Constitutionalizing Health: Rights, Democracy And The Political Economy Of Health Policy

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Constitutionalizing Health: Rights, Democracy And The Political Economy Of Health Policy

Abstract
In recent decades there has been an increasing trend toward “constitutionalizing” health—identifying health as a right in national constitutions. Today more than half of written constitutions in the world contain such a right. Whether that is good, bad, or immaterial for the production of population health, however, is much debated. Does constitutionalization improve wellbeing or might it simply distract from or distort good health policy? This dissertation uses a nested analysis that pairs a large-N statistical analysis of 40 years of global health data with in-depth interviews with over 165 policymakers, activists, elected officials, lawyers, and judges in South Africa, India, Malawi, and Thailand. Empirical evidence shows that constitutionalizing health is a significant development in the institutions of health governance and can contribute to improved wellbeing. Over forty years of global health data, we can observe a small but significant health dividend for countries that have adopted the right to health, when controlling for the major alternative explanations of cross-national variation in mortality. Tracing health policy issues in South Africa and India reveals a right that operates as a “policy anchor”—tying health to the fundamental national political bargain and providing an innovation in the institutions of governance that helps policy entrepreneurs gain a foothold from which to drive policy to expand health capabilities. Shadow cases in Thailand and Malawi show that this shift can matter even without judicial intervention but depends on sufficient support structure to enable the full institutionalization of health as a right. These findings contribute to literature on law and rights, sharpen models of the public policy process, and respond to the need to better understanding the broader set of institutions in the political economy of development that drive improvements in population health. In a broader context, this study suggests that constitution-writing is health policymaking. Greater attention to constitutions and the process of institutionalizing rights is warranted for those engaged in global health, with implications for the U.S. and other countries of the global North as well.

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CONSTITUTIONALIZING HEALTH:
RIGHTS, DEMOCRACY AND THE POLITICAL ECONOMY OF HEALTH POLICY

Matthew M. Kavanagh

A DISSERTATION
in
Political Science

Presented to the Faculties of the University of Pennsylvania
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ABSTRACT

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Matthew M. Kavanagh
Devesh Kapur
Jennifer Prah Ruger

In recent decades there has been an increasing trend toward “constitutionalizing” health—identifying health as a right in national constitutions. Today more than half of written constitutions in the world contain such a right. Whether that is good, bad, or immaterial for the production of population health, however, is much debated. Does constitutionalization improve wellbeing or might it simply distract from or distort good health policy? This dissertation uses a nested analysis that pairs a large-N statistical analysis of 40 years of global health data with in-depth interviews with over 165 policymakers, activists, elected officials, lawyers, and judges in South Africa, India, Malawi, and Thailand. Empirical evidence shows that constitutionalizing health is a significant development in the institutions of health governance and can contribute to improved wellbeing. Over forty years of global health data, we can observe a small but significant health dividend for countries that have adopted the right to health, when controlling for the major alternative explanations of cross-national variation in mortality. Tracing health policy issues in South Africa and India reveals a right that operates as a “policy anchor”—tying health to the fundamental national political bargain and providing an innovation in the institutions of governance that helps policy entrepreneurs gain a foothold from which to drive policy to expand health capabilities. Shadow cases in Thailand and Malawi show that this shift can matter even without judicial intervention but depends on sufficient support structure to enable the full institutionalization of health as a right. These findings contribute to literature on law and rights, sharpen models of the public policy process, and respond to the need to better understanding the broader set of institutions in the political economy of development that drive improvements in population health. In a broader context, this study suggests that constitution-writing is health policymaking. Greater attention to constitutions and the process of institutionalizing rights is warranted for those engaged in global health, with implications for the U.S. and other countries of the global North as well.
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In 2005, democratic South Africa’s African National Congress—the party of liberation and avowed social democracy—was presiding over strong economic growth and dismantling racial hierarchies. Together these factors should have yielded a time of improving health and health policy. But in fact ANC leaders were refusing to roll out AIDS treatment despite aid and scientific consensus, costing the country an estimated 3.8 million “person years” over five years.¹ It was only when lawyers, social movement actors, and the courts mobilized the country’s constitutional right to health that policy was rewritten and a robust AIDS response began in earnest. Today, South Africa’s infant mortality is dropping and life expectancy is increasing, in considerable part because of that move.

