UNIVERSITY OF NAIROBI

CENTRAL AND COLLEGE BASED SENSITISATION OF RAPID RESULTS INITIATIVE (RRI) ON CONSTITUTIONAL IMPLEMENTATION AND PUBLIC SERVICE INTEGRITY PROGRAMME

PUBLIC LECTURE

Delivered by Naomi N. Njuguna on 26th September 2013 at College of Health Sciences, University of Nairobi

Ladies and gentlemen, it is indeed a great honour to be invited to the College of Health Sciences to deliver this lecture on the implementation of the right to health and health services within the Constitution of Kenya 2010.

Our Constitution is now three years old, and while we are to appreciate the fact that it is still in its "toddler" stages, we have the right to expect that its implementation (particularly the Bill of Rights) shall gradually and purposefully be carried out maturely to achieve the vision and aspiration of all Kenyans espoused in this document.

This lecture is divided into four (brief) parts:

A. The first part will examine the nature and the meaning of the right to health as envisaged in the Constitution
B. The second part will discuss the complexities involved in enforcing socio-economic rights (health rights being part of this category of rights)
C. The third part will analyse the implications of devolution on the right to health and healthcare service delivery.
D. The final part will be the conclusion with suggestions on how to be involved in the implementation of the right to health in line with the leadership and integrity provisions of the Constitution.

A. RIGHT TO HEALTH OR RIGHT TO BE HEALTHY?

Health has been defined in the preamble to the WHO Constitution as ***" a state of complete physical, mental and social well – being and not merely the absence of disease or infirmity."***

In modern society, a wider perception of health is being advanced which considers factors such as the distribution of resources, gender differences (both men and women are more susceptible to certain diseases more than the other), race (black males/females are more susceptible to certain diseases and so are white males/females) violence, armed conflicts, terrorism, chronic and terminal illnesses (some which are lifestyle illnesses).

Since health is not the mere absence of disease or infirmity, in order for one to achieve the state of mental, physical and social well – being, other socio – economic factors must be in place to promote health. For example housing, food and nutrition, access to safe water, adequate sanitation, safe and health working conditions and a clean environment.

Discussions about the right to health must therefore all inclusive where it is recognized that health is dependent on the realization and attainment of other rights.

The Bill of Rights in the Constitution of Kenya 2010 was not only informed and influenced by what we desired as Kenyans to be basic minimums that the State should guarantee its citizens but was also influenced by our ratification of certain pertinent international human rights instruments which automatically become part of our law by virtue of Article 2(6).

The right to health has been recognized in the International Covenant on Economic, Social and Cultural Rights, the African Charter on Human and People's Rights, the Universal Declaration of Human Rights, the United Nations Convention on the Rights of the Child, the Convention on the Elimination of Violence against women, among others.

By Constituionalising health and healthcare it becomes an entitlement. It is not a "good" or a "commodity" that should be traded in the market place. It is something that the State has an obligation to guarantee its citizens.

Some scholars (e.g. Timothy Goodman (2005)) have argued that it is impossible for governments to guarantee good health to its citizens because death, disease, physical deterioration are all things that are intrinsic to the human condition (regardless of cutting edge technologies that seem to defy this e.g. gene therapy, organ regeneration –) One's health status is partially a function of one's behavior and lifestyle – smoking, excessive consumption of alcohol, irresponsible sexual behavior, lack of exercise, etc. The question is whether the Government can step in to criminalize the consumption of junk food, or can it compel people to give up sedentary lifestyles (can it force people not to be "couch potatoes'?)

Another argument against recognizing health and healthcare as a human right is that fundamental human rights are universally and uniformly applicable. However this might be impossible to achieve because there are no shared perceptions as to what constitutes good health or good health care. Patients differ in their healthcare preferences and standards. They are not universal.

So what is the justification of classifying the right to health as a human right and not just an aspiration or a policy statement?

One justification is that good health is one of the conditions of human flourishing. It is part of ensuring that the human life is treated with dignity which is an intrinsic part of human nature. When you recognize the right to health you recognize the right to human dignity – the inherent worthiness of the human being.

