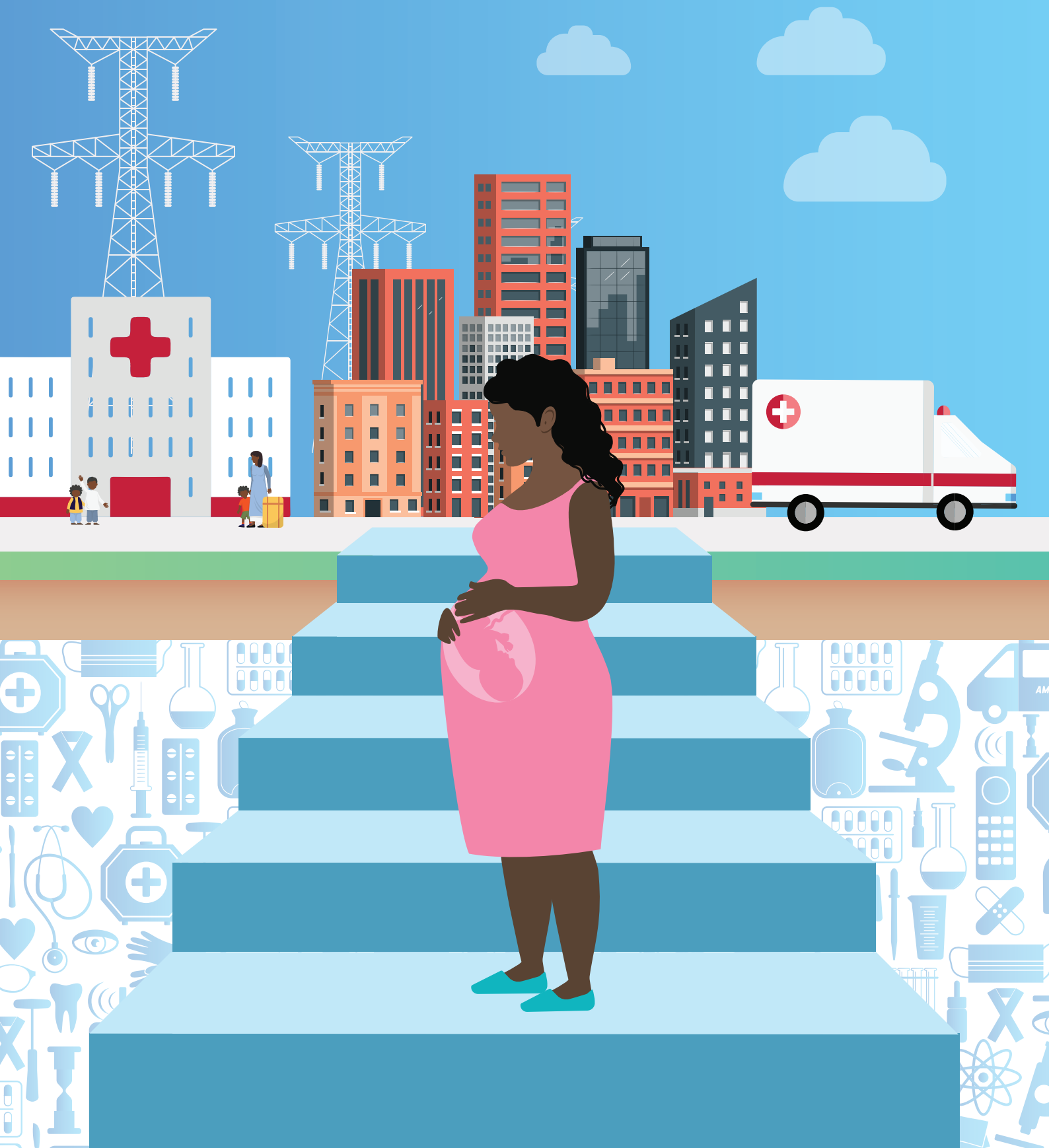
FREE HEALTHCARE

SERVICES IN SOUTH AFRICA:

A case for all mothers and children



CONTENTS

+SECTION27 catalysts for social justice | CENTRE FOR CHILD LAW | JRS SOUTH AFRICA JESUIT REFUGEE SERVICE | LAWYERS FOR HUMAN RIGHTS | MEDECINS SANS FRONTIERES DOCTORS WITHOUT BORDERS | TAC TREATMENT ACTION CAMPAIGN

Part 1: Contextualising migration

Migration is not a new phenomenon. Human beings have been moving and resettling since the dawn of humankind. While the contexts of (and actors involved in) migration have changed over time, movement itself has been a constant feature of the human experience.

Migration is a complex phenomenon because the reasons people move are varied, and subject to change.[1] Some flee persecution, conflict or war in their country of origin, while others want to reunite with family, or seek self-development through opportunities for employment and education.[2]

Migration researchers have found that migrant persons may migrate for multiple reasons.[3] This is "partly because poverty, inequality and conflict often co-exist: those who flee a country where conflict, persecution, discrimination and human rights abuse are rife, may also be trying to escape dire economic circumstances".[4]

Many states – including South Africa – have signed international agreements and declarations, and passed domestic laws and policies, in efforts to regulate international migration (the movement of an individual or community from one country to another). South African law confers different rights on different migrant persons.[5]

Using the evidence that is available, this online resource seeks to unpack to what degree South Africa is allowed to treat migrant[6] persons differently from citizens in relation to the right to access healthcare services, **with a particular focus on pregnant and lactating women, and children under the age of 6.**

Human migration is a history of the world, and the present is a reflection of this history."

— Russel King
The History of Human Migration

THE EQUALITY CLAUSE

Section 9(3) of the Constitution states that: "The state may not **unfairly discriminate directly or indirectly** against anyone on one or more grounds, including ... ethinic or social origin".

[1] Francesco Castelli (2018) *'Drivers of migration: why do people move?' Journal of Travel Medicine*, 25(1): 2.
[2] Ibid.
[3] Fatima Khan (2018) *Immigration Law in South Africa*, 4.
[4] Bridget Anderson and Michael Keith (2014) *Migration: The COMPAS Anthology*, 81.
[5] Khan (n3) *Immigration Law*, 16.
[6] SECTION27 recognises that the term 'migrant' has become contentious, and its definition has several variations. For the purposes of this resource, 'migrant persons' is an umbrella term for refugees, asylum seekers, undocumented persons and persons affected by statelessness.