¹ Chigwedere et al. 2008.
A decade later, the Indian government of Narendra Modi declared its intention to pass legislation to deepen the institutionalization of health as a right in India’s legal foundations—following South Africa’s path toward constitutionalizing health. In the final Health Policy, however, this idea was abandoned.

Did the Modi government miss an opportunity to improve public health or was it wise to avoid the move toward constitutionalization? Is there any reason to believe that casting health as a right actually matters for the wellbeing of populations and, if so, in what ways? Or is that too high a hope in a world in which the law is more often a tool of the powerful and where judges, after all, cannot order improvements to the health of individuals or groups in society.

This dissertation makes the case that the right to health can make a difference for health outcomes. “Constitutionalizing” health—casting it as an enforceable right in the central legal bargain governing the state—can contribute toward improvements in population health. A constitutionally enshrined right to health (RtH), in the data analyzed here, is linked to both better health outcomes and improved health service delivery. This relationship relies on the ways in which constitutions can shift the political economy of health policy—the structures of decision-making, power relationships, and ideas that shape the distributive politics of health. It is not that judges have hit on brilliant jurisprudential logic to address intractable health problems where health experts fail. It is also not uniformly beneficial, with some examples where rights do not live up to their promise. On balance, though, this dissertation shows constitutionalization as a political process that expands the venues of policymaking, opens previously closed policy processes, and shifts the terms of debate in ways that can be particularly positive for a set of issues involving complex negotiations over resources, regulation, and access. The core contention here is that constitutionalization shifts the institutions governing health in a country. My argument advances the burgeoning comparative literature on institutions and development and provides particular insights on institutional change and its consequences.
In the contemporary world, rights bring both an ideational framework and a distinct set of actors to a given policy arena. There is no guarantee, however, that this will improve matters. Indeed, there is reason to be wary of overly-individualist frameworks and inexpert judges in an arena of complex, policy-centric decisions about contentious resource allocation issues. Saving a life with an expensive new medicine, for example, could doom many more to early mortality if it undermines the ability of the health system to procure vaccines. Setting minimum benefits for private health insurance schemes could improve access to basic medical care, but might trigger price increases that deny others coverage altogether. With such complex ethical and policy questions, it is reasonable to be skeptical that what is written in the constitution will have any significant effect on aggregate levels of wellbeing or worry that inexpert judges will actually distort public health policy and undermine overall health. Empirical evidence, however, suggests greater optimism. As I show in the evidence here, following South Africa’s lead toward constitutionalization can prove distinct benefit to long lives and pro-health cycles of policymaking.

**Constitution Writing as Public Health Policy**

Part of the motivation for this inquiry is that constitutionalization of health is increasingly common, as figure 1.1 illustrates. Before the 1940s, health did not figure in the set of rights embodied in national constitutions. That began to change in the post-war period and, in recent decades, not only has the number of written constitutions in the world expanded rapidly, so too has the portion that include a facially-enforceable right to health. In 1970 just 17% of written constitutions had an explicit right to health, but by 2010 that number grew to 51%. The norms change is clearer still by looking at the choices made by the drafters of new constitutions: In the decade of the 1970s only 35% of the over three hundred new constitutions written included a right to health, but it was included in 64% of new constitutions in both the 1990s and 2000s.

U.S. constitutional longevity can encourage thinking of constitution-making as a rare and rarified activity. In reality, however, the average life expectancy of a national constitution is just 19
In any given year several new or significantly revised constitutions are being drafted and writers must decide what to include. The right to health has joined the “menu” of oft-adopted constitutional provisions, though there is still significant variation in the decision whether to adopt. While the South African constitution drafters included a right to health in 1996, the Nigerian drafters did not in 1999. When the newly created country of Kosovo wrote its constitution in 2008 drafters opted not to include a specific right to health, but drafters in Timor-Leste did in 2002. Grappling with conflict, the Democratic Republic of Congo’s leaders chose a different constitutional path when they included a right to health in their 2011 revised constitution than did South Sudan the same year. Finland, with world’s lowest under-5 mortality rate, left the right to health out of both the constitution it approved in 1999 and the major amendments of 2011, even as Hungary’s 2011 constitution included such a right.

