public healthcare system from time to time and – as a result – cross-border migrants are often unfairly blamed for placing a burden on the public healthcare system.

15. Providing the required care and treatment to any migrant is not just good for the individual him or herself, but also makes prudent public health sense. Taking infectious disease as an example, drug resistant (DR-TB) and multidrug-resistant tuberculosis (MDR-TB) are spreading, even if the numbers of patients with drug susceptible TB (DS-TB) are slowly dropping. The number of reported new cases with DR/MDR-TB increased from 3,200 in 2004 to 14,000 in 2012. MDR-TB represents 2.2 percent of South Africa's TB cases but accounts for 32 percent of the national TB budget. The per patient cost of treatment for extensively drug-resistant TB (XDR-TB) in 2013 was US$26,392 – four times greater than MDR-TB ($6,772), and 103 times greater than drug-susceptible TB ($257). For comparison purposes, antiretroviral therapy (ART) cost $113 for one patient for one year.[7] While not the only example, TB is a highly contagious communicable disease that requires early diagnosis and treatment. Left unattended, the risk to everyone is exacerbated. The logic for early intervention would be the same for many infectious diseases, such as HIV, pneumonia and other respiratory tract infections.

16. In terms of non-communicable diseases, like hypertension, diabetes, hyperlipidaemia, epilepsy and asthma, treatment of migrants at primary care level to prevent future complications such as the need for dialysis, amputations, rehabilitation after a stroke, expensive hospitalisation and emergency medical treatment makes good financial sense. The cost of largely generic medications and counselling regarding lifestyle changes required for chronic disease

[7] Dr Gilles Van Cutsem "One patient, one nurse, one file – it isn't that hard" NSP Review Volume 14 http://www.nspreview.org/wp-content/uploads/2015/12/NSPreview14-web.pdf.

management demonstrate clearly the public health (and public purse) advantages of proactively treating health conditions in migrant populations rather than waiting for avoidable (and expensive) complications to occur.

MARGINALISATION OF MIGRANTS

17. We now turn to address what we see as the marginalisation of migrants in the White Paper.

18. We commend the explicit mention by the White Paper of permanent residents, refugees, and asylum seekers in chapter 5.2 (para 118, 121, 122 respectively). We are, however, concerned by the limited extent to which refugees, asylum seekers and other migrants appear to be covered by NHI in the White Paper. Consequently, we submit that the coverage envisioned in the White Paper may not pass constitutional muster.

The law

19. The Constitution is the supreme law of the Republic of South Africa. Any law or conduct inconsistent with it is invalid; and, the obligations imposed by it must be fulfilled.[8] It is in the Constitution that all law and policy in the country find their legitimacy.

20. As a result of our understanding of the Constitution, legislation and case law that has further assisted interpretation, we disagree with the view expressed in Chapter 1 (para 3 and 4) of the White Paper that the NHI as envisioned is consistent with the constitutional commitment to the right of access to health care services including reproductive health care and that NHI: "reflects the society we live in: which is based on values of justice, fairness and social solidarity".

[8] Section 2, Constitution of the Republic of South Africa.

21. The Constitution provides that everyone has a right to have access to health care services including reproductive health care services and that no one may be denied emergency medical treatment. It is important to note that this section has an equality-threshold that forbids group-based distinctions in the provision of health care services[9]. Moreover, "the section supplements the right to equality, by embodying an entitlement against arbitrary or unfair exclusion from the ambit of policies, laws and programmes which confer health-related benefits and by forbidding the inequitable provision of health care services".[10] This makes it clear that access to health care services cannot be limited to South African citizens. The Constitutional right to health care services is then given effect to by the National Health Act[11].