Part 2: Categories of international migrant persons

There are different classifications of migrant persons recognised by South Africa:

a. ASYLUM SEEKERS[7]

An **asylum seeker** is a person who (a) has fled their country of origin, (b) is seeking recognition and protection as a refugee in the Republic of South Africa, and (c) whose application is being considered by the Refugee Reception Office located in the Department of Home Affairs.[8]

While waiting for the outcome of their application, an asylum seeker is issued with a visa (formerly a 'permit') in terms of section 22 of the Refugees Act 130 of 1998 ('the Refugees Act'). This visa allows an asylum seeker to live in the country temporarily, and it can be endorsed to reflect that they can also work or study in the country. The visa is valid for a period of up to six months and can be repeatedly renewed until the claim has finally been resolved, including any appeal and review processes.

b. RECOGNISED REFUGEES[9]

A **refugee** is a person whose asylum-seeker application has been accepted and who has been granted refugee status and protection by the Republic of South Africa. This is because their claim has been found to meet the grounds for the conferral of refugee status as set out in section 3 of the Refugees Act. Under section 24 of the Refugees Act they are granted a visa that is valid for two years. The visa may be renewed after the initial two-year period has expired.

A refugee can apply to be a permanent resident once they have lived in South Africa for ten years with a refugee-status visa.

c. UNDOCUMENTED PERSONS[10]

An **undocumented person** is one without a government-issued proof of identity, for example a birth certificate, an ID or a passport.[11] Some of the most common reasons a person can be considered undocumented while in South Africa are:

The person entered the country without any proof of immigration status, whether issued by the Department of Home Affairs of South Africa or from their country of origin. Such a person is also known as an 'irregular migrant' because they have entered South Africa without following the proper immigration procedures.

[7] Chapter 3 of the Refugees Act 130 of 1998.
[8] See useful infographics on the application for asylum in South Africa at: https://www.scalabrini.org.za/information-about-asylum-in-south-africa/
[9] Section 22 and Chapter 5 of the Refugees Act 130 of 1998.
[10] Presentation to the Department of Home Affairs Portfolio Committee on *Statelessness and Nationality in South Africa* by Lawyers for Human Rights and the UNHCR, 9 March 2021.
[11] An undocumented migrant person is without the necessary authorisation from the Department of Home Affairs to be in the country: SAHRC, *Migration: Non-nationals* booklet, p.3.

The person entered the country with proof of identity from their country of origin, or followed the lawful processes and was issued with a document by South Africa's Home Affairs, but the document has been lost or has expired and the person has not applied for a renewal.

The person is subjected to maladministration and other systemic challenges at the level of the Department of Home Affairs, which results in an inability to follow proper processes or in delays in the issuance of their document. These persons may be South African citizens.

d. PERSONS AFFECTED BY STATELESSNESS

A person affected by statelessness is one who is not considered a national under the laws of any country.[12] In other words, they do not have the nationality of any country. Some people are born stateless, but others become stateless, and there are several historical and current structural barriers that may cause this.[13] Most stateless persons live in the country of their birth.

Children are among the most vulnerable groups and are the most at risk of statelessness, often due to being:[14]

- **Orphaned and abandoned infants, or unaccompanied or separated migrant children**
- **Adults whose births have never been registered**
- **Undocumented long-term migrant persons and their children, for example when one or more generations have lived in a resettled country without documentation**
- **People from remote areas or border populations**
- **People of mixed parentage, for example when the parents of a child are nationals of different countries.**

Statelessness and the arbitrary denial of citizenship is a serious human rights violation. In many cases, persons affected by statelessness are unable to obtain identity documents, and are often denied access to education, employment, healthcare, and other essential services.[15] Access to nationality is a problem faced by migrant persons as well as by individuals born in South Africa.

e. ECONOMIC MIGRANTS

An economic migrant is a person who moves outside of their country of origin in search of education, employment or other opportunities. The Immigration Act 13 of 2002 provides for the issuing of visas for work, study and for medical purposes, among others. +

[12] Article 1(1) of the 1954 Convention Relating to the Status of Stateless Persons.
[13] For a brief outline, see: 'Presentation to the Department of Home Affairs Portfolio Committee on *Statelessness and Nationality in South Africa* by Lawyers for Human Rights and the UNHCR', 9 March 2021.
[14] Ibid.
[15] Jessica P. George and Rosalind Elphick *Promoting Citizenship and Preventing Statelessness in South Africa: A practitioner's guide* 2014, Pretoria University Law Press, p. 1.

Part 3: Health rights and state obligations

a. INTERNATIONAL AGREEMENTS

South Africa has signed several international human rights agreements:

I. International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by South Africa on 18 January 2015

Article 12(1) of ICESCR recognises the right of everyone to enjoy the highest attainable standard of physical and mental health.

Notably in relation to maternal and child health, Article 12(2)(a) of ICESCR declares that States have the obligation to provide **"for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child".** The ICESCR Committee further prohibits discriminatory access to healthcare services based on nationality.[16]

II. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), ratified by South Africa on 15 December 1995

Article 12 of CEDAW contains specific provisions calling on States to guarantee access to family planning and perinatal care. Article 12(2) provides that State Parties must ensure that women have appropriate services in connection with pregnancy, confinement and the postnatal period, **granting free services where necessary,** as well as adequate nutrition during pregnancy and lactation.

[16] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, para 18.

III. Convention on the Rights of the Child (CRC), ratified by South Africa on 16 June 1995

Articles 24(1) and (2) of the CRC provide that States must pursue the full implementation of 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. The appropriate measures to be taken include to **diminish infant and child mortality,** and to ensure **appropriate and postnatal healthcare for mothers.**

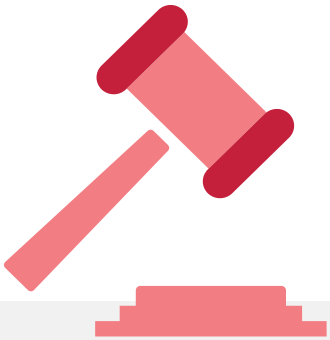
b. REGIONAL CONVENTIONS

South Africa signed the African Charter on Human and Peoples' Rights in 1996 and the Southern African Community Development Treaty in 1994, as well as its Protocol on Health in 1998, where it is accepted that it is a **shared responsibility** of African States to fulfil the health needs of African refugees and migrant persons.