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In this context, the question of whether constitutionalizing health has any affect at all on population wellbeing is a significant one. If the right to health can be beneficial, as I suggest, then constitution making is health policymaking and should be of significant interest to public health experts, officials, and scholars. So too if putting health in rights terms actually distorts good health policy and undermines wellbeing—in which case a great many countries are being led down the proverbial garden path and public health officials should sound the alarm. There is, however, remarkably little empirical evidence to guide drafters.

**The Debate: does constitutionalization help, hurt, or just distract?**

Prominent ethicists and theorists of law, human rights, and public health have argued on normative grounds that a right to health should improve both health and health policy. A wide variety of analysis has explored its philosophical grounding, legal basis, imperatives for medical and public health practice, and the obligations of states under international standards, given that nearly every country is now party to at least one treaty touching on the right to health. Recognizing health as a right is theorized to improve equity, quality, and quantity of health-related policy while also affecting the political norms and coalitions that govern health. Human-rights based approaches to health, scholars have argued, increase accountability and access to quality healthcare as well as other public goods essential to wellbeing.

However, many of the broad findings in social science, law, and public health cast doubt on whether a constitutional RtH will ever have a meaningful, let alone beneficial, effect. These

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1 Sen 2008; Sen 2004; Ruger 2010aa; Farmer 2005; Mann et al. 1994.
2 Ruger 2007; Wolff 2012; Daniels 2001; Meier, Brugh, and Halima 2012.
4 Mann et al. 1994; Gruskin, Mills, and Tarantola 2007; Beyrer et al. 2007; Beracochea, Weinstein, and Evans 2010; Yamin 2015.
6 Backman et al. 2008; Ruger 2007; Forman, Ooms, and Brolan 2015.
7 Yamin 2015; Bustreo and Hunt 2013.
8 Reviewed in Hirschl and Rosevear 2011.
might be described in two broad categories: skeptical intimations that constitutional health rights will not matter for wellbeing, and pessimistic findings that suggest they will actually harm public health.

The idea that a right to health will not actually matter, in practice, finds support in many of the theories and findings in social science. Skeptics point, for example, to the example of Nordic countries that have largely not moved toward constitutionalizing health, yet have achieved world-leading health outcomes. Across a variety of high performing countries from the OECD—from Norway and Iceland to South Korea—skeptics suggest moderate population size, electoral democracy, strong market economies, a large middle class, and well-developed labor and civil society are what matters driving strong welfare states, relatively equitable distribution of resources, and high overall standard of living for better health. “And what is the net impact of the variance on the constitutionalism axis?” asks Hirschl. “Quite negligible, frankly.” Studies in development support this contention, suggesting health is dictated almost exclusively by demographic and economic factors—poorer, more unequal, and more ethnically stratified countries are less healthy because of a paucity of resources, coordination problems, state capacity, and other mechanisms. Studies of the social determinants of health show how economic and social status inequalities structure a clear gradient of health. Explanations range from the psychosocial impact of life in unequal societies to unhealthy living conditions due to urbanization, material deprivations from class and gender inequality, and deeper political economy pathologies.

There is a small but growing literature exploring political institutions’ effect on health, but among comparative studies that include the global South, this has largely been confined to studies of electoral democracy and related freedoms. There is a robust debate in the political economy of development literature whether democracy improves health, with proponent suggesting it does by

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11 Hirschl 2011.
12 Hirschl 2014, 181.
expanding incentives for public goods provision, information, and accountability.\textsuperscript{16} As a “meta institution,” democratic participation has been described as a critical element for health and development,\textsuperscript{17} alongside some limited attention to the role of political parties and power of left/labor forces.\textsuperscript{18} Constitutional health rights have little to contribute independently that is not accounted for by these factors and so, while not explicitly stated, many seem to dismiss health rights as essentially epiphenomenal.\textsuperscript{19}