The minimum standard that is envisaged by the Constitution is that it must be the "highest attainable standard of health". This entails:

- The removal so far as possible the causes of ill health – protective/paternalistic aspect – protection of citizens from ill health which can be caused from other persons (contagious diseases) and from impersonal substances or environmental situations. (Disease prevention and health promotion)
- The provision of advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health
- The prevention as far as is possible of possible epidemic, endemic and other diseases.

The right to health further has the following elements:

- **Availability** of functioning public health care facilities, goods, services and programmes. This of course depends on the developmental level of each country
- **Accessibility –** health facilities have to be available to all without discrimination and they also have to be within safe physical reach for all sections of the population especially the marginalized and the vulnerable groups. Economic accessibility is also an aspect of this point where health services, goods and facilities have to be affordable for all. Any person who does not have adequate resources and who is unable to secure resources either by his own efforts or from

other sources, should be granted adequate assistance and in the case of sickness, the care necessitated by his condition. Payment for these services has to be based on the principle of equity. Information also has to be accessible. This however should not compromise the right to confidentiality.

- **Acceptability** – this means that medical facilities, goods and services must conform to medical ethics and must also be culturally appropriate.
- **Quality** – health facilities, goods and services must be scientifically and medically appropriate and of good quality. Medical personnel also must be competent and skilled.

So, what is the State to guarantee and protect. Is it the right to health or the right to be healthy? The State cannot guarantee a right to be healthy. Being health is a both a pre-existing and a continuing state of being. States cannot provide protection against every possible cause of human ill health. Genetic factors, individual susceptibility to ill health, adoption of unhealthy or risky lifestyles cannot be the responsibility of the State to prevent. The right to health is essentially about the right to access those facilities, services, products and programmes as well as healthcare professionals that will promote well – being.

B. RIGHT TO HEALTH AND HEALTHCARE: ASPIRATIONAL OR JUSTICIABLE? THE JUDICIAL ENFORCMENT OF THE RIGHT TO HEALTH AND HEALTHCARE

Most progressive Constitutions around the world, have moved to having only first generation rights to having second and third generation rights as well in their respective Bills of Rights.

First generation rights are classic civil and political rights that emerged from French and American Revolutions. These reflect the fundamental rights of citizens and free persons. They are to with the manner in which citizens are to live in a civilized society where government power is restricted in terms of its being able to limit freedoms of citizens.

Second generation rights are concerned with the entitlements concerning health, education and welfare. These were introduced by Bismarck in Germany in the late 19th century. After the 2nd World War, these rights gained international support and were integrated with civil and political rights.

Third generation rights are rights which belong to the whole community and to future generations and not just to individuals. For example environmental rights, culture, etc.

The State is in a very precarious position when it comes to the enforcement or the implementation of socio-economic rights. Socio economic rights are about bridging the gap of social inequalities within a State. They are about fulfilling or meeting the daily basic needs of the citizenry. It then seems easier for the State to accept these rights as aspirational principles or goals of policies – rather than Constitutional entitlements.

The reason is that the achievement of socio-economic rights requires resources. Each of these rights is competing with each other. The right to health is competing with the right to housing, the rights to social welfare, the right to adequate and wholesome food, etc. These rights may also be competing with other civil and political rights e.g. the right to security, the right to privacy and access to information, etc.

The challenge with socio-economic rights is that resources within the State (whether in developing or developed countries) are scarce. This means that rationing will be involved. As was observed in the Soobramoney case (South African case):

"***The exercise or a right that by its nature is shared, often competitively, with other holders of this right, must have different legal characteristics from the exercise of a classical individual civil right that is autonomous and complete in itself."*** – This means that the right to health, for example, is not the same as the right to vote. When a person votes, he does not affect the right of another person to vote or even how he is to vote. But when a mother receives free maternity services from a government hospital or if a person were to receive free dialysis treatment, then the cost of providing that treatment is taking away financial resources from another socio-economic right, e.g. education, or even another person who also needs treatment in the same or other government health facility.

The judicial enforcement of socio-economic rights which includes the right to health then becomes a very tall order indeed.

Let us take the example of the South African case of **Thiagraj Soobramoney v Minister for Health (Kwa Zulu Natal)** which was decided in the Constitutional Court of South Africa in 1997. This case involved a 41 year old diabetic man who also suffered from ischaemic heart disease and cerebro – vascular disease which had caused him to have a stroke. His kidneys also failed. At the time the case was reaching the Constitutional Court, Soobramoney was in the final stages of chronic renal failure. But his life could be prolonged by regular renal dialysis.