22. Section 28 (1) (c) of the Constitution states that "Every child has a right to basic nutrition, shelter, basic health care services and social services". The right of a child to the undefined "basic health care services" is not subject to progressive realization. In addition, in *Khosa v Minister of Social Development; Mahlaule v Minister of Social Development,*[12] the Constitutional Court stated that children have a right to not be discriminated against on the grounds of their parents' nationality.[13]

23. The National Health Act[14] states that subject to any condition prescribed by the Minister, government, clinics and community health centres funded by the State must provide all persons, except members of medical aid schemes and their dependents and persons receiving compensation for compensable occupational diseases, with free primary health care services. It

[9] M Pieterse (eds), Can Rights Cure? The Impact of Human Rights Litigation on South Africa's Health System (PULP, 2014).
[10] Ibid.
[11] National Health Act 61 of 2003.
[12] 2004(6) SA 505 (CC).
[13] Iain Currie & J De Waal (eds), The Bill of Rights Handbook, sixth edition, (Juta, 2013) Chapter 27 p599 para 27.1
[14] Section 4(a).

moreover provides that all pregnant and lactating women and all children below the age of six (regardless of nationality) are eligible for free health care services according to need, including access to all district, regional, tertiary and central health facilities.

24. The Refugees Act[15] further provides that refugees have the right to the same basic health care services as South Africans. As noted above, the term "basic health care services" has never been defined.

25. The Uniform Patient Fee Schedule provides that people who are not South African citizens or permanent residents are expected to pay the full fees as laid out in the Uniform Patient Fee Schedule, except refugees, asylum seekers and undocumented migrants from SADC states, who are treated in the same way as South Africans and subjected to a means test based on their income. The assessment will determine how much their fees are subsidised.[16]

26. In ensuring access to socio-economic rights, the state is under an obligation to reasonably work to towards the realization of socio-economic rights.[17] This principle means "that a reasonable government policy should not exclude a significant segment of the population, especially not those whose needs are the most urgent and whose ability to enjoy all rights is most in peril".[18]

27. The meaning of these provisions, when read together, is as follows. Everyone (regardless of citizenship or status) is entitled to free primary health care services. All pregnant and lactating women (regardless of citizenship or status) and children under age six are

[15] Act 130 of 1998, section 27(g).
[16] Annexure H.
[17] Government of the Republic of South Africa V Grootboom 2001 (1) SA 46 (CC)
[18] Iain Currie & J De Waal (eds), The Bill of Rights Handbook, sixth edition, (Juta, 2013) Chapter 27 p611 para 27.6

entitled to free health care services, which includes not only both primary health care services but hospital-based care at any level as well. Children over the age of six also have a right to health care services that is not subject to progressive realisation. Refugees, asylum seekers and undocumented migrants from SADC states are entitled, when accessing hospitals, to be treated in the same way as South Africans and subjected to a means test to determine their classification as H0, H1, H2 or H3 patients (and therefore the level of subsidisation).

Regression

28. The legal status quo has implications for NHI. The obligation on the state to realise socio-economic rights progressively means that it cannot regress in the realisation of rights. In other words, it cannot deny people access to health care services when they previously enjoyed such access.[19]

29. The coverage envisioned by NHI for refugees and asylum seekers is not commensurate with the coverage that these categories of people are entitled to receive currently. The prohibition of regression means that the following aspects of the White Paper are particularly problematic:

27.1 Under the White Paper, refugees will be entitled to "basic health care services", a term that is used in the Refugees Act but that has never been defined. Currently, refugees are treated in the same way as South Africans. They are means tested to determine the level of subsidisation in hospitals, while being provided with all primary health care services free of charge.

27.2 Asylum-seekers are, under the White Paper, entitled only to emergency medical treatment and treatment for notifiable conditions. The treatment of asylum-seekers

[19] ibid p596.

currently is the same as that of South Africans and refugees.

27.3 All other non-nationals under the White Paper will have to pay in full for health care services. Currently, both the Uniform Patient Fee Schedule and the SADC Protocol on Health mandate special treatment of nationals of SADC states. No such provision has been made in the White Paper.

27.4 The White Paper provides that a special contingency fund will be used to pay for health care services to refugees. This separation does not appear warranted under domestic, regional and international law; and, the reason behind the development of this fund is unclear and raises concerns about the future funding of health care services to all types of migrants. It also reveals the Department's apparent view that migrants are necessarily a burden on the state and should be treated as a contingency. In fact, as noted earlier, many migrants are productive economically and socially and contribute to public funds through taxation.

27.5 The White Paper makes no mention of, and therefore appears to offer no coverage to, pregnant and lactating women from outside South Africa or to their children below age six. This directly contradicts the protection given to pregnant and lactating women and children in the National Health Act and in the Constitution[20], and the policy imperative of providing special treatment to marginalised groups. It also impacts negatively on some of the most vulnerable migrants, including unaccompanied minors who will be particularly unable to pay for their own care.