In addition, on 17 December 2004, South Africa ratified the African Charter on the Rights of Women in Africa (Maputo Protocol), in which:

Article 14(2)(b) provides that State Parties shall take all appropriate measures to establish and **strengthen existing prenatal, delivery and postnatal health** and nutritional services for women during pregnancy and while they are breastfeeding.

c. CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996



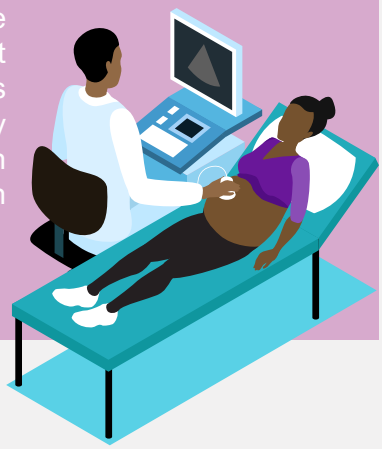
The Constitution is central to promoting and protecting the rights of all persons within the borders of South Africa. The Preamble to the Constitution states that South Africa "belongs to all who live in it", making no distinction between citizens and foreign nationals, or between documented and undocumented persons.

The term 'everyone' as contained in the Constitution has been explicitly interpreted by our courts[17] to include non-nationals. The Bill of Rights contains certain rights that apply to everyone within the territory of South Africa.

Section 27(1)(a) of the Constitution provides that **"Everyone** has the right to access healthcare services, including reproductive healthcare". This means that everyone who resides within the borders of South Africa, whether documented or otherwise, should benefit from this right.

The Constitution further provides for an immediately realisable right under section 27(3) that "No one may be refused emergency medical treatment", and under section 28(1)(c) that "Every child has the right to basic healthcare services".

The right to access healthcare services must be read together with section 9 of the Constitution – the right to equality and non-discrimination. The Constitution defines equality to include "the full and equal enjoyment of all rights and freedoms". Our Constitution sees human rights as indivisible, interrelated and mutually supporting. This means that to fully enjoy the right to health, it is necessary to also realise other rights, such as human dignity (section 10) and freedom and security of the person (section 12).



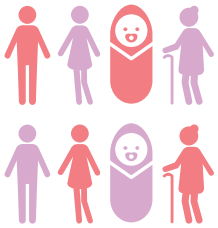
[17] *Khosa v Minister of Social Development* 2004 (6) BCLR 569 (CC) para 45 and 47 (see '*Purposive interpretation of rights*'); *Centre for Child Law v Minister of Basic Education* 2020 (3) SA 41 (ECG) para 21.

d. NATIONAL HEALTH ACT 61 OF 2003

The National Health Act (NHA) was enacted to give effect to the state's constitutional duties regarding the provision of healthcare services. The primary objective of the NHA is to regulate national health and provide for uniformity in access to health services across the nation. To achieve this purpose, the NHA makes provision for:

The constitutional right to access healthcare services for **people living in South Africa**

The rights of vulnerable groups, such as women and children.[18]



Children's constitutional right to basic health services

Under the NHA framework, irrespective of nationality and migration status:

Everyone is entitled to free primary health services, including people with communicable diseases such as HIV and TB.[19]

Every woman is entitled to access abortion services for free.

All pregnant women and children under 6 are entitled to free health services.

Objects of the Act (section 2)

The objects of this Act are to regulate national health and provide uniformity in respect of health services across the nation by -

- Establishing a national health system which:
  (ii) *Provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford.*

- Protecting, respecting, promoting, and fulfilling the rights of:
  - **the people of South Africa** to the progressive realisation of the constitutional right of access to healthcare services, including reproductive rights.
- **Children to basic nutrition and basic healthcare services** contemplated in section 28(1)(c) of the Constitution, and
- Vulnerable groups such as women, children, older persons, and persons with disabilities.

[18] Section 2(c)(i), (iii) and (iv) of the NHA.
[19] Since the early 2000s, the National Department of health has issued several national policy directives to make both TB treatment and HIV care and treatment free of charge in public health facilities, to increase treatment accessibility for everyone living in South Africa. See: National Department of Health, The South Africa national tuberculosis control programme – practical guidelines (2004), and National Department of Health, Operational plan for comprehensive HIV and AIDS care, management, and treatment for South Africa (2003).

As at October 2022, the Minister of Health had not determined any conditions regarding eligibility for free health services. That means there are no restrictions on the list of people eligible for free health services or free primary health services.

Section 3 of the NHA outlines the responsibilities of the Minister of Health, which includes the duty to determine policies and measures necessary to protect, promote, improve, and maintain the health and well-being of the *population.* The Minister further has the obligation to ensure the provision of essential health services, which must at least include primary healthcare services, *to the population of the Republic.*

Did you know?

"South Africa has not ratified the 2009 SADC Framework for Population Mobility and Communicable Diseases, despite the development of financing models to support equitable cost-sharing in the regional response to migration and communicable diseases, such as HIV." - Jo Vearey in '*Moving forward: why responding to migration, mobility in South(ern) Africa is a public health priority*' (2018).

However, "South Africa has contributed to promoting regional health through regional policy and cross-border healthcare initiatives, including the SADC HIV and AIDS Cross Border Initiative, the Elimination 8 Strategic Plan (MOSASWA) and TB in Mines (TIMS)." - Jo Vearey et al., in 'Towards a migration-aware health system in South Africa: a strategic opportunity to address health inequity (2017).

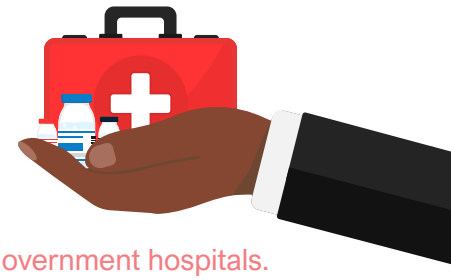
e. NATIONAL HEALTH POLICY FRAMEWORK

Free Healthcare Notice

Under the old National Health Act 63 of 1977, the Minister of Health published Notice 657 of 1994 in the Government Gazette. The Notice provides that as from 1 June 1994, free health services must be provided to pregnant women and to children under the age of 6. The Notice also specifically states that the free services in respect of pregnant women and children also apply to migrant persons in South Africa.