He sought such treatment (free of charge) from a government hospital in Durban. But he was declined the treatment on the following grounds:

a) The hospital did not have enough resources – the renal unit only had 20 machines and some of them were in poor condition. There was no budgetary provision to train more staff or to buy more machines from the provincial health department
b) Soobramoney did not meet the guidelines that were set out by the hospital for the receipt of free dialysis treatment. Only patients who suffered from acute renal failure and who did not suffer from significant vascular or cardiac disease, were automatically eligible for free dialysis treatment until an organ donor is found and kidney transplant has been completed.

Clearly Mr. S did not qualify as his renal failure was chronic and he had cardio vascular issues.

His application to court was to have his right to emergency medical treatment and his right to life upheld.

In Kenya, we also have our very own jurisprudence in the case of **Matthew Okwanda v Minister of Health and Medical Services & 3 others (High Court Petition No 94 of 2012)**.

Mr. Okwanda was a 68 year old man who was diagnosed with diabetes mellitus in 1996 and in February 2012 was diagnosed with Benign Hypertrophy which called for specialized treatment especially due to his advanced age. He argued that he was in dire need of medical attention . He argued that he was entitled to receive care and attention as an older member of society and also sought free drugs and medicine to take care of his condition in addition to free treatment at the State's prime hospitals. He also sought a monthly stipend to rent a decent house and to have food and water.

I have picked on these two cases to demonstrate the challenges and the balancing acts that courts have to face in enforcing socio-economic rights. The decisions that they gave would determine whether there would be a reasonable interpretation of the Constitution or whether a "flood gate" would be open so that everybody who had a similar case would come to court and get a remedy…and that would be virtually EVERYONE!

So how did the courts deal with this issue? One important provision that in my opinion has assisted both courts in dealing with the enforcement of socio-economic rights is the Constitutional provision allowing for "progressive realization" of these rights.

Article 21(2) of the Constitution of Kenya 2010 provides that:

"The State shall take legislative, policy and other measures including the setting of standards, to achieve the progressive realization of the rights guaranteed under Article 43."

The similar provision in the then Constitution of South Africa was section 27(2) which provided that:

"The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights."

The key in determining whether the State has met its obligation is in this phrase "progressive realization."

What does progressive realization mean? **The Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment No. 14** has provided some insights into what this phrase means for member states.

The Committee recognizes that the right to the highest attainable standard of health is dependent on State resources. Progressive realization means that states have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health.

In recognition of the fact that resources is a factor that has to be taken into account in determining whether a State has met its obligations, the court in Soobramoney declined to grant the declaration that he was seeking for. A balancing act had to be done by the courts. If they granted him the relief that he was seeking for, then it meant that treatment would also have to be provided to all other persons who are similarly placed and this would not be sustainable or achievable by the State.

The Soobramoney case provided some useful insights into what constitutes emergency medical treatment. This is where a person suffers some sudden catastrophe which calls for immediate medical attention. Such a person should not be refused ambulatory or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment.

Justice David Majanja (skillfully) declined to make any declaration or give any relief simply because there was no evidence that was adduced in court by the applicant that the State has violated any Constitutional provision regarding its obligation to protect or fulfill his right to health (something I blame on the advocates handling the case!!!!!). This case would have provided some landmark guidance on the implementation of the right to health.

The challenges therefore with judicial enforcement of socio – economic rights are:

a) Judges are likely to take the approach that they are not responsible for making the decision as to how resources should be best used. They are not policy

makers. In the words of the late Judge Albie Sachs of the SA Constitutional Court "Whether government policy is wise or stupid is something for public opinion and the electorate to decide, not for the judges. In a constitutional democracy this must be the general rule."

b) The petitioner also has to disclose a particular violation of the right and the manner in which that right is violated. In Trusted Society of Human Rights Alliance v Attorney General & Others (Petition No. 229 of 2009), the court noted that it was not necessary to set out the violations in a mathematical manner but in a manner that will enable the respondent to have notice of the allegations and to defend himself or herself and to enable the court to adjudicate on the matter.

