Constitutionalizing Health: Rights, Democracy & Public Policy in South Africa

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Abstract:

Just over half of countries now include a “right to health” in their constitution—but does this matter? This paper builds a theory of how a constitutional right to health impacts health policymaking in the context of evidence that electoral democracy alone is important but insufficient to significantly improve health. An initial test of this theory is conducted on a health policy case from South Africa.
In the previous chapter I have shown that countries that have included a right to health in their written constitutions have better health outcomes after controlling for the dominant social, economic, and political explanations for cross-national variation in wellbeing. The impact we see is small but statistically significant—which, as I will describe below, is in keeping with what we might expect from a relatively recent institutional and ideational changes in the last three decades. These countries do not spend more on health overall, but a larger portion of what they do spend is public spending, with lower out of pocket costs, wider availability of medicines, and better coverage of services. This finding accords with the hypothesis that the right to health acts, at least in part, through improving health-related policy processes. But how?

From one perspective there is a significant basis on which to be skeptical about the right to health as an intervention with positive impact on health policy. It is hard to spot a vast landslide of landmark court rulings that are reshaping policy to promote wellbeing. Yet scholarship in law and society has long pointed to the reality that issuing orders is a tiny portion of what courts do, while courts are a small portion of why rights and the legal complex matter for policy. Indeed it is often in the “shadow” of the law where it matters most.

Understanding the right to health as having institutional affect on policy instead forces us to look at the whole policy system—to ask what is different where rights are mobilized in that system and whether that can account for the improvements we see in the quantitative analysis. Here we can take an important cue from the literature on electoral democracy and health—which finds effect not in an election per se but in processes that change political incentives, information, actors, and venues for health policy and, over time, change policy. The quantitative analysis shows clear interaction effect between electoral democracy and the right to health—and as I will outline below the mechanisms at work reveal complex institutional effects that may contribute toward explaining why democracy alone seems empirically important but insufficient for consistent health improvement.

**Policy Change & Improving Health**

In health, perhaps more than in any other area, policy change is almost inherently required to improve outcomes and equity over time. As examined in the previous chapter, cross-national variation in health is explained not only by economic determinants and background social conditions, but also by the capacity and willingness for state and social action. Knowledge, technology, and capacity drive progress in health, yet all require political action to be translated into health affect. Whether it is allocation of resources, regulation of the public or private sphere, or structuring state services, policy ties advances in understanding with advances in wellbeing. As Angus Deaton traces, right up to the present day significant differences in health outcomes can be attributed to the translation of basic germ theory into practice—translation mediated by politics, policy, and state capacity. More contemporary examples of population-level impact can be found from maternal health to HIV to chronic disease. Advances in knowledge to prevent death in childbirth only matters in the rural Eastern Cape of South Africa if human resources for health policy shifts to bring skilled birth attendants to the region. Death related to HIV, which infects over a quarter of women in the province along with nearly 6 million others, can be prevented with medication proven effective 15 years ago—but that is only available through a decision to import affordable generic drugs. Health impact of either of these medical interventions are significantly diminished by social realities when the region lacks a system of patient transport: families

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1 Pierson 2004.
3 David and Collins 2014; Walt 1994; Birn, Pillay, and Holtz 2009.
4 Deaton 2013, 93–100.
5 South African National AIDS Council (SANAC) 2011.
with urgent health needs not only cannot reach medical care but can see their nutrition suffer when pushed into poverty to finance expensive emergency transport to far away clinics. Policy change to address medical, economic, and social drivers of wellbeing is a critical feature of improving health. In particular, addressing health inequities, which requires addressing historical legacies in healthcare and social determinants, is especially dependant upon policy change.\(^6\)

For some health issues the best policy is not particularly clear—addressing obesity, for example, has proven complicated in rich and poor countries alike. However for most of the biggest drivers of cross-national differences in wellbeing, including most of the issues examined for this project, the solution is not particularly controversial. AIDS treatment saves lives; ambulances and midwives are critically important for rural areas. There is no consensus, of course, on the ideal financing mechanisms or management structures, but in many issues examined here this controversial element is not the source of conflict. Instead, we find that for many health policy issues change is need to

- a) decide to act in the first place
- b) spread the decided action to all places and parts of the population
- c) ensure implementation at the front-lines, and
- d) ensure tools and resources for implementation are made available.

Policy change is, of course, not inherently positive—history is replete with inequity-causing policy change and the issue of health-impairing policy change is dealt with below.\(^7\) In large part, however, room for health policy change is necessary for progress. Without opportunity for change, health services are not expanded to reach those excluded; emerging health issues are not tackled in new and technologically optimal ways; financing systems are not reformed to meet changing economic, political and demographic conditions; social determinants identified as drivers of health disparities are not tackled with new policy responses; and local officials and implementing institutions are not required to adopt to changing national priorities. Therefore there is every reason to expect that policy stability is a barrier to improving health and health equity.

There is a clear set of theories linking political institutions to policy change—most prominently linking electoral democracy to improved health policy. Despite the worries of skeptics that the constitutionalizing health will either not matter or will prove disruptive to good public health policymaking, evidence below suggests institutionalizing the right to health can actually improve it.

**Democracy\(^8\) & Health Policy/Change**

Electoral democracy has been suggested by researchers in public health, economics, and political science to contribute to lower child mortality and improved life expectancy.\(^9\) The connection is distal—with the effect working largely, though perhaps not exclusively, through policy change. Other researchers, however, contest this link on theoretical and empirical grounds—finding the link between democracy and health to be missing, small, or highly contingent, which we will return to later.\(^10\) Nonetheless, there is a well-developed set of five broadly-constructed mechanisms that suggest a link between democratic governance and a greater likelihood of pro-health policy and policy change.

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\(^7\) Schrecker and Bambra 2015; Rowden 2009; Kentikelenis et al. 2014; Stuckler, King, and Basu 2008.

\(^8\) Note! that following most of the work in this area, I ground this discussion of in a “democracy that most closely resembles what Dahl labels “polyarchy”—focused on electoral competition, constraints on executive power, and protection of civil and political freedoms. Dahl 1971.

\(^9\) Lena and London 1993; Moon and Dixon 1985; Przeworski et al. 2000; Besley and Kudamatsu 2006; Gerring, Thacker, and Alfaro 2012.

Work in political economy broadly suggests that governments facing popular elections have an incentive to provide public goods in general, and public health goods in particular. The most basic model in this vein comes from Meltzer and Richard who famously argue that under democracy the “median voter” favors redistribution, which drives public goods provision.\textsuperscript{11} Under autocracy, the small and comparatively wealthy “selectorate” that chooses and maintains a leader is more identifiable and often against redistribution, giving leaders incentive to choose targeted club goods.\textsuperscript{12} Moving to mass suffrage means that any winning coalition will benefit from public health improvements and leaders will compete to provide these improvements. Huber and Stephens argue against the Meltzer-Richard hypothesis, drawing attention to how unequal power distribution in unequal societies prevents simple translation of the interests of median voters into public goods, but nonetheless find that electoral democracy expands health and welfare provision, largely by opening conditions for the emergence of left parties programmatically committed to welfare expansion.\textsuperscript{13} Politicians in democracy, it is argued, are thus incentivized to support pro-health policy change by electoral competition.

Electoral competition also provides the accountability mechanism through which voters can punish poor performers.\textsuperscript{14} Democracy raises the expectations of equity, changing the demand for provision of health services to which politicians must respond as they compete for favor.\textsuperscript{15} Literature in political science shows that retrospective voters evaluate performance and sometimes, but not always, effectively incentivize elected officials to enhance public welfare.\textsuperscript{16} Policy change is thus encouraged where politicians worry they will face electoral punishment for failing to act.