The Notice provides that free health services will only be rendered at state healthcare facilities that expressly include hospitals, and at state-aided hospitals. However, the Notice provides that persons (and their dependants) who are (a) on medical aid, or (b) migrant persons on a medical visa[20] who visit South Africa specifically for the purposes of obtaining healthcare, are excluded from receiving free health services.

The Notice for free healthcare services continues to be applicable and in operation at a national level.



Uniform Patient Fee Schedule (UPFS)

The UPFS sets out the fees for different categories of patients charged at government hospitals. In other words, when a patient needs to be admitted to a hospital, they are classified into fee-paying categories. The UPFS makes provision for three groups of patients:

FULL-PAYING USERS

Full-paying users are those with external funding, for example those on medical aid, and non-South African citizens who are on a tourist, visitor or medical visa, as well as undocumented persons who are **not** from the SADC region.

SUBSIDISED USERS

Subsidised users are categorised based on their ability to pay for health services. In other words, users are means-tested and are placed into one of four categories: H0, H1, H2 and H3. Asylum seekers, refugees, foreign nationals with permanent residence and undocumented persons from the SADC region are eligible for subsidisation in the same way as South African citizens.

FREE SERVICES

There are certain circumstances in which users will receive services free of charge, regardless of whether they are classified as full paying or subsidised users. These circumstances have a statutory basis, such as section 4(3)(a) of the NHA, which offers free healthcare services for pregnant women and for children under the age of six.

See more: Explanation of the Current Policy Regarding the Classification of Patients for the Determination of Fee.

[20] In terms of section 17 of the Immigration Act.

CASE STUDY:

GAUTENG HEALTH AND ITS MISALIGNED REGULATIONS AND POLICIES

It is evident that the right to access healthcare services has received significant consideration in both international and national legislation and policy, with particular attention given to the particular health needs of pregnant women and young children.

However, the prevailing laws and policies in Gauteng provide contradictory guidance to medical and administrative staff in hospitals, which often results in unlawful barriers to accessing healthcare services.

Did you know?

In 2021, the National Department of Health introduced the Maternal, Perinatal and Neonatal Health Policy, which aims to reduce maternal and child mortality by 50%, in accordance with the Sustainable Development Goals.

Hospitals Ordinance 14 of 1958 is Gauteng provincial legislation that makes provision for the classification of patients accessing services in hospitals. The MEC for Health in Gauteng has the discretion to exempt certain categories of persons from the payment of fees. However, the Hospital Ordinance makes no mention of free health services for all pregnant women and children under six. Neither do the regulations to the Hospital Ordinance ('Gauteng Regulations')[21], which are meant to set up the classification of and fees payable at provincial hospitals.

On 11 May 2020, the Gauteng Department of Health issued the *Policy Implementation Guidelines on Patient Administration and Revenue Management* ('the 2020 Policy'). The 2020 Policy is fraught with internal contradictions, and has enabled hospitals to interpret its provisions to deny pregnant women and children access to free services if they are asylum seekers, undocumented persons or persons affected by statelessness. Only pregnant women and children under six who are refugees and have valid documents are permitted to access free health services.

In effect, the Hospital Ordinance, the Gauteng Regulations, and the interpretation of the 2020 Policy are inconsistent with the NHA and its recognition of the right to free health services for **all** pregnant women and young children, irrespective of their nationality or documentation status.

In June 2022, SECTION27 and three affected persons **launched** court proceedings

[21] *Classification of and fees payable by patients at provincial hospitals*, General Notice 1426 in Provincial Gazette 414 of 24 November 2021 (effective 1 December 2021).

against the MEC of Health in Gauteng, the Minister of Health, the Director General for Health and Charlotte Maxeke Johannesburg Academic Hospital, to challenge the current state of affairs. The purpose of the case is to confirm access to free healthcare services for all pregnant and lactating women and children under six, including persons seeking asylum, undocumented persons and persons affected by statelessness. The Jesuit Refugee Service, Doctors Without Borders/Médecins Sans Frontières (MSF) and the Southern African HIV Clinicians' Society have provided evidence in support of the application, based on their experiences with cases of pregnant women and young children denied healthcare services.

The impact of denied free healthcare services

The denial of healthcare services affects pregnant women and children in different ways. For pregnant women, lack of access to healthcare services is a leading cause of maternal mortality and morbidity. Pregnant women are often referred to hospitals for antenatal care when their pregnancies are high risk (for instance, if they are living with HIV or they have gestational hypertension). Patients with high-risk pregnancies are prone to miscarriages, and maternal death in pregnancy or during childbirth. For such patients it is critical that they have access to timely, routine tertiary follow-up.

When women with high-risk pregnancies are unable to access necessary health services at hospital level, they are unable to monitor the progress of their pregnancy or identify and manage risk factors appropriately. Some women end up not accessing antenatal care consistently during their pregnancy. This results in the loss of an opportunity to make early interventions to manage and treat underlying problems. By the time pregnant women do present at hospitals, they are often already in labour and cannot be denied access to healthcare services. Where risk factors are either unknown or unmanaged, the birth process can lead to complications that could put both the pregnant woman and the foetus or the newborn in serious danger.

In the case of children, the first few years of life are critical stages of development. In the neonatal period, infants born of a mother who is living with HIV require the administration of Nevirapine within the first few hours of birth (between 48 to 72 hours). In the case of some childhood health problems, such as cerebral palsy, the type of treatment that is necessary requires input from specialist allied medical professionals, which if lacking can further complicate early childhood development. Often, these types of allied services can only be found in a hospital setting; thus, a failure to allow such patients access to a hospital is tantamount to a denial of the necessary care.

Furthermore, apart from children in the care of the state, children usually access healthcare facilities with their parents. In these instances, the documentation status of the child flows directly from their parent, and in most cases it is the documentation status of the mother that determines the status of a child. Consequently, children's access

to healthcare services is often dependent on their parents' documentation status. To illustrate why this is problematic, a worrying discriminatory trend has emerged in some healthcare facilities in Gauteng, where migrant women who give birth there have their infant's proof of birth withheld because hospital fees have not been settled. This leaves children at risk of de facto statelessness, which negatively affects a child's ability to access essential services such as healthcare, education, and social assistance).