30. In the ways described above, the White Paper constitutes a regression in access to health care services by migrants and is, therefore, subject to legal challenge.

Equal treatment and the limitation of rights

31. The wording of the Constitution that, "<u>everyone</u> has the right to have access to … health care services" must have some meaning. While it is not the case that rights are not subject to

[20] See above para 22.

limitation, it is the case that both international and domestic law prohibit an unjustified group-based distinction in the realisation of rights, or unfair discrimination.

32. In regional and international law, to which South Africa has indicated its assent, the position is clear. There may be no unfair discrimination between groups of people in the provision of health care services.[21] This position is relevant because the Constitution states that when interpreting the Bill of Rights, or any legislation, a court must consider international law.[22]

[21] See in particular:

- Article 25 of the Universal Declaration of Human Rights provides everyone the right to "security in the event of sickness".
- World Health Assembly Resolution WHA61/2008/REC/1 makes clear the undertakings by signatories (including South Africa) to ensure equitable access to health care services without discrimination.
- Article 16 of the African Charter on Human and People's Rights provides that, "every individual shall have the right to enjoy the best attainable state of physical and mental health".
- Article 24 of the Convention on the Rights of the Child provides the "right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". It also provides that South Africa "shall strive to ensure that no child is deprived of his or her right of access to such health care services".
- Article 2(1) of the International Covenant on Economic, Social and Cultural Rights provides "each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures." Article 2(2) provides "The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." Article 12 recognises the right of everyone to the "highest attainable standard of physical and mental health".
- Article 1(3) of the Convention on the Elimination of All Forms of Racial Discrimination provides "Nothing in this Convention may be interpreted as affecting in any way the legal provisions of States Parties concerning nationality, citizenship or naturalization, provided that such provisions do not discriminate against any particular nationality."
- Article 8(1)(c) of the Declaration on the Human Rights of Individuals Who are Not Nationals of the Country in which They Live provides "The right to health protection, medical care, social security, social services, education, rest and leisure, provided that they fulfil the requirements under the relevant regulations for participation and that undue strain is not placed on the resources of the State."

[22] Section 39 and 233.

33. In South African law, unfair discrimination in the provision of health care services is prohibited through the equality clause in the Constitution (section 9) and through section 27 of the Constitution itself, which, as stated above,[23] embodies the equality provision.

34. To assess whether denial of health care services would amount to unfair discrimination, the three-stage test developed in *Harksen v Lane*[24] is useful. First, it must be assessed whether any differentiation in the treatment of different categories of people is rationally connected to a legitimate government purpose. If the measure fails to pass this hurdle, then it is irrational and violates section 9(1) of the Constitution. If the measure is rationally connected to a legitimate government purpose, then one considers the fairness of the measure. If the measure fits within the confines of section 9(2) of the Constitution by promoting the achievement of equality and advancing the position of disadvantaged persons, then the differentiation will be presumed fair and the enquiry ends there. If the differentiation is not one contemplated by section 9(2) then it is assessed whether the differentiation implicates one of the grounds of discrimination under section 9(3) of the Constitution (including "ethnic or social origin") or an analogous ground that results in the violation of the dignity of the complainant or group. If the measure is thereby unfair, there is then a consideration of whether the discrimination can be justified in terms of section 36 of the Constitution: the limitation clause.

35. In the case of exclusion of migrants from the equal enjoyment of the right of access to health care services, while the Department may be seeking to extend coverage of NHI to as many people as possible within its available resources, the distinction between South African citizens and others on the basis of their citizenship is likely to be found to amount to unfair discrimination.

36. The right to access healthcare services is subject to limitation if such limitation can be justified, is reasonable, and complies with section 36 of the Constitution. It is possible,

[23] See above at 21.
[24] 1998 (1) SA 300 (CC)

for example, that resource constraints prevent the state from providing asylum-seekers, refugees and undocumented migrants with the same entitlements as citizens and permanent residents. In such circumstances, where the state can demonstrate its resource constraints, a limitation to the rights of certain groups may be justified.[25] Where no such evidence is produced, the limitation will not be justified. Any limitation will only be justified to the extent that it is necessary – the Department is obliged to maximise access.