Information is another critical part of the power of democracy to affect wellbeing. Amartya Sen has shown how the flourishing of free press and opposition politics under democratic freedoms is especially critical for the flow of information to and from government that is necessary to address health issues.\textsuperscript{17} On the one hand the provision of information to the population is essential—from the value of the correct course of vaccinations to methods to prevent the spread of Ebola—and democracies encourage more, better, and more trusted information.\textsuperscript{18} On the other hand, effective government response to health threats requires accurate information come to government about health needs and performance of health-related systems, especially from poor and rural areas—a process that is compromised when speech, expression, and press freedoms are restricted.\textsuperscript{19}

Information also comes in the form of greater explanations and data transparency in democracies. Where classic autocrats need not justify their public health decisions, voters in more democratic systems will exercise the punishment function of democracy described above insofar as they are have sufficient information to be able to judge performance of government and to be able to assign responsibility for that performance.\textsuperscript{20} This creates a cycle that promotes pro-health policy change. As Ruger notes, “democratic elections (with a choice of parties) forces the party in power to justify its policies or reform them in accordance with people’s needs.”\textsuperscript{21}

\textsuperscript{11} Meltzer and Richard 1981.
\textsuperscript{12} De Mesquita et al. 2002; Boix 2011; Acemoglu and Robinson 2005.
\textsuperscript{13} Huber and Stephens 2012, 105, 148; and see Moon and Dixon 1985; but see Haggard and Kaufman 2008 who find a much less clear role for left parties and an impact of regime type that is weakly positive but largely contingent on economic context.
\textsuperscript{14} Sen 2001, 179–81.
\textsuperscript{15} McGuire 2010.
\textsuperscript{16} Healy and Malhotra 2013; Fiorina 1978; Kuklinski and West 1981.
\textsuperscript{17} Sen 2001; Sen 2002.
\textsuperscript{18} Ruger 2005.
\textsuperscript{19} Dreze and Sen 1989, 213.
\textsuperscript{20} Powell Jr and Whitten 1993; Berry and Howell 2007; Hobolt, Tilley, and Banducci 2013.
\textsuperscript{21} Ruger 2005, 301.
Finally, the freedom of association under electoral democracy plays a critical role in policy change insofar as it allows experts, activists, and social movements to engage in collective claims-making.22 “With democratization, NGOs, unions, and civil society organizations burst onto the scene and press for a broader public role in the provision of social insurance and services.”23 The development of “knowledge networks” through associational life can play an outsized role in encouraging and capacitating pro-health policy change.24 Social movements, meanwhile, have played a critical role in improving public health—both by championing healthy behavior to the public and making demands on the state to respond to critical health needs.25

These key mechanisms of electoral democracy—incentivizing public goods; punishing poor performance; providing information from, to, and about government; and encouraging pro-health associational life—suggest that democracies should encourage policy change toward improving public health.

Policy Stability & Policy Change: Monopolies, Information and the Limits of Electoral Democracy

As noted, the broad research program looking for connections between health and electoral democracy suggests the link is weak or, perhaps more correctly, conditioned on certain political contexts.26 Certainly the mechanisms described above sometimes work on health policy much as theorized. McGuire shows how, for example, a South Korean coalition of progressive doctors, academics, and former prodemocracy activists built electoral pressure after the introduction of multi-party democracy to reform a dysfunctional health insurance system, over the objection of state bureaucracy, and secured a now highly-praised single payer plan in the 1990s.27 In Indonesia, information from the Demographic and Health Survey showing a significantly increasing maternal mortality rate despite an “expert”-designed and defended midwife program sparked mass media attention and politician-led restructuring of maternal health in the country.28

In other cases, however, these mechanisms work much less effectively to produce the theorized results in health. As I detail below, in the Eastern Cape in South Africa basic life-saving emergency health services remained unavailable for decades despite clear need for policy change—through multiple elections, significant media attention, and even protest marches. In India, HIV treatment was not rolled out in earnest until nearly eight years after the critical scientific breakthroughs, long after similar lower middle income countries had done so and despite a mounting death toll long-ago exposed by open media and the democratic process.

These examples illustrate the reality that the effects of democracy are highly contingent. In practice, health policy sometimes shows a marked resistance to democratic pressure. As Haggard & Kaufman note, “The effects of democracy and authoritarianism depend on the underlying coalitional alignments and economic interests....”29 Electoral pressures do not always hold as politicians short time horizons encourage trading short term gains for long term health benefits.30 Information about politicians performance is often hard to attain, even with a free press. Associational life may empower some actors

22 McAdam, Tarrow, and Tilly 2001; McAdam, McCarthy, and Zald 1996.
24 McGuire 2010.
25 Brown and Zavestoski 2004; Cordner, Brown, and Morello-Frosch 2014; Kapstein and Bushy 2013; Smith and Siplon 2006.
26 Haggard and Kaufman 2008; Ross 2006; Shandra et al. 2004; Huber and Stephens 2012.
28 Ibid., 269–73.
29 Haggard and Kaufman 2008, 16.
to secure pro-health policy, but this may not work as effectively for the poor and marginalized who often account for a large portion of avoidable morbidity and mortality.

None of these limitations are surprising when viewed from the perspective of contemporary public policy research. A standard model in political science is based on the principle that “elections matter” and preferences change policy. The nature of democratic accountability is that elections change preferences by either replacing policymakers with other policymakers or triggering shifts in preferences of those seeking to maintain their offices. However this narrative has been sharply challenged by leading scholars of public policy. Many policy changes, some argue most, are simply not empirically accounted for actual elections or electoral pressures, nor do they fit into ideological shifts tied to elections.

In practice a great deal of health policymaking occurs instead in what Cobb & Elder called “systems of limited participation.” These systems have been well described in political science literature within several leading theoretical frameworks. Similar ideas with different names have variously been called policy monopolies, policy sub-systems, iron triangles, and sub-governments.

Kingdon’s description of multiple streams—problem, policy and politics—helps explain the often-slow process of policy change. Even as significant need for policy change arises, it is often blocked until the emergence of feasible solutions that align directly with political conditions and coalitions. Building off this insight Punctuated Equilibrium Theory (PET), led by Baumgartner & Jones and others, incorporates a robust research program explaining how and why equilibria are maintained in policy cycles for long stretches of relative policy stability, characterized by only incremental changes, but are interrupted occasionally by significant, rapid changes. Policy “monopolies” mobilize a powerful positive “policy image” to deflect attention and legitimize limiting policymaking to a select group of actors. Sabatier’s Advocacy Coalition Framework (ACF) argues that key decisions are taken inside “subsystems” and the dynamics of competition between competing coalitions within this sub-system is at the heart of policy change. Below I use the term “monopoly” to reflect the often-pernicious effect of these closed systems of policymaking on the policy-change needed for health and health equity.

The core idea of a policy monopoly is that an identifiable group of participants—bureaucrats, experts, interest groups—exercises control over both the decision-making and political understanding of a policy issue and can block (or enact) change.

“Policy monopolies have two important characteristics. First, a definable institutional structure is responsible for policymaking, and that structure limits access to the policy process. Second, a powerful supporting idea is associated with the institution. These buttressing policy ideas are generally connected to core political values…” which legitimate the exercise of exclusive authority over policymaking.

The institutional arrangements for decision-making (e.g. Congressional committee rules or federal autonomy) and the dominance of a particular idea (e.g. nuclear power as “progress”) make it all but impossible to challenge the existing policy regime. Actors whose interests are served by the policy monopoly work directly to maintain it by building the legitimacy of the central idea. This deflects the attention of the macro political sphere—high level politicians and officials—who lack both the interest.

31 Klingemann, Hofferbert, and Budge 1994.
32 Baumgartner, Foucault, and François 2009; Workman, Jones, and Jochim 2009.
33 Cobb and Elder 1971.
34 Kingdon 2003.
35 Baumgartner and Jones 1993; Jones and Baumgartner 2012.
36 Sabatier 1988; Sabatier and Jenkins-Smith 1993; Weible, Sabatier, and McQueen 2009.
37 Baumgartner and Jones 1993, 7.
in attending to the policy issue (since they see delegation to the monopoly as legitimate) and the capacity to attend to the issue (given constraints on time and competition for space on the political agenda). Policy entrepreneurs are thus not able to mobilize the macro political stream to attend to their framing of problems and solutions. Without that political attention, policy entrepreneurs will not have sufficient power to interrupt the status quo—there will be no window for policy change.

In health policy, monopolies can help explain the lack of policy change where democratic pressures seem to have been applied and failed. Several examples are described in detail below including: In India the decision to delay roll out of antiretroviral HIV drugs was maintained as a technical one, delegated to debates inside the National AIDS Control Organization, and guided by the idea of a fiscal constrained health system that had to prioritize public health and prevention. In the Eastern Cape, failure to effectively expand emergency health services occurred despite media attention, demands from the population, and even pressure from the national Department of Health. A small monopoly of self interested actors—some directly benefiting from procurement contracts that failed to expand services to the poor—were protected by a few powerful regional politicians and the dual ideas of health as a provincial area of control and the ANC as slowly but steadily implementing “transformation” of the health system.

The original U.S.-based PET works showing policy monopolies in operation in nuclear power, tobacco, and auto safety have been augmented by studies showing the same in a wide variety of policy areas from environmental policy to civil rights, education, and farming. Studies have also brought the original U.S. framework into comparative perspective—most often in Western Europe but also in Africa, Asia, and Latin America, including on issues of health policy. In each of these settings, policy monopolies have been shown to be powerful forces for maintaining relative policy stability.

Importantly, while this mechanism is perhaps most clear in electoral democracies, it has also been shown to operate under authoritarian governance as well. There attention of the macro-political structures may be different in character but is also limited—sometimes even more so.