A dysfunctional asylum system: an additional barrier to accessing healthcare

The Department of Home Affairs Refugee Reception Offices (RROs) were closed for a period of two years, due to the COVID pandemic leading to the national lockdown in terms of the Disaster Management Act 57 of 2002. Over this period, all asylum and refugee permits were extended through a Ministerial Directive. The Directive clearly stated that no person could be penalised for the expiry of their documents during this period.

In effect, some asylum seekers and refugees (including pregnant women and children under the age of 6) then had expired documents, which led to them being classified as private patients in Gauteng hospitals because they did not have valid documents. The hospitals considered the situation beyond their control; and to make matters worse, the Department of Home Affairs failed to communicate the Ministerial Directive to hospitals.

Around April 2021 the Department of Home Affairs introduced an online renewal system for refugees and asylum seekers, and the Minister ceased issuing Directives to extend the validity of the permits.

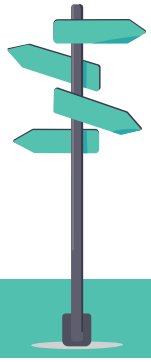
In May 2022, online services were introduced for new asylum applications; but these are already backlogged. During a parliamentary portfolio committee meeting in September 2022, the Department reported that "Since resuming new-comer services, the Department has processed 4 218 newcomers and has 9 057 booked for future dates, as of [the] end [of] July 2022".

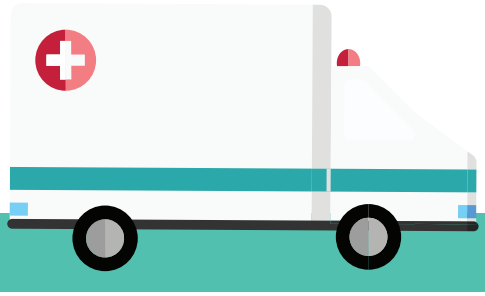
In recent months the Desmond Tutu Refugee Office (DTRRO) in Pretoria has added a further obstacle, in that they agreed with the Steve Biko Academic Hospital that patients who have valid refugee permits issued online must return to the DTRRO and obtain an additional stamp and a signature to authenticate their documents.

There does not appear to be a clear plan from the Department of Home Affairs to document refugees and asylum seekers as quickly as possible; and the only anticipated outcome is that the barriers to accessing healthcare will remain.

[21] *Classification of and fees payable by patients at provincial hospitals*, General Notice 1426 in Provincial Gazette 414 of 24 November 2021 (effective 1 December 2021).

Part 4: Looking forward: Universal healthcare coverage and the climate crisis





National Health Insurance (NHI)

There are significant changes coming to the South African health system in the form of the National Health Insurance (NHI) scheme. The NHI Bill of 2019 is currently before Parliament for deliberation. The detail of this draft legislation is important, and can be further explored **here.** The 2019 iteration of the Bill has seen a slight improvement in terms of population coverage, where the 2018 version of the Bill excluded most migrant persons from any health coverage. However, in the 2019 NHI Bill refugees are entitled to the same coverage as South African citizens, and all children are entitled to an undefined set of "basic healthcare services".[22]

Asylum seekers and undocumented migrants, on the other hand, are entitled only to pre-hospital emergency medical services. This means that such people can receive care in ambulances, but are not covered to receive emergency medical treatment and stabilisation in a health facility.[23] Such limited provision contravenes section 27(3) of the Constitution, which gives provision that "no one may be refused emergency medical treatment".

As with the current situation in Gauteng, the 2019 NHI Bill makes no reference to free maternal healthcare services for everyone living in South Africa. While asylum seekers and undocumented people are entitled to services for notifiable conditions of public health concern (such as TB, Ebola, cholera, etc.), the 2019 Bill further removes their right to receive treatment for HIV and other communicable diseases.[24] Such an approach has the potential to undermine public health efforts (both nationally and internationally) to prevent HIV transmission and reach the 90-90-90 HIV targets, which are that 90% of all people living with HIV know their status, 90% of those diagnosed receive antiretroviral treatment, and 90% of those on treatment achieve viral suppression.

As it stands, the exclusionary provisions of the 2019 NHI Bill pose a clear public health threat and constitute an unconstitutional regression in the right to access healthcare services.[25]

[22] Sasha Stevenson (2019) 'Spotlight on NHI: What has actually changed in the new Bill?' Spotlight.
[23] *Ibid.*
[24] *Ibid.*
[25] SECTION27 *The National Health Act Guide*, 3rd ed 2019, 3.

Climate refugees

The role played by the climate crisis in the future of human migration should not be underestimated. In June 2021, the World Food Programme released a report on *Climate change in Southern Africa*, which found that climate change not only has a negative impact on food security, but its recurrent shocks and stressors exacerbate existing political and socio-economic pressures.[26] With the strongest impacts of the climate crisis likely to be most evident in sub-Saharan Africa, the report forewarns that climate refugees will leave their places of origin due to the lack of adaptive capacity in the face of persistent environmental threats, and will search for safety in other countries.[27]

South Africa's National Climate Change and Health Adaptation Plan 2014-19 recognises that the climate crisis will intensify problems associated with migration. The Plan notes that the provinces that share borders with neighbouring countries need to assess their health system readiness and effectiveness to address the health needs of climate refugees.[28] As it stands, South African refugee law does not recognise the effects of climate change as a valid basis for receiving refugee status.

However, in January 2020 the UN Human Rights Committee issued a landmark ruling in which climate refugees were recognised for the first time. The Committee found that returning people to countries where their lives could be threatened by climate change would be in violation of rights and the principle of non-refoulement.[29] This principle to not refuse entry to people whose lives and freedoms are in danger by factors beyond their control is expressed in section 2 of South Africa's Refugee Act, and leaves a possible opening for refugee protection based on the threat posed by the climate crisis. +

Did you know?

Public health is also funded by users who pay for certain services at public health facilities. Those fees are determined through the Uniform Patient Fee Schedule.