37. Relevant in this regard is the Constitutional Court case *Khosa v Minister of Social Development; Mahlaule v Minister of Social Development*[26] in which the Court held that it was unreasonable for permanent residents to be excluded from social benefits and declared the policy in this regard unconstitutional. In light of the Constitutional provision that everyone has a right to access to social security and the importance of the right to equality, the Court considered the purpose served by social security, the impact of the exclusion of permanent residents and the relevance of the citizenship requirement to that purpose. The Court found that the state's arguments relating, among others, to financial constraints did not make the discrimination against permanent residents fair and that the exclusion of permanent residents was unreasonable and unconstitutional.

38. The Court went on to hold that there were compelling reasons why social benefits should not be extended to all who are in South Africa. The Court thus drew a distinction in this case between permanent residents and asylum-seekers, refugees and

[25] See further the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (which are based on the Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights). The Principles provide useful tools for assessing the reasonableness of a limitation of rights that mirror South African jurisprudence on limitation of rights.

[26] 2004(6) SA 505 (CC).

undocumented migrants. The case illustrates both that the meaning of "everyone" in the Constitution cannot be limited without appropriate justification and may extend beyond citizens, and also that distinctions between groups of people who are not citizens may be considered reasonable, depending on the evidence.

39. There are two additional important issues to note in regard to the *Khosa* case as it relates to access health care services: First, it is unlikely that a similar distinction (separating permanent residents from other migrants) could be made in the case of access to health care services due to the current legal position and the public health implications of denying access to health care services to migrants (both discussed above). Second, the Department of Social Development decided in 2012 to extend access to social grants to refugees,[27] revealing a changed view about the obligation on (and presumably financial resources of) the Department between 2004 and 2012.

40. The need to justify any limitations to the right of access to health care services ties to but is not the only reason for the importance of evidence-based decision-making: the cost of providing healthcare services to asylum-seekers, refugees and undocumented migrants must be known before it can be shown what the state can, or cannot, afford it. Thus while it is possible for the reach of the NHI to be limited, such limitation must be based on clear evidence in the light of the Constitution and international law requiring equal access to healthcare services. The denial of emergency healthcare services is unlikely to pass constitutional scrutiny, as is the denial of healthcare services to children under age six[28] and pregnant women, but the full range of healthcare services may, on evidence, be limited in respect of some groups of people.

[27] See amendments to the Social Assistance Act, published in GG 269 GN35205 30 March 2012.
[28] In accordance with Constitution, 28(1)(c), Convention on the Rights of Children, Article 24.

VARIATION IN TREATMENT OF MIGRANTS ACROSS PROVINCES

41. The White Paper currently does not offer any clarity on the responsibility and role of local authorities (eg: municipalities) and provinces in the implementation of NHI. While this may be one of the more politically difficult issues to tackle, it is vital for those responsible for the implementation of the policy to know exactly what is expected of them in fulfilling their legal responsibilities and also for the public, currently caught in the middle of the structural problems between national, provincial and local government authorities, to understand how NHI is going to improve the health care system. Clarity will strengthen accountability and increase the chances of the successful roll out of NHI. It would also give credence to the principle of cooperative governance in the Constitution.[29] For migrants in particular, this is vitally important due to the variation in how migrants are treated within the health systems of different provinces. For the purposes of certainty, there should be consistency in how migrants access health services across the country.

CONCLUSION

42. The Constitution, other domestic and regional legislation, and international law require a different approach to migrants under NHI to that laid out in the White Paper. Given that NHI is based so firmly on primary health care principles, and given the need to prevent the transmission of communicable diseases and contain non-communicable diseases early in their natural course, it seems clear that there should be no differentiation in access to primary health care services between citizens and migrants of any status/category. Access to health care services by migrants may not regress, meaning that NHI must include in its most comprehensive coverage pregnant and lactating women, and children under six years old, regardless of their nationality. NHI should also cover undocumented migrants from the SADC region. Finally, NHI should cover refugees and asylum-seekers to the same extent as South Africans and should

[29] Section 40(1).

provide special consideration to children of all ages. If a decision is taken to exclude certain people from the coverage of the White Paper, such a decision can only be based on clear evidence that the limitation of rights is necessary and justifiable—and done in a clear and transparent manner.

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