Policy change, of course, does happen and central part of PET is an explanation of how equilibrium gets punctuated by change. The critical insight is that policy change generally requires the destruction of the policy monopoly. This often occurs as those left out of the exclusive space of policymaking effectively do what Schattschneider famously refers to as “expanding the conflict.” Policy entrepreneurs, those promoting alternative policy choices not supported by the interests inside the monopoly, work to reframe the issue using a new “policy image” of way of thinking about the policy issue that attracts and legitimates the involvement of new actors in the policy space of the issue. In particular, some policy images allow policy entrepreneurs to engage in venue shifting—moving consideration of the issue to a new committee or federal agency, for example, that is more favorable to entrepreneurs and is now willing to exert policy control because the new policy image now makes its engagement legitimate. Reframing the policy issue may also successfully mobilize support—in public and in the media—which in turn may attract the attention of the macro political sector. Once this happens, the mode of policymaking and government information processing shifts. Since there are inherent limits on the amount of attention the macro political sphere has to allocate to different policy issues, work is delegated.

38 Jones and Baumgartner 2012.
39 Baumgartner and Jones 1993; Wood 2006; Vergari 2007; Worsham and Stores 2012.
40 Timmermans and Scholten 2006; Baumgartner, Green-Pedersen, and Jones 2006; Green-Pedersen and Walgrave 2014.
41 Ohemeng and Anebo 2012; Liu and Jayakar 2012; Tosun 2013; Lam and Chan 2015.
42 Walt et al. 2008; Shiffman 2007; Martin and Streams 2015.
43 Chan and Zhao 2015; Lam and Chan 2015; Baumgartner et al. 2015.
44 Schattschneider 1975.
to a small set of actors so that multiple sub-systems could engage in “parallel” processing. Macro politics instead engages in “serial” processing—where issues are dealt with sequentially but in so doing they receive sufficient attention for major change, or punctuation.  

This move to reframe and attract support, however, is not easy—especially given unequal distribution of power that enables effective maintenance of monopolies, even under direct challenge. Powerful interest groups—the winners of a given system—have a variety of mechanisms to support policy stability in their favor, which plays out clearly in health policy. Even under democracy, various factors can compound the problem: Where policy entrepreneurs are largely from poor and marginalized communities, for example, it is easy for monopoly actors to prevent them from seizing legitimacy. We see this where people living with HIV in India—including drug users, sex workers, and queer communities—were effectively barred from participating in policymaking by NACO who claimed to know better. Meanwhile, where issues are characterized by multi-level governance (e.g. federalism) monopolies may be easier to maintain. In the Eastern Cape, the backing of seemingly powerful actors in the national Department of Health was insufficient to cause policy change because of the institutional arrangements restricting policymaking to the provincial level. Finally it must be recognized that some monopolies are composed of actors who are simply very powerful—holding vastly more resources than those who would challenge them. Another reason that the national Department of Health was not an effective ally in policy change in the Eastern Cape—theoretically at a higher level of governance—was that within the ANC hierarchy Eastern Cape leaders at times simply outranked the Deputy Minister of Health and chose to protect the monopoly against challenge.

This suggests one reason why electoral democracy has, at times, quite limited impact on health policy change. Policy monopolies are, as noted above, only sometimes overcome by the pressures of elections and political freedoms. More generally we should understand that a focus on the preferences of elected politicians can miss a critical point about information. Sometimes new information—either about the policy issue or about what voters want—changes behavior. But if that information is ignored it does not. In a world of complex political relationships and a wide variety problems facing any government—elected or not—policy change is as much about which information the macro political sphere focuses on as it is about the preferences of political actors. “Much of politics is about highlighting information as actors compete to define a political issue. If such ‘attention shifts’ occur, behavior might very well change whereas preferences do not.”

We should hardly be surprised that the question of ambulances for poor rural Black South Africans has a hard time breaking through to national politics; insofar as focusing attention means challenging powerful regional political actors, national politicians have every incentive to direct their attention elsewhere. And in this way the politics of attention is critical to understanding health policy change.

What is Different Under a Right to Health? Institution, Idea, Opportunity

“… democracy that does not extend beyond civil and political freedoms provides few tools to address inequalities underlying poverty,” writes Hari Englund in his study of Malawi. On health, both empirical data and studies of public policy seem to back him up—more tools are needed for more and deeper policy change to improve health and health equity. The quantitative analysis presented previously shows a clear benefit of health rights and an interaction between the right to health and electoral democracy—

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46 Wood 2006.
48 Fox and Reich 2015; Marmor and McKissick 2000; Gottschalk 2000.
49 Mortensen 2007, 376.
50 Wood 2006.
51 Baumgartner, Jones, and Wilkerson 2011, 499.
rights matter, and matter more under democracy. What is different, then, with a right to health—and might it provide a different set of tools for health policy change?

The right to health, as outlined in the introductory chapter, is complex—with institutional properties that shape the “rules of the game” as well as ideational aspects that provide a certain weight in favor of some policy ideas. Where the right is institutionalized it provides what Scheingold labels a “resource”—available to be used by a variety of actors in ongoing struggles over policy—and in the next section I explore how that resource acts positively on health policy, rather deleteriously one as critics worry. But to start, we should understand what is different under a right to health.

On the institutional front, the cases explored below in South Africa, India, Malawi, and Thailand suggest the right to health should be understood in the context of political economy work that sees institutions as setting a logic of “appropriateness” for actors and venues. While it is tempting to see the right to health as mere window dressing, an institutional view suggests law and constitutions are not simply instrumental rhetoric for the interests of political actors, but assert an ongoing structural influence that constrains some actors, empowers others, and privileges a certain range of policy options.

A right to health, thus has important institutional characteristics. First, as previous studies have clearly shown, a constitutionalized right to health provides new venue options for health policymaking—including courts, human rights commissions, and other judicial and quasi-judicial settings. Related to this, it also provides legitimacy to an expanded set of actors to engage in health-related policy—this includes lawyers, judges, and human rights activists who are not otherwise involved in health policymaking cycles. As institutionalist scholars note, institutional developments give rise to new organizations and reshape existing organizations, who seek to take advantage of the environment—in this case often NGOs and legal support groups. But we also see that institutions shape collective action—social movement groups and groups of patients who might otherwise not act together may find common cause in a lawsuit or the process of submitting a human rights complaint.

Like any set of rights, the right to health has an important ideational component—and that component does important work in policy change. As we look to questions of change, ideas have an important role in explaining how policy change happens quickly inside institutions that do not. Schmidt argues that “ideas and discourse overcome obstacles that the three more equilibrium-focused and static older institutionalisms posit as insurmountable.” They do so by helping explain agency—ideas are central tools by which policy entrepreneurs do their work. Ideas matter because they provide interpretive frameworks that give definition to values and preferences—they make political interests actionable in many ways. And they operate at multiple levels—from the most simple type of policy solutions to broader macro frameworks and philosophies.

The right to health operates as a mid-range idea—a framework or “program” that underpins policy and policy cycles. Though debates around the idea of a “minimum core” of specific state obligation continues to rage within jurisprudential and human rights literature, the right to health does not operate most essentially as a clear, specific policy solution. Instead, the right to health gives “weight” to certain policy ideas. Putting health policy in rights terms creates a framework in which arguments can be

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52 Scheingold 2004.
53 March and Olsen 1983; Chang 2011.
54 Smith 1988; Burgess 1993.
55 Gauri and Brinks 2008; Yamin and Gloppen 2011.
56 Hall 1993; Schmidt 2002; Béland and Cox 2010.
57 Schmidt 2008, 304.
58 Mehta 2010.
59 Schmidt 2008.
60 Young 2008; Forman et al. 2013; Bilchitz 2003.
made—and a new language for claims making and decision making.\textsuperscript{61} This “program” operates in traditional health policy venues—the South African Minister of Health, for example, has recently requested outside legal opinions about how various policy choices implicate constitutional duties. It also operates in venues that have less traditionally dealt with health—lawyers taking a case to court being the most obvious. Ideas also shape coalitions—as “magnets” that attract some while repelling others.\textsuperscript{62} Some individuals and groups may be excited by rights talk on health and come together to push for change under its umbrella—South Africa’s Treatment Action Campaign and AIDS Law Project shaped a long-running mutual relationship around this idea. Others may in turn be alienated—nurses, for example, who may see their roles shift from provider to target of rights demands.

Where the right to health is available to health actors, it provides an opportunity—a potential set of tools that can make health policymaking different than it would otherwise be in the absence of a constitutional protection. The question, then, is whether there is a real mechanism connecting the right to health to better health policy. Does the change described above help, or does it hurt by distorting policy and resource allocations?