Part 5: Health system deficiencies and migration: FAQs

[26] Sasha Stevenson (2019) 'Spotlight on NHI: What has actually changed in the new Bill?' Spotlight.
[27] *Ibid.*
[28] National Department of Health 'National Climate Change and Health Adaptation Plan' (2014-2019), *19.*
[29] Aimée-Noël Mbiyozo (2020) 'The UN ruling will ideally lead countries to invest more in preventing the effects of the climate crisis', *Institute for Security Studies.*

Public health is a complex matter. The ability (or inability) of the public healthcare system to deliver quality services in an efficient and effective manner to everyone must be understood in the appropriate socio-political context.[30]

South Africa has a divided and unequal healthcare system, with the public sector catering for about 70% of the population and the private sector servicing around 30%.[31] The private health sector is funded largely through individual contributions to medical aid schemes, which are increasingly expensive and unaffordable for most. The private sector is neither sufficiently regulated nor measured to ensure that its services are of high quality and meet other standards.[32] The public health sector, on the other hand, is "overburdened by patients with a limited choice of healthcare options, and crippled by severe mismanagement fault lines, deep-seated corruption, historic underdevelopment, and instances of poor policy choices, including the poor implementation of sound polices."[33]

Below, we answer frequently asked questions and bust myths about how migrants interact with the South African public health system.

1

DOES SOUTH AFRICA BUDGET FOR MIGRANT PERSONS TO ACCESS PUBLIC HEALTHCARE SERVICES?

Public health is largely state funded, and provincial health departments receive an unconditional allocation of the funds from the equitable share. The equitable share is revenue raised at national level, which is then divided and shared to provinces to enable them to deliver basic services and perform their functions.

Health is one of the largest components[34] of the equitable share, after education. A formula is used to determine how much the National Treasury allocates, based on each province's risk profile and how many people on average attend public healthcare facilities each year.[35]

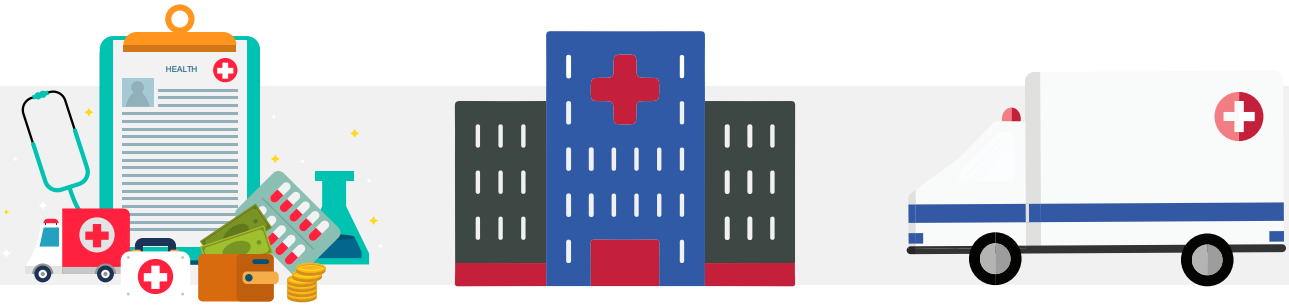
To determine the risk profile of a province, the number of uninsured people (without medical aid) in a province is considered, together with certain other factors including:[36]

The age and sex of the uninsured people, to determine their probable health needs based on the different stages of life.

The total fertility rate, which accounts for the number of times a woman is expected to give birth in her lifetime. This is an important factor because a significant portion of healthcare resources is dedicated to maternal and child health.[37]

Premature mortality data, to measure the burden of disease. For example, high premature mortality implies a high rate of disease burden, and therefore the need for more and specific healthcare services.

[30] Katusha de Villiers (2021) 'Bridging the health inequality gap: an examination of South Africa's social innovation in health landscape', *Infectious Diseases of Poverty* 19(10). Also see: Lilita Gcwabe (2022) 'Phaahla: Don't blame migrants for healthcare challenges' *Heath-E News.*
[31] Russel Rensburg (2021) 'Healthcare in South Africa: how inequity is contributing to inefficiency' *The Conversation.*
[32] SECTION27 (n25) *The National Health Act Guide 2. Also see* the final report and recommendations of the Competition Commission's Health Market Inquiry, 2019.
[33] SECTION27 (n25) *The National Health Act Guide 1.*
[34] For the 2022 medium-term budget, the health component makes up 27% of the equitable share.
[35] *Ibid.* 14.
[36] *Ibid.* 14-15.
[37] Maternal and neonatal healthcare services in South Africa have seen marked improvement. In 1998, the country's mortality rate stood at 150 deaths per 100 000 live deaths; by 2020, this had reduced to 88 deaths per 100 000 people.



To determine how many people use public healthcare facilities, the District Health Information Service submits the average number of visits to primary healthcare clinics in the past financial year, and public hospitals submit the average cost per patient-day equivalent (PDE), which measures the average cost per patient seen at hospital per day.[38]

None of the components above, used by National Treasury to allocate health funds, use nationality as a factor to differentiate between people who seek healthcare services at public health facilities in South Africa. The objective criteria merely account for the relative demand for services and the change in demographics in each province.[39]

2

ARE MIGRANTS OVER-BURDENING THE HEALTHCARE SYSTEM?

There is no evidence that migrants are placing an undue burden on the public healthcare system. The number of migrants in South Africa has been grossly exaggerated over the years.[40] The best available data by Statistics South Africa from the mid-year population estimates of 2021 found that there are about 3.95 million migrants in South Africa. This figure includes all migrants, irrespective of legal status, country of origin and socio-economic standing.[41]

The number of migrants in the country amounts to 6.5% of the country's population of over 60 million people.[42] Statistically, it is highly improbable that such a small percentage of people is responsible for overwhelming the entire public healthcare system of the country.

It is unknown how many undocumented or irregular migrants there are in South Africa at a given time.[43] The difficulty in measuring such groups is a problem faced worldwide. However, if it were the case that South Africa had an unreasonably high proportion of undocumented migrants, there would be indirect indicators to suggest as much; for example, there would be a demographic footprint.[44] Put differently, although the official number of undocumented persons in the country is not known, if their estimated numbers were far below the actual numbers then other data sources would exist that could assist in determining this.