Foundational judicial politics studies, while not focused on health rights, imply important policymaking will simply reflect the preferences of the dominant or hegemonic political coalition; while executives may well delegate tasks to other branches such as courts, the health policy decisions that result will not significantly differ from the will and interests of this coalition, regardless of any constitutional rights.\textsuperscript{20} Upendra Baxi, for example, suggests that social rights litigation in India offers little to the masses because it is more about aggrandizement of elites (lawyers and judges) than about transformative change.\textsuperscript{21} Actors such as judges will be unlikely to act meaningfully in important but politically sensitive policy areas like health, many have argued, due to incapacity, fear of reprisal or loss of legitimacy.\textsuperscript{22} Similarly, studies of health and welfare states suggest political parties and ideological alignments largely influence health-related policies. Social democratic government is what matters.\textsuperscript{23}

More pessimistic findings suggest that the right to health \textit{will} matter, but will have a negative impact. 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


\textsuperscript{17} Rodrik 2008a, 166.


\textsuperscript{19} See, for example, the Commission on Social Determinants of Health, which, while mentioning human rights in several places, includes laws and rights only to land tenure and gender equity among the 59 recommendations aimed at impacting health outcomes—no mention of a constitutional right to health as possibly beneficial. CSDH 2008; Solar and Irwin 2010.

\textsuperscript{20} Dahl 1957 suggests this broad formulation; theories of hegemonic preservation put forward by Hirschl 2004 and Smith 2009; and the concerns about an “establishment revolution” that does little for the poor in Baxi 1985. This is also the logic that underlies the claim that some nations have “sham constitutions,” especially when it comes to socioeconomic rights in Law and Versteeg 2013.

\textsuperscript{21} Baxi 1985.

\textsuperscript{22} Cross 2000; Michelman 2008; Rosenberg 2008.

\textsuperscript{23} Huber and Stephens 2012; Muntaner et al. 2011; Navarro and Shi 2001.
interests. Rights are too individualist, too adversarial, and don’t address the core problems of cooperation, state capacity, and institution-building needed to improve wellbeing. The middle-class may use rights claims to gain access to expensive medicine, for example, but the poor are unlikely to access rights-based venues or effectively make rights-based claims on health issues. The result, in limited resource environments, will be to shift resources away from public goods and toward club goods.

Insofar as rights lead to courts, the literature on judicial politics challenges the legitimacy and utility of courts as actors in policy issues such as health. From a normative perspective, many see the real power of the right to health as an ethical framework for public policy and decision-making, rather than for legal enforcement. Unelected courts face a “countermajoritarian difficulty” when they overrule policies enacted by elected officials that are assumed to reflect the will of the majority. Socio-economic rights raise the specter of undercutting democracy—“in the end, we would have the courts running everything—raising taxes and deciding how the money should be spent.” Even if we wanted them to, though, pessimists also suggest courts are simply not set up to tackle polycentric health policy issues, in which each change to regulation, financing, and governance affects the rest of the system. Working on a case-by-case basis, courts lack the tools to readily develop appropriate policies in a system characterized by “irreducible uncertainty, contestability, and contingency.” Courts can only offer a “pretentious, inexpert, probably vain but nevertheless resented attempt to reshuffle the most basic resource-management priorities of the public household against the prevailing political will.” The judiciary lacks real “influence over

26 Horowitz 1977; Daniels 2001; Ross 2006; Landau 2012; Ferraz 2010; Glendon 2008.
27 Ruger 2010a; Daniels 2008.
28 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.
29 Tushnet 2000, 169.
30 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.
either the sword or the purse,” 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. Octavio Ferraz argues this leads to an intractable dilemma for courts stuck between usurpation and abdication that cannot be reconciled under democracy, such that it is likely better to avoid constitutionalizing health.

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. As a result, in areas like health, rights mobilization and a turn to legal challenge is unlikely to effectively address major issues driving ill health and health inequities. Instead it has the potential to harm reformist social movements by distracting activists, resources, and political energy from more effective political and lobbying strategies. “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.”