C. DEVOLUTION OF HEALTHCARE SERVICES IN KENYA

Devolution is part of the wider concept of decentralization. It means the transfer of governance responsibility for specified functions to sub – national levels which are either publicly or privately owned that are largely outside the direct control of the Central Government. It is the transfer of rights and assets from the Centre to local governments or communities.

The Fourth Schedule to the Constitution sets out the various functions of healthcare that will remain at National Level and those that will be devolved to county level.

National Government will be responsible for National referral health facilities, National Health Policy and Veterinary Policy.

County governments will be responsible for county health facilities and pharmacies; ambulance services; promotion of primary health care; licensing and control of undertakings that sell food to the public; veterinary services (including regulation of the profession); cemeteries, funeral parlors and crematoria; and refuse removal, refuse dumps and solid waste disposal.

The question that has been lingering at the back of the minds of all the stakeholders especially healthcare professionals is what the level of preparedness of the counties to deliver healthcare services to the public? Will they be able to meet the Constitutional objects and principles of devolution that are set out in Articles 174 and 175 particularly the requirement under Article 175(2) that:

"County governments shall have reliable sources of revenue to enable them govern and deliver services effectively."

The main challenges that would be faced are:

1. Uneven inter – county levels of development – this means that there will be unequal distribution of health facilities, human resources, poor communication infrastructure, etc
2. Poverty levels which are unequal throughout the counties

Even as these questions are being answered by the experts and consultants, it is worth considering the demerits of a Centralized system of healthcare.

a) The regional disparities in the distribution of healthcare services
b) Inequities in resource allocations
c) There is unequal access to quality healthcare services
d) There are wide regional differentials in health indicators

The advantages of decentralization are:

a) Assists in the promotion of access to health services throughout Kenya
b) Addresses "discrimination" of the low potential areas – Nairobi and other urban areas have had better healthcare services than rural areas
c) To address issues of bureaucracy in matters of healthcare provision – e.g. procurement issues
d) To promote efficiency in the delivery of healthcare services
e) To address the problems of low quality of health services
f) To allow for more effective partnerships with the private sector and the international community to deliver healthcare services
g) To ensure better accountability levels

The challenges/opportunities to ensure that this "ideal" and goals of devolution are met include:

- There needs to be a clear criteria for the determination of referral facilities (the provisions of the Health Bill and the Health Policy need to be synergized)
- The minimum number of referral hospitals needs to be provided to ensure equitable access
- Human resources issues – counties are empowered under Article 235 of the Constitution to establish offices and employ individuals performing functions allocated to them in the Fourth Schedule. Some counties will have the benefit and ability of employing more qualified healthcare providers than others (more marginalization); strikes at county level (are counties prepared for this)
- Healthcare workers and practitioners need to be assured of their welfare; staff preparation for the changes

D. CONCLUSION

In conclusion it is worth noting that the Government has taken certain progressive steps to achieving the right to health. For example:

1. The Kenya Health Policy (2012-2030)
2. The national Health Sector Strategic Plan
3. The Second Health Sector Plan of the Kenya Vision 2030
4. The Health Bill
5. The HIV and AIDS Prevention and Control Act (No 14 of 2006)
6. The Cancer Prevention and Control Act (No 15 of 2012)
7. Increase in the number of hospitals from 167 in 2008 to 275 in 2012.

8. Increased employment of staff

(But funding and budgetary allocation still remains a challenge)

For the University of Nairobi, as part of our role as experts and professionals in the health care sector there are still opportunities for partnership with the Government in drafting policies and programmes that will ensure the sustained progressive realization of not only the right to health but all other socio – economic rights guaranteed in the Constitution.

Let me conclude by saying this. As we demand certain entitlements from the State, there are also certain responsibilities that we have as citizens and particularly as public officers in this University. The University of Nairobi was at the forefront in the drafting of the Constitution of Kenya 2010. We must be at the forefront in espousing and advocating for the values and principles of leadership and integrity that are in Chapter 6 of the Constitution and Article 232 on the values and principles of Public Service. We must be consistent, ethical, professional, competent, respectful, faithful, trustworthy and virtuous in all that we do in the workplace and in all aspects of our individual lives. We need an attitude change in ensuring that what we have struggled for (that is an end to impunity and corruption in this country) can be achieved.

Thank you