Each year, Statistics South Africa measures the number of births and deaths to determine population estimates. It would therefore be able to identify if there was an unreasonably high

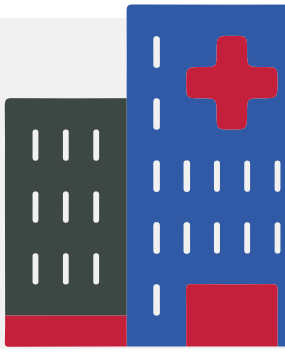
[38] According to the South African Health Review (2011: 41), the calculation of PDE combines the number of inpatients plus half the number of day patients plus one third of emergency or outpatient visits.
[39] Division of Revenue Bill 2022, *Annexure W1: Explanatory memorandum to the division of revenue,* 13.
[40] Anthony Kazaiboni *et al.* (2022) 'Scapegoating in South Africa: busting the myths about immigrants' *Institute for Security* Studies, 5.
[41] Statistics South Africa (2021) *Press Statement: Erroneous reporting of undocumented migrants in South Africa*
[42] *Ibid.* This is in line with international norms: See ISS report on busting myths about immigrants in South Africa, 2.
[43] See the Minister of Health's response to Parliament on 9 June 2022.
[44] See discussion by Institute for Security Studies 'Busting the myths about immigrants in South Africa' (14 September 2022).

proportion of undocumented migrant persons. For instance, there would be a spike in premature mortality, which refers to deaths occurring before a person reaches the age of 65. The mortality data collected by Statistics South Africa is used for various indexes, for example to determine the country's life expectancy or the burden of disease in each province.[45] Another indicator would be spikes in the total fertility rate, which would see increased demand for the provision of healthcare services for maternal and child health.[46] Such demographic 'footprints' are yet to be seen.

PHAKAMISA JUDGMENT

In the landmark case of *Centre for Child Law v Minister of Basic Education* 2020 (3) SA 41 (ECG), the High Court in the Eastern Cape recognised that denying undocumented children fundamental rights, such as the right to basic education, was not a legitimate form of immigration control. And any requirements for the submission of identification documentation for learners as a precondition to access basic education at public schools were declared to be unconstitutional.

The judgment is also significant in the context of the right to access healthcare services, where it can be argued that it is not the role of medical personnel or the Department of Health to act as immigration officers. Their obligation is to provide healthcare services as outlined in the Constitution and the NHA.



3

IS IT THE RESPONSIBILITY OF THE DEPARTMENT OF HEALTH TO IMPROVE THE ADMINISTRATION AND MANAGEMENT OF IMMIGRATION?

Section 44 of the Immigration Act places a worrying obligation on all organs of state (including departments such as health and education) to ascertain, where possible, the legal status of a person receiving its services, and report any 'illegal foreigner' to the Department of Home Affairs.

[45] Division of Revenue Bill (n39), *Annexure W1*, 16.
[46] *Ibid.*

However, section 44 further states that the determination of a person's legal status **should not prevent the provision of services to that person, as entitled under the Constitution or any law of the Republic.** This is important because to provide otherwise would be to place obligations relating to immigration on departments other than Home Affairs, and to elevate such immigration obligations above the primary responsibility of the service-providing department (such as the provision of healthcare services or education). Even in the context of warzones, the continued delivery of healthcare services to patients is considered a humanitarian issue and a fundamental practice in the protection of human rights.[47] The ability of healthcare workers to perform their medical duties and to treat patients regardless of nationality, age, gender, race or any other characteristic is a central tenet of medical ethics.[48]

4 IN TERMS OF THE LAW, WHAT HEALTH SERVICES DO MIGRANT PERSONS HAVE TO PAY FOR AND WHICH ONES ARE FREE?

Free services:

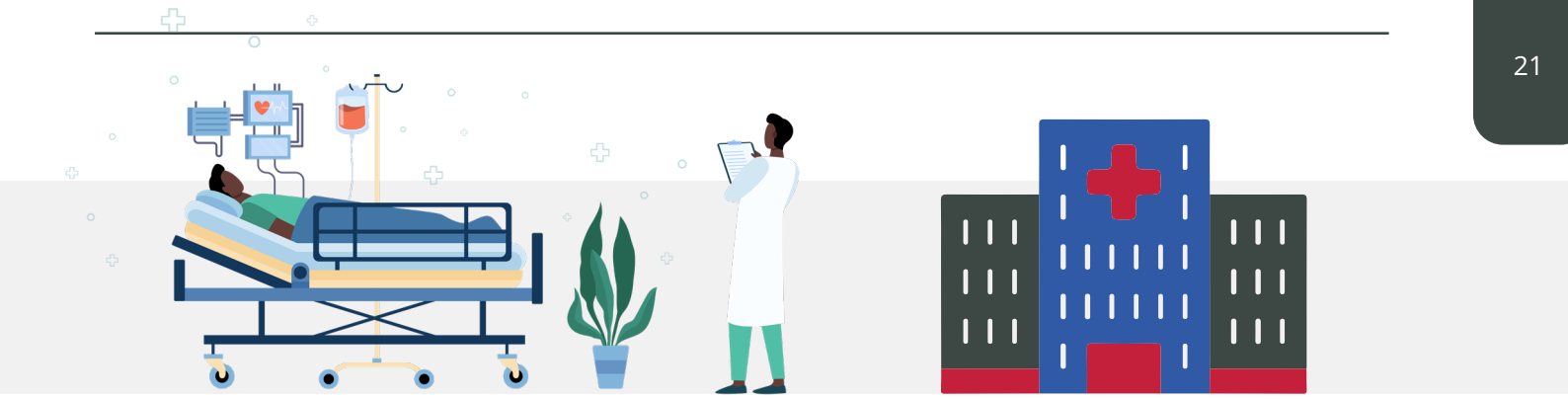
These include services for termination of pregnancy; infectious diseases such as HIV and TB; psychiatric assistance; and services in terms of the Criminal Procedure Act 51 of 1977.

According to national law and policy, pregnant and lactating women and children under six, regardless of nationality, are entitled to free health services. The unconstitutional change in policy in Gauteng on this issue is being challenged in court.

Emergency healthcare:

These services refer to urgent medical care. According to the Constitution, no one may be refused this service. However, South African citizens, asylum seekers, refugees, undocumented persons from the SADC region and those with a temporary or permanent residency permit will be billed for the services according to their income determined by a means test. Persons affected by statelessness and undocumented persons from outside the SADC region also have access to the services but will be charged the highest hospital fees.