Are both the ethicists and constitution-writers mistaken? Is it simply a façade with little real impact? Worse yet, could well-intentioned rights implementation undermine wellbeing by distorting health policy and shifting power away from the poor?

Despite scholarly attention, there remains insufficient empirical evidence on the effects of constitutionalization on health to answer these questions.

An extensive empirical literature on human rights treaties helps drive the skepticism—many scholars have found that states that ratify human rights treaties often do not actually change their behavior or may even engage in worse behavior. Studies of health-focused treaties and impact on health outcomes have not been shown to perform any better. Rights instruments are

33 Hamilton 1788.
34 Sunstein 1993, 37.
35 Ferraz 2014.
37 Bond 2014.
38 Gauri and Gloppen 2012; Gauri and Brinks 2015.
40 Hoffman and Rottingen 2015.
thus criticized as empty promises at best or, worse, as fig-leaves used as cover for rights violation. While some important studies have shown a positive effect, this is often conditional on other factors such as regime type and domestic politics.\textsuperscript{41} Ratification of the Convention on the Rights of the Child, for example, has been shown very weakly linked to immunization rates—but with effects only on some immunizations and among countries in some income levels.\textsuperscript{42} With international instruments often the inspiration and guide for constitution-writing it is fair to question whether constitutional provisions will prove any more robust.\textsuperscript{43}

Rigorous comparative empirical work on the impact and performance of constitutional rights is relatively limited, but recent studies have advanced the discussion, in part building off the insights from the international treaties literature.\textsuperscript{44} Several studies have found that while judicial institutions matter, constitutional rights themselves are not associated with improvements in the realization of those rights.\textsuperscript{45} More recent works by Melton, Camp Keith, and Chilton & Versteeg do find a benefit from some constitutional rights provisions, but with strong variation across categories of rights.\textsuperscript{46} Few of these studies, however, have addressed the constitutionalization of health and other socio-economic issues. Law and Versteeg find countries that promise a wide variety of rights to be less successful at honoring their constitutional obligations than those that promise few—with the authors labeling many constitutions “shams” for promising rights they do not deliver.\textsuperscript{47} The right to health is one example of such a sham, they argue, because life expectancy rates are worse in countries with an explicit constitutional right to health than in countries that lack such rights. This model, however, fails to effectively account for the widely recognized economic and social determinants of cross-national variation in mortality—from wealth to inequality to racial/ethnic stratification—which are not simply erased by constitutionalization. As Elkins, 

\textsuperscript{41} Simmons 2009; Risse et al. 2013; Fariss 2016.
\textsuperscript{42} Simmons 2009, 332; Gauri 2011.
\textsuperscript{43} Elkins, Ginsburg, and Simmons 2013.
\textsuperscript{44} Davenport 1996; Camp Keith 2002; Chilton and Versteeg 2016a; Ginsburg and Huq 2016.
\textsuperscript{45} Cross 1999; Camp Keith, Tate, and Poe 2009.
\textsuperscript{46} Chilton and Versteeg 2016a; Melton 2014; Camp Keith 2012.
\textsuperscript{47} Law and Versteeg 2013.
Ginsburg and Melton note this also fails to account for the effect of time and the mechanisms at work in constitutionalization. Chilton and Versteeg apply a more robust model and find countries with the right to health do not spend more on health, which they suggest is evidence constitutional provisions have little impact. It is not clear, however, that public health spending is a good way to evaluate the impact of constitutions since there is significant debate about whether health expenditure data is comparable across countries and whether it is a good predictor of either health system strength or population health outcomes. Furthermore, one major critique of health as a right is that it will lead to distort budgets and increase spending on expensive health goods for individuals. A better set of measures is needed that considers the broader political economy contexts in evaluating the effect of constitutionalization on health outcomes and policy.