**Rights vs. Democracy**

The claims about democracy and health are not only empirical but also normative. Democracy not only produces better health, it is claimed, but it provides the best model for health policymaking. Democracy gives voice to population, allows for the balancing of different needs and interests, and promotes polycentric policymaking in which trade offs are inherently necessary [citation]. If elections are the key to democracy, and related pressures change the preferences of rulers, then policy change that cannot be explained by elections lacks democratic legitimacy.\textsuperscript{63} This relates to the right to health because there is a significant scholarship in public health and law that suggests a constitutional right to health meets neither the normative nor the empirical bar for how to improve policy.

The criticism takes three broad forms.

First, based on a view of rights as “trumps” in the words of Dworkin, many worry they are an inappropriate framework for use in health policy, which requires balancing multiple interests.\textsuperscript{64} Rights are too individualist, too adversarial, and don’t address the core problems of cooperation, state capacity, and institution-building needed to improve wellbeing.\textsuperscript{65}

Second, prominent thinkers point to the high performing countries from the OECD—from Norway and Iceland to South Korea—and suggest strong democracy, planning, market economy, and civil society are what matter. “And what is the net impact of each country’s approach to the constitutional status of rights and judicial review?” asks Hirschl. “Quite negligible, frankly.”\textsuperscript{66} Rights, then, are a distraction.

Third, insofar as rights lead to courts, leading judicial politics literature challenges the legitimacy and utility of courts as actors in policy issues such as health. Courts face a “countermajoritarian difficulty” when they overrule policies enacted by elected officials and assumed to reflect the will of the majority.\textsuperscript{67} Socioeconomic rights, then, undercuts democracy—“in the end, we would have the courts running

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\textsuperscript{61} Ruger 2006.
\textsuperscript{62} Béland and Cox 2016.
\textsuperscript{63} Baumgartner, Jones, and Wilkerson 2011, 984.
\textsuperscript{64} Dworkin 1978. Note Dworkin himself argued against inclusion of socioeconomic rights in the South African Constitution as described in Sachs 2009, 168.
\textsuperscript{65} Siegler 1980; Kapur 2013.
\textsuperscript{66} Hirschl 2014, 181.
\textsuperscript{67} Bickel 1962. But see Graber 1993 arguing judicial review can actually increase accountability and Scheppele 2005 arguing that under some conditions courts can be more democratic than elected officials—a theme I return to below.
everything—raising taxes and deciding how the money should be spent.”68 Even if we wanted them to, though, critics suggest courts are simply not set up to tackling polycentric health policy issues, in which each change to regulation, financing, and governance affects the rest of the system.69 Working on a case-by-case basis, courts lack the tools the readily develop appropriate policies in a system characterized by “irreducible uncertainty, contestability, and contingency.”70 Courts can only offer a “pretentious, inexpert, probably vain but the nevertheless resented attempt to reshuffle the most basic resource-management priorities of the public household against the prevailing political will.”71 The judiciary lacks real “influence over either the sword or the purse,”72 and as Sunstein reminds us, courts do not control the bureaucracy needed to create systems and programs to improve health—and so their orders will make little or no difference, except to instill cynicism about rights.73

Finally, a challenge from the left argues rights talk and courts are too often captured by neoliberal discourse and are structured to serve the interests of the middle- and upper-classes.74 In health, rights will never address the issues of the poor that drive ill-health and health inequity, serving only to distract energy from social movement and attention from reform. “Ultimately, the Constitution facilitates inequality because it serves as a myth-making, deradicalising meme, its grounding in property rights typically trumps activist claims to human (socio-economic) rights.”75

This broad literature paints a deeply pessimistic picture of the potential of constitutionalizing health to have a positive impact—suggesting the quantitative findings in chapter 2 should be viewed with skepticism. Is there reason to believe, however, that the institutional and ideational changes described above act in ways other than this pessimistic set of assumptions? I find that qualitative tracing of the public policy process suggests there is.

It's Not (just) About Court: How Rights Drive Health Policy Change

A central finding of this study is that, contrary to the skeptics, a clear and powerful mechanism connects the right to health to better health outcomes by way of improved policy. Rather than a contrary, anti-democratic model of policymaking, I find the function of the right to health has significant overlap with theorized mechanisms by which democracy affects health policy. Electoral democracy is supposed to change incentives of political actors, provide information to and from the state, and increase accountability—yet as described above these mechanisms have difficulty breaking through policy monopolies and attention deficits in many contexts. The right to health, meanwhile, provides an opportunity to address some of these exact barriers to policy change—enhancing, rather than detracting from, participatory health policymaking. It acts through a mechanism that actually relies very little on court rulings alone. This explains why the very real worry about the structural and ideological limitations of judges and courts does not undermine good public health policy in the countries under study here. Where the right to health is available and mobilized, constitutionalizing health primarily acts to create an opening for policy change—it can deconstruct policy monopolies, increase information, and secure political attention.

Socio-legal scholars have long shown that most disputes that could be brought to court never are, and most of those disputes that are brought to court result in bargaining rather than clear, authoritative decisions. Much of the import of the legal system on civil matters is what happens not in court decisions

68 Tushnet 2000, 169.
69 Kaye 1989; Fuller 1960. And see Epstein and Stannard 2012, 265; Epstein 1997 for a broader economic attack on the idea of a right to healthcare, arguing it distorts markets and results in poorer health overall.
70 Michelman 2008, 21; and see Rosenberg 2008, 16, 21.
72 Hamilton 1788.
73 Sunstein 1993, 37.
74 Sunstein 1993.
75 Bond 2014.
and their specific enforcement, but “in the shadow of the law.” Law and rights protection holds the broader prospect of changing the relative power of actors because the threat of third party intervention shapes social interactions. Courts provide “bargaining endowments” to actors outside the courtroom—giving information to all parties about both the substantive entitlements and the rules/process that would likely be applied if a party were to resort to a courtroom challenge.

Looking from a policy process perspective shows us that the right to health works in this way. Court cases play an important but largely indirect role, with few policy changes directly attributable to court orders, but may traceable to the threat of orders and the experience of being challenged in courts. Rights become resources in the hands of a variety of actors which they can make use of outside the courtroom.

**Rights as Ideas**

In a real sense, as discussed above, rights are ideas—they certainly exist as they are constructed by human minds. Insofar as they are accepted and given definition to ongoing discourse and action, the ideational component of rights become “resources” with cognitive power mobilized in policy and political struggles.

Those who worry about a right to health, worry that these ideas will be too strong—that they will be understood as simplified Dworkinian “trumps” that will be captured by those with resources and distort policymaking to the detriment of public health. Even some supporters have this worry and thus urge caution by courts. In this study of the right to health, however, I find little evidence to support this worry. Instead, as Scheingold notes, “rights are declared as absolutes, but they ripple out in the real world in an exceedingly conditional fashion.” Empirical evidence in this analysis supports a much more mundane role for rights. By tracing policy areas in which the right to health has been mobilized, as I do in section 3, we see the right to health helps mobilize coalitions, legitimate engagement of certain actors in policymaking, provide new language to define policy problems, and support certain policy orientations within boundedly rational decision-making processes. And in that sense it does not short-circuit policy process but fits neatly inside a our understanding of typical policymaking.

Sen and Beitz both call human rights “reasons for action” by particular agents—a description I find fits quite well with the right to health. The RtH provides not just institutional opportunity for courts to get engaged in health policy, but also the reason to take up cases. Ruger adds to this a focus on the policy sector as where reasons are best considered. It provides a reason that officials should be compelled to provide information about their implementation of public health programs when demanded by activists, courts, human rights commissions. The RtH provides a reason for government to consider the health equity implications of seemingly non-health issues—like mining regulation or intellectual property rules. In some circumstances these reasons raise the political power of health actors within the state and provide an alternative source of legitimacy for state action on health vis-à-vis national or international economic pressures. Push back against neoliberal policy measures that can undermine health, for example, is supported by the RtH.

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76 Mnookin and Kornhauser 1979.
77 Galanter 1983.
78 Feldman 2000; Scheingold 2004; Silverstein 1996.
79 Scheingold 2004.
80 Dworkin 1978.
81 Tushnet 2009.
82 Walgrave and Varone 2008; Béland and Cox 2016.
83 Sen 2004; Beitz 2009.
84 Ruger 2010.
Destruction of Policy Monopolies

The right to health can be a tool for addressing one of the key impediments to policy change—policy monopolies. The “losers” in health policy are often those whose shorter lives and higher rates of illness drive poor health statistics. These are the people negatively affected by inequity-enhancing policy and who are depending on some form of policy change to better address their ill health. Alongside them a class of less dramatic “losers” also exist—the “policy entrepreneurs” inside and outside government who are promoting policy ideas that are not taken up and policy change that does not happen. In health these may include civil society actors and activists, academics and bureaucrats with ideas that challenge the status quo, opposition politicians. Entrepreneurs may be individuals with ideas or organizations such as patient advocacy groups.