[47] Common Article 3 of the four Geneva Conventions, which establishes fundamental rules from which no derogation is permitted.
[48] Doctors Without Borders (MSF) Press release: *Urgently safeguard people's access to healthcare, healthcare workers and medical supplies as social unrest deepens in South Africa*, 14 July 2021.



Primary healthcare:

These are services that can be provided at the level of clinics and community healthcare centres (CHCs). CHCs are larger than clinics and smaller than hospitals and have doctors and nurses attending to patients. In addition to the main sites, there are also mobile and satellite clinics that offer services. The free services offered at clinics and CHCs include sexual and reproductive health services; health service users can obtain contraceptives, and HIV and TB testing and treatment.[49]

There are currently no restrictions issued by the Minister of Health on the list of people eligible for primary health services; and therefore, everyone – regardless of nationality or other characteristics[50] – must be provided with such free health services. The Minister has the power to expand the range of free services currently available, in consultation with the Minister of Finance.[51]

Hospital treatment:

Hospitals ordinarily treat serious illnesses or other medical issues that cannot be dealt with at clinics or at CHCs, such as performing surgery and providing emergency treatment. Unless it is an emergency, a person cannot present themselves at a hospital without a referral from a clinic, CHC, or private doctor.

South African citizens, asylum seekers, refugees, undocumented persons from the SADC region and those with a temporary or permanent residency permit will be billed for the services according to their income, determined through a means test. Persons affected by statelessness and undocumented persons from outside the SADC region also have access to the services, but will be charged the highest hospital fees.[52]

A useful summary produced by the Scalabrini Centre can be found **here.**

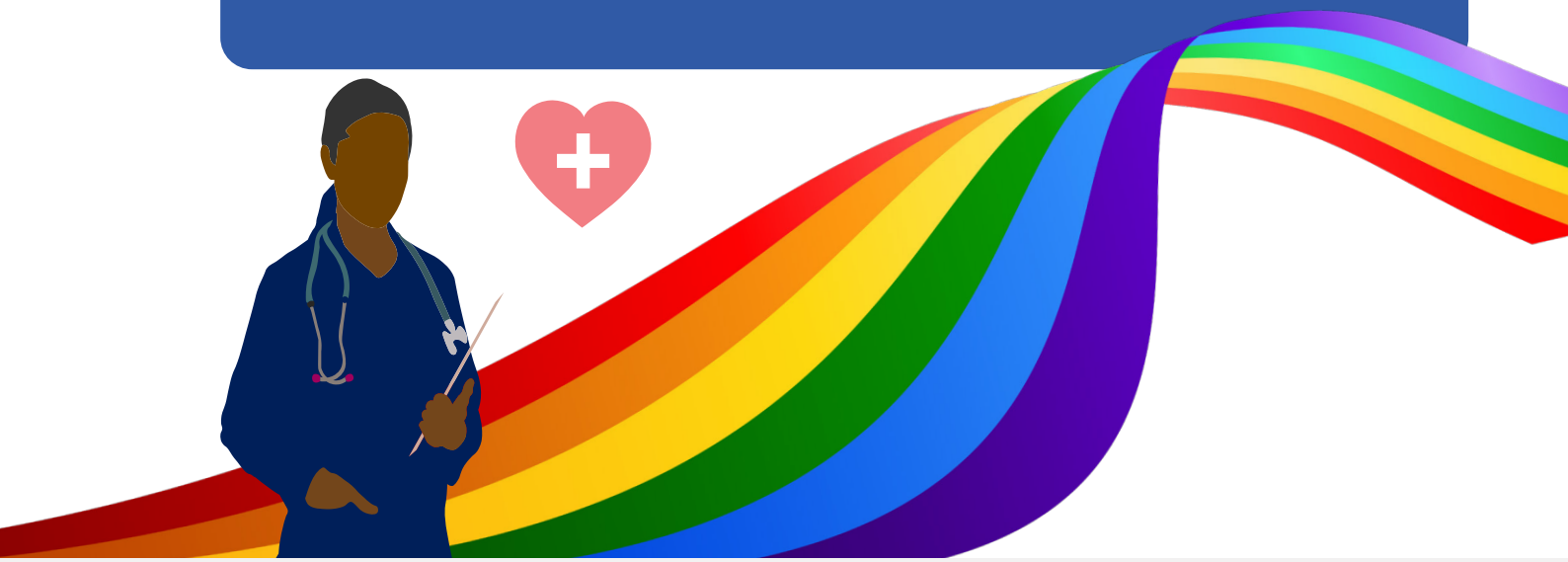
[49] Sonke Gender Justice (2022) *Report: Access to Healthcare Services for Migrants: Engagement with public health officials.*
[50] Whether a migrant person is has a disability, a mental illness or is a member of the LGBTQIA+ community, they are entitled to free primary health services and free health services if they are pregnant or under the age of six.
[51] SECTION27 (n25) *The National Health Act Guide, 55.*
[52] *Ibid.*

5

IN TERMS OF THE LAW, WHAT HEALTH SERVICES ARE AVAILABLE TO MIGRANT PERSONS WITH DISABILITIES OR MENTAL ILLNESS, OR WHO ARE MEMBERS OF THE LGBTQIA+ COMMUNITY?

Like everyone else, migrant persons with disabilities or mental illness or who are members of the LGBTQIA+ community are entitled to the same free primary healthcare services.[53] Hospital care will be billed according to income, determined through a means test.

Persons affected by statelessness and undocumented persons from outside the SADC region also have access to the services but will be charged the highest hospital fees.



6

WHAT IS MEDICAL XENOPHOBIA?

Medical xenophobia is a term used by scholars to describe the negative attitudes, perceptions and practices of healthcare providers towards people based on their nationality.[54] Healthcare providers include nurses, doctors, administrative clerks, security personnel, and others working in a healthcare setting.

[53] Section 27(1)(a) of the Constitution provides that "**Everyone** has the right to access healthcare services, including reproductive healthcare". This means that everyone who is within the borders of South Africa, whether documented or not, is a holder of this right.
[54] Kudakwashe Vanyoro (2022) 'Myths, migrants, and who benefits from medical xenophobia' *Bhekisisa.*

Useful contacts

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Human Rights Commission	www.sahrc.org.za	**Switchboard:** 011 877 3600
Equality Court	www.justice.gov.za/eqcact/eqc_main.html	**Email:** nseleka@justice.gov.za **Tel:** 012 357 8813
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