Another robust and growing empirical literature that bridges political science, law, and public health has focused on litigation of health rights through case studies on the role of courts in enforcing a positive right to health. This work has found decidedly mixed results. It provides mounting evidence that courts, legislative bodies, and civil society in a significant number of countries are engaging with the RtH in complex ways. One set of national examples is aggregated and coded in Table 1.1 showing whether the authors found significant court action—which I define as multiple cases in which courts use a fundamental right to health to order changes against the

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49 Chilton and Versteeg 2016b.
preferences of some other part of the state. In thirteen out of the sixteen country cases, there was clear court action on the right to health. The impact of this litigation varies between case examples, with some that fit the skeptical, pessimistic, and optimistic viewpoints on framing health as a right.

Brinks and Gauri look across five countries to analyze the opportunity structures that enable health rights litigation and then track the impact based on an analysis of the number of cases, degree of implementation of decisions, and expected benefits based on type of case. Using qualitative and quantitative evidence, they argue there is a modest net benefit of health rights litigation, but with wide differences between countries and varieties of litigation, with some types that “seem more prone to regressive effects.”

Yamin and Gloppen build off this study to construct a framework that incorporates greater attention to the political sphere and adds the dimensions of efficacy, cost, 

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Table 1.1: Legal case studies of the right to health

<table>
<thead>
<tr>
<th>Country</th>
<th>Major authors</th>
<th>Significant court action?</th>
<th>Type of enforcement</th>
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<td>Bergallo(^b)</td>
<td>Yes</td>
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<tr>
<td>Brazil</td>
<td>Biehl et al., Hoffmann &amp; Bentes, Ferraz(^b)</td>
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<td>Canada</td>
<td>Jackman &amp; Porter, Flood(^d)</td>
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<td>Guatemala</td>
<td>Godoy(^b)</td>
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<td>Individual</td>
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<tr>
<td>Hungary</td>
<td>Foldes(^b)</td>
<td>Yes</td>
<td>Collective</td>
</tr>
<tr>
<td>India</td>
<td>Shankar &amp; Metha, Parmar &amp; Wahi(^b)</td>
<td>Yes</td>
<td>Individual &amp; Collective</td>
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<td>Indonesia</td>
<td>Susanti(^b)</td>
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<td>Kenya</td>
<td>Maleche &amp; Day(^b)</td>
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<td>South Africa</td>
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<td>Gonzalez, Cabrera &amp; Gomes(^d)</td>
<td>Yes</td>
<td>Individual &amp; Collective</td>
</tr>
</tbody>
</table>

Authors gathered in edited volumes (others in citations):
\(^a\) Brinks & Gauri; \(^b\) Yamin & Gloppen; \(^c\) Langford; \(^d\) Flood & Gross.

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52 Biehl et al. 2012.
53 Landau 2012.
54 Godoy 2013.
55 Maleche and Day 2014.
56 Forman 2008.
57 Gauri and Brinks 2008.
58 Yamin and Gloppen 2011.
59 Langford 2008.
60 Flood and Gross 2014.
61 Gauri and Brinks 2008.
62 Ibid., 340.
and recipient characteristics to the analysis of the impact of litigation. Overall the picture they paint is even more complex, with some indications of “improved governmental responsiveness and systemic changes that benefit disadvantaged groups” but other examples where the benefits of the particular case were marginal and the costs high. Flood and Gross look more broadly at health rights in a large selection of upper- and middle-income countries. They find that the impact varies substantially based on the financing structure of the health system, making it very difficult in the majority of settings to assess how court victories expanding access in the public sector are balanced against cleavages in access and resources between public and private health systems. Some of the most robust debate has centered in Latin America, especially Brazil where Ferraz has argued strongly that judicialization undermines health policy by serving middle class interests while Biehl and collaborators have presented evidence from a multi-year study of thousands of cases that counters that claim—showing litigants are primarily poor, seeking access to medicines they were supposed to receive under government programs, and can serve as an instrument for the poor to hold the state accountable.

These mixed findings are perhaps unsurprising in the context of law and social science literature, which finds that law and rights operate on multiple levels—and that courts are but one venue in which they play out. It is in the “shadow of the law” rather than in the courtroom that much of the most important impact of legal thinking, institutions, and actors is seen. Starting with litigation, then, is likely to give only one view of the broader institutional shifts under constitutionalization.