These actors are often excluded from exercising influence over health-related policy because policymaking is monopolistic—delegated to a smaller set of actors who exercise exclusive authority over what is often cast as a complex technical issue. This may be in traditional health policy: human resources policy in Indian primary health centers is decided between state/center health officials, clinic administrators, and public sector unions, with organized patient groups impacted by staffing failures have a hard time inserting themselves in the process; procurement of AIDS medicines and treatment policy in South Africa is a negotiation between Department of Health, medical experts, and drug companies largely closed to input by civil society groups advocating alternative intellectual property rules. But this same phenomenon exists when health actors are excluded from policy issues with health implications that are not “health policy” issues: even when TB and silicosis is rampant among miners in South Africa, with large community impacts, regulation of mines is a question of commerce that includes mining companies but excludes doctors; similarly, multi-drug resistant TB transmission in prisons in South Africa is a matter of concern for the Department of Correctional Services—while doctors concerned by transmission in communities are actively excluded.

The right to health opens new opportunities for policy losers to “expand the conflict” to include others who may be more favorable to their position and shift the power dynamics that allow their perspective to be ignored. The institutional environment under constitutionalized health rights makes a specific “venue shift”—going to court—a clear recourse for excluded actors. Both the idea of rights and the possibility of going to court brings a powerful potential ally into health policy: the legal complex. This includes, most prominently, lawyers—and particularly “cause lawyers”—who hold a position of power and privilege in society. Cause lawyers, however, are just one part of this broader legal complex that includes government lawyers, judges, court administrators, bureaucratic actors as drafters andappers of regulation, and technical specialists in law such as accountants. In many countries in addition to official judiciary there are quasi-judicial enteritis such as Human Rights Commissions, Ombudsman offices, and others, which exercise some of the key power and capacity of other judicial bodies.

In health policy, excluded health policy entrepreneurs—especially those facing policy monopolies that are particularly resistant to democratic pressures—who can harness the power and legitimacy of the legal

86 Of course, there are certainly examples of other losers in some health policy decisions—tobacco corporations in high income countries, for example. In public health policy, however, not only are corporations less often the obvious losers but importantly they largely were previous winners. The move to regulate an industry on public health grounds was often itself policy change that began with destruction of a previous policy monopoly. (Cairney 2007; Worsham 2006; Givel 2006). This idea of winners becoming losers who then continue as actors in the policy cycle admittedly requires further explanation in the literature, but as “losers” regulated companies face a distinctly different challenge than attracting attention to destroy a policy monopoly.

87 Schattschneider 1975; Mortensen 2007, 347.

88 Karpik and Halliday 2011.
complex to challenge the monopoly are more likely to open space for policy change. It is worth noting that most of the work of the legal complex is not rights work, per se—it is instead the adjudication of disputes of various sorts, including disputes between different branches of the state. Courts get their “courtness” from this work, which provides a reserve of legitimacy that can then be used in the service of rights work that may challenge the state more directly. Thus, a shift in venues out of health-related policy spaces inside the state bureaucratic and political policy arms and into judicial or quasi-judicial bodies can bring powerful allies in the goal of opening policy the review and participation by others. Even strong policy monopolies may be required to open themselves to review and questioning in courts, given the broad power they exercise the legitimately do just that.

Baumgartner and Jones suggest that some ideas or policy images that are impenetrable in certain venues are less so in others. In health, ideas or images have played a key role in supporting the types of marginal changes that promote policy stability. In what are really fundamentally questions of distributive politics, about who receives what type of medical care and social protection, concepts like “cost effectiveness analysis” or in developing countries “sustainability” and “financial risk protection” have walled off key decisions as technical, bureaucratic areas of authority. Thinking in rights terms, the legal complex brings a new set of standards for judging acceptable conduct—both the spectrum of acceptable policy options and in the ways in which reasoning should happen. Providing a host of ideational possibilities to undermine the positive idea that maintains the policy monopoly—“multi-drug resistant TB treatment in prisons is/is not cost effective” is quite a different idea than “people who get TB due to overcrowding in prisons do/do not have a right to life-saving treatment.”

The claim of “rights violation” triggers a response from judicial and quasi-judicial bodies—a “hearing” in all senses of the word—which is, on its face, a change in the politics of attention on that issue. As the issue moves venues and the dominant idea that might otherwise have deterred intervention is undermined in the framework of rights, the policy monopoly begins to crack. Interests are likely to push back, maintenance efforts for the policy monopoly will occur—but the opportunity for policy change presents itself.

Insofar as health policy monopolies are maintained by deflecting attention of macro politics, mobilization of the right to health can attract that attention. On the one hand courts can issue decisions directing arms of the state to change policy, and may enforce that order with contempt charges that carry the threat of police action. In this way courts act as a macro-political actor in and of themselves, and may act directly to destroy a health policy monopoly and shift health policy. The Indian Supreme Court is, among our cases, the clearest actor in this regard as they have ordered changes in mental health administration, free emergency care at government health facilities and other policy change backed up by contempt order. (Cases) However, of the many areas of health policy issues that could be litigated, most are not—and even among those, most policy change comes about through negotiation not judicial order (or not only judicial order).

On the other hand, mobilizing the right to health can bring a far wider set of “repertoires of action” than just enforceable court orders to open health-related policy issues to attention. I will mention just four examples here—though there are several more that reveal themselves in the cases below. First, the judicial and quasi-judicial bodies have the power to compel the sharing of evidence—what is often called “discovery”—and this enforced sharing can have significant impact on destabilizing policy monopolies that thrive on selective sharing of information. Second, the power to subpoena is a key judicial power—

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90 Shapiro 2002.  
91 Baumgarner and Jones 1993.  
92 Mondou, Skogstad, and Houle 2014.  
93 Gauri and Brinks 2008; Bilchitz 2003; Gloppen 2008; Maleche and Day 2014.  
94 Karpik and Halliday 2011, 226.
and one that in the case of health policy can be critical since court ordered appearance by an official can be enough, in itself, to break up monopolistic policymaking. Third, the subpoena and related powers provides not just the ability to require open dialogue, but it also offers a reputational risk that shifts incentives—officials prefer not to be ordered into court and will take action to avoid it. Finally, court cases—at least high profile ones—often come with media. The law requires a certain kind of language and argumentation that, while often inaccessible in itself, can help provide a far clearer narrative about the need for policy change than constructed elsewhere. Whether exonerated or condemned in the end, the spotlight turned on health policies are challenged as producing rights violations is bright and can be especially important where arcane, technical-seeming issues are couched as such to preserve monopoly.

Bargaining Endowments: Information, Accountability & Incentives

The threat of third party intervention may actually be far more important for eventual impact than any actual decision as it changes the relative power of actors in the policy debate. Indeed simply the ability to win standing in a judicial body may be enough to pressure opponents into bargaining. Understanding rights as resources available to health actors to provide opportunities for health policy change to break through, we can see how the broader mechanisms at work are quite similar to those related to electoral democracy—and the right to health may actually be more effective in some circumstances in making them work. Judicial bodies can, in this way, be a “policy partner” to governments, addressing the limitations of electoral democracy as a driver of good policy.

Information is understood to be key to improving health policy—but is often locked away because of technical, bureaucratic, or simple power politics. South African activists knew anecdotally that drug resistant TB rates in prisons were sky-high, but the actual rates were kept from view as prison officials both refused to release existing data on the one hand and refused to actually even test some patients to collect data on the other. Bringing litigation against the Department of Corrections forced release of this data—which even the Department of Health reported it did not fully have or comprehend. Even without winning any order, this information itself changed policy.

Accountability is difficult when the community affected by life-or-death decisions does not hold the votes or power over elected officials. It is further complicated in multilevel governance in which one level of the state may want to enact policy change, but it does not carry through to other levels—either higher or lower. Beyond just revealing information, courts can be critical mechanisms of accountability—requiring officials to present themselves, explain their actions, and defend their rationale even when those making claims cannot mobilize votes to turn them out of office. Indeed one of the key benefits of shifting venues into a legally oriented body is the degree to which it formalizes the policy process, which can be especially helpful to marginalized groups by setting our standards of debate. Ideationally, judicial venues can force officials to speak and reason in rights-based terms and respond to argument—which can further undermine policy ideas or images that stymie accountability efforts. And of course, they can issue orders seeking to compel action, though my argument rests surprisingly little on the power of court orders per se. Courts are also not the only venues with similar accountability potential—human rights commissions, ombudsman offices, even entities within health bureaucracies charged with rights enforcement have this potential. Communities of poor, rural Black people in the Eastern Cape of South Africa, for example, could not get the local official in charge of health to even meet with them, let alone explain why the promised ambulances had never materialized, resulting in needless deaths. Threats of a lawsuit and a complaint to the Human Rights Commission (HRC) resulted

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94 McCann 2004.
95 Schepple 2005.
96 Tushnet 2009; Robinson 2009.
97 Delgado et al. 1985; McCann 2004.
in a public hearing in which political leaders in the provincial and health and treasury ministry were compelled to both listen to the testimony of residents of the community and answer questions about financing, corruption, planning, and service delivery. A follow up HRC report documented the failings, resulting in major changes in personnel and practices—accountability that had eluded the EC health system for years.

Incentives for action are also challenged by a context of policy monopolies. While we know provision of public health goods is undermined under authoritarian government, health policy broadly faces similar incentive problems regardless of regime type. Many important health-related interventions neither affect, nor come to the attention of, large, important blocks of society—be they voters or junta members. Need for HIV treatment outside Southern Africa is often concentrated in gay men, intravenous drug users, sex workers, and ethnic minorities. Inside South Africa, meanwhile, Silicosis and TB is a major health hazard, but among the largely-migrant field of miner workers. Neither of these blocks are likely to sway elections and are easily and often scapegoated in democracies or autocracies. Meanwhile, even where issues do affect large swaths of the population, political capture is a huge problem. See, for example, the arcane world of intellectual property law that despite having massive implications on the affordability of life-saving medicines is largely subject to policy monopoly because of the power of multinational pharmaceutical companies. Rights mobilization can play an important role in shifting the incentive structure. Marginalized people can harness the legitimacy and power of courts and other rights-based venues and use the ideational power of rights-based frames to increase the reputational cost of maintaining policy stasis. Political and bureaucratic leaders alike do not want to be hauled into court to be accused of rights violations. Courts quite obviously side with the interests of capital over populations often,98 yet where the success of political capture relies on keeping policy areas off limits, courts can be venues to inject public interest claims and activate public attention. The Treatment Action Campaign’s case against the Mbeki government, explored more below, illustrates the point as the democratically-elected party of liberation was nonetheless refusing to roll out HIV treatment with disastrous effect. People with AIDS were never able to harness enough power to threaten the ANC electorally and, despite clear scientific consensus against it and major media attention, the government’s reliance on African nationalist themes helped justify and uphold bad policy. That policy was finally overturned after a venue shift to the courts where the legitimacy of Constitutional Court alongside the reputational damage to the ANC from in-court revelations (plus continued social movement pressure) finally shifted ANC incentives and forced the roll out of HIV drugs over the President’s objection.

Causal Chain and the Necessary Support and Opportunity Structures

This causal chain moves from policy at time\(_1\), characterized by a policy monopoly, to rights mobilization that breaks that policy monopoly, to increased power for pro-health actors. In the end, that increased power plays out largely in a situation of some form of bargaining to reach the health policy improvements at time\(_2\) in a process of punctuated equilibrium. While important attention has been paid to the jurisprudential questions around health as a right and the process of court cases,99 my argument is a step removed from that—looking at impact on the broader policy cycle. That cycle does not end in a court decision—and need not even involve one to be an example of rights mobilization, though it often does. Instead, court decisions are best seen in the broader context of a multi-level governance scheme in which they are one particular event. They can serve as a “focusing” event\(^{100}\) and reverberate throughout the policy system. The final bargain reached—explicitly or implicitly—before a return to a more equilibrium-like state involves multiple actors and venues, more than at time\(_1\), and is more likely to result

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100 Baumgartner and Jones 1993.
in good policy outcomes because the pro-health actors have more power both inside and outside the state.

The likelihood of pro-health policy change is significantly impacted by several key factors—centrally among them whether sufficient “support structure” is available to allow effective mobilization of the right to health. 101 This includes the lawyers and supportive NGOs to facilitate rights mobilization in response to exclusion and policy monopoly. Without the work of key support organizations—Section 27 and the Bulungula Incubator as described below—the problem of emergency health transportation in South Africa’s Eastern Cape would never have resulted in a human rights complaint and the follow on response from the HRC would not have been nearly as robust. Without support structure, the right to health can remain a dead letter as some critics worry—just words written on the page. Meanwhile, factors can eliminate this benefit such as hostile courts and failed mobilization. Backlash by opponents of policy change must also be accounted for and can, in some cases, erase the gains of especially court decisions.

There is no guarantee that the policy at time $t_2$ is different or better—this is not a simple determinative process. My argument is that on balance constitutionalizing health gives opportunities for policy change. After rights mobilization prisoners are more likely to get better healthcare, people living with HIV are more likely to get medicines, and poor performing hospitals are more likely to be improved.

**A Case from South Africa**

As a first example of the causal mechanism described above, we look to South Africa—a widely celebrated and studied example of instantiation of socio-economic rights. Legal scholars and social scientists have extensively explored the jurisprudential questions and operation of courts dealing with the right to health and other socio-economic rights. 102 There remains, however, significant debate over the value of these rights in addressing health and health equity in the context of massive need and the complex politics of post-apartheid South Africa. 103

A significant part of the debate stems from the reality that South Africa is not, by most measures, a success story on health. Mortality rates are far higher and (public) health services far poorer than we would expect for an upper middle income country. South Africa’s child mortality rates are far closer to India and Uzbekistan—each with less than half South Africa’s GDP per capita. Given our previous discussion in Chapter 2, however, South Africa’s poor health outcomes are not such a mystery. A significant factor is South Africa’s current hyper-epidemic HIV rates—which cut life expectancy dramatically in recent decades. From a broader social and economic perspective (which also affects the impact of HIV), South Africa’s endowments would predict poor health outcomes. First among them, the legacies of colonialism and apartheid have left South Africa with among the most unequal wealth distributions on the planet. 104 Relatedly, the county is highly ethnically “fractionalized,” with strong ethnic/racial boundaries. 105 From these two factors alone we might expect serious challenges in coordinating effective policy to address health. In addition, South Africa is has seen rapid urbanization since the fall of Apartheid and is facing significant challenges in education and state capacity. Together, then, we should expect South Africa to face serious health challenges and difficulty driving policy change to improve wellbeing and equity. What, then, is the role of political institutions in addressing this challenging context?

103 See, e.g. conflicting perspectives in Bond 2014; Berger 2008; Pieterse 2010; Pieterse 2014; Heywood 2009.
104 World Bank 2015.
105 Lieberman 2009.
Meanwhile, South Africa ranks high in electoral democracy and political freedoms in the measures widely used by political scientists—with a 9 (out of 10) in Polity and a strong designation of “Free” by Freedom House.\textsuperscript{106}

The 1996 final constitution also includes a strong right to health, seeking to eliminate the fundamental inequities of apartheid-era health services. Section 27 of the Constitution states that:

1. Everyone has the right to have access to health care services, including reproductive health care…
2. The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
3. No one may be refused emergency medical treatment.

Building off the two concepts outlined above, this right can be considered to have become both institutionalized and available. In the interests of space, I will just briefly touch on both here with more extensive exploration to come. We can say the right is institutionalized based on the three criteria of constitutional language, legislation, and court cases. Building off the constitutional language above, the National Health Act of 2003 is the main post-apartheid legislation governing health and it explicitly references the right to health and requires the state to build a health system “taking into account the obligations imposed by the Constitution.”\textsuperscript{107} Apropos of our discussion here, the Eastern Cape Province Health Act of 1999, similarly references Section 27 of the Constitution’s explicit health right as a principle that must govern the health system.\textsuperscript{108} Finally, the Courts have taken up the right to health in numerous cases, including Constitutional Court rulings on dialysis and emergency health, HIV/AIDS, prisons, pharmaceutical regulation, and others.\textsuperscript{109}

The right is also available to be mobilized by actors insofar as an active idea in public debate. Between 2001 and 2010 the largest 10 newspapers in South Africa ran over 90 articles that explicitly dealt in one way or another with the constitutional right to health. Early in this period, there were fewer articles, dealing mostly with HIV/AIDS. However figures X and Y below show, across the time period the subject matter was extensive—dealing as much with Maternal and Child health as with HIV. Importantly, and giving some early evidence for the contention that the right to health is only partly centered on lawyers and courts, the “major actors” in these articles more often included both activists/NGOs and doctors than they did courts.

\textsuperscript{107} Marshall and Jaggers n.d.; Freedom House 2014.
\textsuperscript{108} § VI(7)(a)
\textsuperscript{109} Soobramany vs. Minister of Health, TAC v. Minister of Health, New Clicks v. SAfrica, Dudley Lee vs. Correctional Services
Illustrative Case: Emergency Medical Services in the Eastern Cape

I turn now to a specific case study of one policy process in South Africa—the issue of Emergency Medical Services and medical transportation in the Eastern Cape Province. I note at the outset this is meant to be an example to flesh out the theory outlined above before moving on to fuller case studies below. As such, in some ways this case is an outlier—it focuses on an instance in which the SA Human Rights Commission was far more active than it has been in other health rights cases for a variety of contingent reasons. In other ways, however, this case is a least-likely case for rights based policy-change based on the alternative narratives. The Eastern Cape is a large, rural area and the beneficiaries of policy change in this case, are poor, Black people living in impoverished rural area—not the elite. The case is not about individual access to a drug and the policy issues at stake are complex and “polycentric”—of the type some believe cannot be handled in rights terms.

Of Ambulances & the Social Determinants of Health

“I am grateful to hear that there is something called an ambulance that the government has issued out; we have never even heard of an ambulance.” —Community member, Xhora Mouth, Submission to the South African Human Rights Commission

“In short, our health emergencies are financially devastating. The drive us deeper into poverty and make it even harder for us to climb out.” —Xhora Mouth community statement to the South African Human Rights Commission

South Africa’s Eastern Cape Province is the second largest in South Africa—home to over 6.5 million people.\textsuperscript{110} It was formed after Apartheid fell by combining two large former Black “homelands” that had been completely underdeveloped (Transkei & Ciskei) with the areas around the white-controlled urban centers Port Elizabeth and East London. It is home to more unpaved roads and roads considered “poor or very poor” than most of the rest of the country combined.\textsuperscript{111} At the time of democratization, healthcare expenditure was at R250 ($25) per person in the previously white part of Eastern Cape, R70 ($7) in the former Ciskei, and "a paltry R40" ($4) in the Transkei.

For well over a decade public health experts, elected officials, community leaders, activists, and the media have bemoaned the massive failures in the Eastern Cape health system. From major staffing shortages to crumbling infrastructure, unpaid bills, mismanaged hospitals, and drug shortages. Corruption and graft have been a major problem—reflecting management failures on a remarkable scale.

Emergency Medical Services has been consistently a major failure in the Province—with stories sparking regular outrage. Newspapers reported in one 8 month period, for example, how a woman gave birth to a stillborn child after waiting more than 40 hours for EMS to arrive; a teenage girl fell from an apartment building and suffered for six hours on the ground with her family waiting for an ambulance to arrive; and an older woman died in a magistrates court after waiting 90 minutes for an ambulance.\textsuperscript{112}

While transportation may not seem like the most essential health system aspect, in South Africa and the Eastern Cape in particular, it plays a critical role in wellbeing and mortality. Given the rural nature of the

\textsuperscript{110} 2011 Census
\textsuperscript{111} South African Human Rights Commission 2015, 66.
Eastern Cape, the poor road infrastructure, the deep poverty, and the high costs of transportation—which can run $40-$80 for a one way emergency trip—this is a major barrier to health. The neonatal mortality rate in South Africa is strikingly high at 15 per 1000 births—neonatal deaths (those in the first 28 days) constitute 40% of all the under-5 deaths, with most deaths occurring in the early days of this period. Maternal mortality is similarly common—with estimates as high as 400 of every 100,000 births ending in death. The Eastern Cape is home to the highest rates of both maternal and child deaths in the country—where a shocking number of women die in childbirth, babies are stillborn, and under-5 children die from basic causes such as diarrhea and pneumonia. A large portion of these deaths—likely more than half—are preventable within the health system with basic interventions. But the challenge in a place like the Eastern Cape is getting people into the system. The province has the lowest rates of attendance at antenatal clinics for pre-natal care—often because parents cannot arrange transportation and, as shown below in Table X, year after year has had the lowest portion of children who are born in facilities, many without the care of a trained birth attendant. While in the U.S. fewer than 1% of babies are born unplanned while women are trying to get to medical facilities, in the Eastern Cape that number is upwards of 7-10%—and problems with emergency health services is a key factor. Strikingly, studies have linked lack of transportation to health facilities and between facilities when a higher level of care is needed to up to a quarter of deaths and severe complications related to birth, both for mother and baby. Not only does this result in death and injury, but also in HIV transmission—which is almost entirely preventable in birth, but only with HIV testing and timely administration of antiviral drugs. With AIDS still the number one killer in South Africa, millions of women giving birth are HIV positive. Meanwhile, while child birth is among the most obvious connections many others need transport along two different lines. Emergency transport is critical for the elderly but also for the young—with stories of infants and young children dying waiting an ambulance because their parents had no way to get them to hospital. Meanwhile, “planned patient transport” is critical for the elderly, those with chronic diseases, and the disabled, for whom the high cost of transport and the long distances to medical care result in missing needed medical care, dropping off treatment, and poorer health outcomes because healthcare is inaccessible for all practical purposes.

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Source: District Health Information System (DHIS), Department of Health.

Equally important, though, is the economic toll of the lack of EMS. An analysis done by Professor Jane Goudge of the University of Witwatersrand found that the cost of transportation regularly pushed medical costs for families in the Eastern Cape well past the level internationally recognized as a “catastrophic burden.” Over half of Eastern Cape households receive a social grant and about 37% are reliant on that grant as the main source of income—grants that usually run about 1,200 Rand (about $85). Incomes for many workers are not that much more. In this context, an emergency requiring a

113 Wang et al. 2014.
114 South Africa Every Death Counts Writing Group 2008.
116 South Africa Every Death Counts Writing Group 2008.
117 Alabi et al. 2015.
118 Velaphi et al. 2011.
119 Department of Health 2015.
120 Goudge 2015.
121 South African Human Rights Commission 2015, 86.
taxi that often costs 400-600 Rand means spending as much as 50% of household income—which comes at the expense of other needs like food and shelter that also impact health. A disability, chronic illness, or repeated emergency needs mean medical transport costs push people into debt, building on the cycle of social determinants that connect income, inequality, and poor health.122

**Limits to the Pressures of Democracy for Policy Change**

Over the decade, there have been waves of pressure for change—marked at various points by the kind of “focusing” events described in the literature.123 Beginning as far back as 1999, the first post-apartheid provincial minister for health Dr. Trudy Thomas resigned in protest against the deteriorating state of the health system. She was quickly replaced, however, by a person close to political leaders in the Province—someone who would later face a series of charges for improper dealings.

Electoral pressures that should incentivize change have been largely not resulted in serious policy change in the Eastern Cape for a variety of reasons. One is the power of the ANC—which has regularly won majorities in the Province. At the both the provincial and national level, however, competition in South Africa has been fierce and the opposition has fought hard for election. Beginning in the 2004 election the ANC began to drop below 50% in some areas of the province but maintained pluralities in multi-party elections, losing some districts like Aberdeen Plain, Kouga, in subsequent elections in 2009 and 2014, with more losses likely in the coming elections. Opposition parties including the Democratic Alliance, United Democratic Movement, Economic Freedom Fighters, and Congress of the People together hold a minority block of seats in the provincial legislature. That the Eastern Cape is an ANC stronghold, however, has also not meant it lack of vote-seeking—because of the size of the population and the history of the region, the national ANC party has counted on votes from the province as a whole to balance less friendly and less populated areas and therefore has conducted major voter drives.

Information has also been widely available—both information for voters about the performance of their political leaders and information to government about the health needs of the population and performance of the system. A series of high profile newspaper stories have revealed health system failures including a Sunday Times investigation of Umtata General Hospital that revealed 91 mothers were sharing 48 beds.124 Legislators responded with grand-standing and the sharing of informational reports of their own.125 At one point the chairperson of the health Standing Committee demanded publicly that the National Department of Health and Office of the Premier intervene to fill critical staffing shortages the ECDoH seemed incapable of filling.126 While this included an indictment of the EMS system, but changes failed to materialize.

In one particularly notable episode in 2007, an award-winning investigation by the Daily Dispatch showed that Frere Hospital was all but collapsing—revealing negligence, staff shortages, incompetence, and lack of equipment—and even the case of a cleaning lady delivering a baby. The national Deputy Minister of Health Nozizwe Madlala-Routledge responded by visiting the Hospital and publicly declared it a “national emergency,” calling for change.127 The provincial health minister later accused her of lying and national Minister of Health Manto Tshabala-Msimang used that as a convenient excuse to get rid of her Deputy with whom she had clashed on HIV.

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122 Marmot 2005.
125 Report of the Standing Committee on Health ‘to investigate the general state of hospitals in the province,’ 18 Sept, 2001
Throughout this period and beyond there were multiple attempts to use the levers of democracy to address the issues. Advocacy group the Public Service Accountability Monitor (PSAM) issued a damning report in 2004 on the Eastern Cape DoH’s accounting and spending practices (finding nearly 80% of funds could not be fully accounted for). Describing what they called the “Emergency Medical Services Fiasco.” They revealed the emergency medical rescue services budget for ambulance and planned patient transport was regularly under spent—by 12% in 2002/3 and 15% in 2003/4. The privatized ambulance fleet was failing to provide services up to 60% of the entire ambulance fleet of the province was out of commission because of mechanical problems. In the short term there were some changes in personnel in response to the report. But PSAM and other civil society groups largely found themselves frozen out of decision-making. For years there were no meetings between organized civil society and ECDoH officials. Most importantly, service delivery did not improve.

In 2010 the new national Minister of Health, Aaron Motsoaledi responded to advocacy by groups by appointing a Head of Department to be the “corruption buster.” He fired the entire regional leadership of the ambulance service along with 1,284 other staff. But two years later he was pushed out by the local provincial political powers that be, but only after several attempts on his life.

A strong policy monopoly existed in the Eastern Cape. What became clear to those close to it was it was backed by several forces: the most obvious was a set of actors who were benefiting directly through misappropriating funds. This included corruption at all levels of the system that resisted transparency and accountability. It ran so deep that at one point it seems clear that staff at the Mthatha medicines depot burned half of it down to cover up their theft. The broader set of actors in the monopoly, however, were political powerbrokers who used the emergency medical services and other parts of the health system to provide patronage jobs. Indeed the pressures around elections in this case were clearly focused toward club-goods and securing resources—personnel and financial—for use in elections. Finally there was a strong contingent within the ANC who simply believed there was insufficient funding overall for the health system and was dedicated to making sure the ANC was not blamed for it because that would undermine their main message of liberation and social democracy. “A better life for all.”

They used two key policy ideas: first the idea of provincial autonomy over health issues and second the idea of “transformation” of the health system—slowly and progressively by the party of liberation. So swings of funding occasionally moved inside the system—but overall there seemed not to be political will forthcoming to address the structural deficits in the areas of the former Transkei and Ciskei. The evidence suggests that very little had changed before 2012. While PSAM had documented under spending and politicians promised to address it, in 2011/12 and 2012/13 underspending on EMS was 4.8% and 14.4% respectively—with as much as 44% of the planned patient transport budget going unspent. More importantly, though, its clear that the planned expenditures were far insufficient to reach even the basic levels of EMS services of 1 ambulance per 10,000 people—so instead the department essentially planned to fail—leasing some ambulances, claiming other ambulances were on the way, procuring ambulances without 4x4 capacity that were in any case unable to reach most of the population, and setting targets that would fall far short of the declared minimum for any foreseeable future. And reports of long waits for ambulances resulting in injury and death continue.

129 Interview SA-17.
130 Interview SA-20.
132 Treatment Action Campaign and Section 27 2013.
Mobilizing the Right to Health

Beginning in 2012, a set of actors began mobilizing the health rights framework in a much more substantive way. Various rights bodies had previously taken note of the failures of the EC health systems, and had written reports. But in 2012 things changed with legal aid organization Section 27 and the AIDS social movement group Treatment Action Campaign got involved in the case of “Village Clinic.” This had been the site of the very first MSF AIDS treatment clinic in the country—profiled in a widely read book by Johnny Steinberg. The government decided to stop paying its relatively low rate to rent the building that housed the clinic, for reasons that are still not clear, and instead move it into a large tent in an open field. Because of connections with MSF, the Treatment Action Campaign, and Section 27 there was a strong response to this move—including the filing of a lawsuit against the national and provincial health authorities on right to health grounds and a settlement with the Minister of Health agreeing to build a new clinic. This is a separate sub-case in itself, but it is raised here to note that what this brought to the region was a significant increase in the “support structure” available for the right to health. Responding to Village Clinic and to the collapse of management at the critical Mthatha medicines depot (that had been set ablaze) the rights-based groups joined together with local health workers unions and a set of older rights groups like Black Sash to create a new coalition—the Eastern Case Health Crisis Action Coalition (ECAC)—which was available to support a broader rights based push on EMS. The rights frame, for example, brought in Black Sash—a women’s anti-apartheid group that was not largely involved in health policy but instead in human rights work.

On March 12, 2013 the Eastern Cape Provincial Office of the Human Rights Commission received a complaint from the community in Xhora Mouth. With the help of a local economic development NGO called Bulungula Incubator, Xhora Mouth residents filed a complaint on the grounds that the constitution guaranteed not just health—but emergency healthcare—as a basic right, which was denied their community where there were no ambulances or PPT. The local HRC conducted an investigation and substantiated the claim—finding the number of ambulances, response times, essential equipment, staffing, and ability to navigate rugged rural terrain were all lacking. A few months later the ECAC groups found out about this inquiry just as they were launching a new, highly critical report labeled Death and Dying in the Eastern Cape: An Investigation into the Collapse of a Health System.

Highlighting this issue in their report, Section 27 and other groups also began to compile affidavits on the EMS issue specifically—seeing a clear case for litigation on the issue, but also recognizing the limitations of litigation. Given the opportunity, they used the founding affidavit material to push the Human Rights Commission head office to take the complaint up as a critical set of questions for the Commission’s mission. The commission agreed and, with prodding from the ECAC groups, agreed to conduct a series of consultations with communities across the region—gathering more and more evidence on the failure of the EMS system. Letters were exchanged between the Commission and the ECDoH, which provided highly unsatisfactory and contradictory information—while claiming, in true monopoly form, that this issue was not appropriate for rights-based inquiry.

In response, the HRC decided to launch a set of hearings. In addition to two commissioners from the HRC, they included Dr. Prinitha Pillay, a former MSF doctor working for the Rural Health Advocacy Project who could provide expertise on the subject and also help ensure the commissioners were focused on the critical questions. Together the Commission and the ECAC identified four communities and gather testimony from those communities—who then elected a representative to attend the formal hearing. Even before the hearing occurred very significant bargaining was happening. The ECAC groups were meeting not just with local officials, but also with national officials including the Minister of Health. In November of 2014, as preparations were getting under way for the hearing, supplemental funding was made available for the EMS service. EMS had been steadily over the years receiving approximately 4% of
the overall health budget—a nominal increase each year, but in real terms adjusted for inflation had essentially been flat for years. Planned Patient Transport had been especially neglected—making up just a tiny portion of the overall EMS budget. As Table X notes, however, under the November increase EMS funding jumped by almost 90,000 rand—bringing the total PPT allocation up to 9.3% of the total EMS budget, the highest ever level.

At the hearing itself, 200 people were in attendance. The ECAC bussed in 20 people from each of the communities, while the Treatment Action Campaign brought out their members from the urban communities. A critical power held by the HRC is the power of subpoena—an institutional tool enabling them to compel government to appear. With this as a background power, the HRC requested not just the Department of Health, but also Treasury and Roads & Transport. When Treasury did not show up, a threat of a Subpoena quickly encouraged them to send a representative. By convening all the parties, the Commission changed the accountability dynamic (common to bureaucracies) that had previously existed in which each department blamed the other for the problem. This finally enabled an apples-to-apples comparison on funding, targets, and goals—and the Commission spent a lot of time sorting fact from fiction—fulfilling a critical informational role. During the two-day long hearing, government officials who had been refusing to meet with civil society groups presented their reports and data but also had to listen the CS representatives present on the impact of failing EMS service on their lives, health, and finances. The hearings were open and public and received quite a bit of media coverage.

“It wasn’t just a foreign court thing,” one respondent shared. “It was really happening in people's lives. It also makes it, I think, even more uncomfortable for department officials. You sit in front of a court, and you've got your lawyer talking for you. You sit in front of 200 people, and you have to stand up and say, ‘This is why the ambulance didn't come when you called it for your sister.’ It's a much more direct-accountability mechanism…. The Minister is currently talking a lot about how there is ‘malicious compliance’ to agree while thwarting the process in some of the provinces with orders from national government and courts, so this was critical.”

The final outcomes of this policy intervention are still being sorted, but so far several outcomes can be seen. The first is increased resources for EMS described above. The second is that, for the first time, the ECDoH is on track to have zero or close to zero underspending on EMS funds. In their recent response to the HRC, the ECDoH reports additional shifts: procuring 141 4x4 capable ambulances and creating a new policy on response time that explicitly sets the target as 15 minutes in urban areas and 45 minutes in rural areas. A not completely unrelated investigation by Special Investigations Unit recently found that between January 2009 and June 2012 provincial health officials pocketed more than R800 million so there may be changes from that realization in financial management, though that is yet to be seen. Finally it is notable that there is a new MEC for Health, who in October hired a new EMS director.

Most importantly, perhaps, Xhora mouth now has an ambulance stationed nearby.

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133 Interview SA 17.
References


Dionne, Kim Yi. 2010. The role of executive time horizons in state response to AIDS in Africa. *Comparative Political Studies*.


Pieterse, Marius. 2010. Legislative and executive translation of the right to have access to health care services. *Law, Democracy & Development* 14 (1).