In this dissertation, while I build off this literature, I also depart from it by decentering litigation and court orders. I focus more broadly on constitutionalization as a process that changes

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64 Ibid., 299–301, 327–8.
65 Flood and Gross 2014, 471.
66 Ferraz 2010; Biehl, Socal, and Amon 2016.
67 Mnookin and Kornhauser 1979; Scheingold 2004, 3, and see Galanter 1983; McCann 2006. Legal mobilization scholarship has been broadly moving away from a focus on courts to the broader political, social, and ideational shifts wrought by rights frameworks.
the rules of the game for policymaking and suggest the jurisprudential questions likely matter less than the ways rights shift power over resource distribution.

A Political Economy of Health Policy: beyond litigation to institutions

Political economy work on institutions does find a broad and important role for “constitutionalized” rights for national development. Institutions in this framework are “rules of the game”—both formal and informal—“embedded in the organizational structure of the polity or political economy” that structure human interaction.68 Arising out of political bargains, political institutions set “appropriate behavior” for actors and situations and, in so doing, create winners and losers. Over time, institutions become “locked in” as they provide increasing returns for compliance and inspire strong defense from those who benefit. Organizations rise and evolve to take advantage of the institutional environment. Institutions come to shape and condition the interests of both individuals and groups as they play an actively “constitutive role” in shaping social values.69 Smith and others argue that there is an “influence of enduring structures of legal ideas” that cannot be simply explained as the instrumental rhetoric of political actors, an understanding that runs counter to those who dismiss the articulation of health as mere words.70 Tushnet and Khosla argue that, in comparative perspective, law “is not merely epiphenomenal or inconsequential with respect to some larger force at work. Implicit is an understanding that legal norms and institutions also have the potential to shape sociopolitical realities in their own distinct fashion; for that reason, legal design matters.”71 Legal frameworks assert an ongoing structural influence that constrains some actors, empowers others, and privileges a certain range of policy

69 Chang and Evans 2005; Hall and Taylor 1996.
70 Smith 1988; Burgess 1993.
71 Tushnet and Khosla 2015, 6.
options in ways that cannot always be easily predicted at the time of drafting, yet significantly shape the distribution of resources and political power.

The most prominent examples of this work in development focus on the relative institutionalization of a variety of rights, including private property, contracts, and market access, as drivers of economic growth. Newer work increasingly suggests that a far wider range of institutions affect the prosperity of nations and that institutions drive not just economic but also broader welfare measures. In political science, electoral democracy and related participation and expression rights are the most widely studied institutions; a significant debate continues about the effect of democracy on economic outcomes and development indicators such as education and health. Meanwhile other politico-economic institutions have also been linked to health. Lieberman, for example, has shown that ethnic boundary institutions have a direct effect on responses to HIV. Peter Evans, in a recent volume on health and institutions, pushes further and argues for identifying what he terms “successful societies institutionalism,” to help explain why democratic governance seems to be important but insufficient to generate large improvements in population health.

Constitutionalization of health as a right can best be understood in this light—as part of the institutional framework governing health and health policymaking. Thinking about constitutionalization in political economy terms—as rules of the game—suggests a move away from using the outcomes of court cases as the starting point for understanding the impact of health rights. To understand its effects and judge their impact we need to look instead at the whole health and health-policy system. We should be able to trace empirically the impact of constitutionalization on both wellbeing and health policy. I make use of a nested analysis in this study to do so—to test for a link between constitutionalization and improved wellbeing and, at the intermediate level, to

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73 Hall and Lamont 2013; Rodrik 2000; Rodrik 2008b; Chang 2011.
74 Gerring, Thacker, and Alfaro 2012; Przeworski 2008; Doucouliagos and Ulubaşoğlu 2008; Stasavage 2005.
75 Lieberman 2009.
76 Evans 2009.
differences in the cycles of health policymaking. From what might be called a “policy process” approach, courts and litigation are an important part of the policy system but neither the only, nor necessarily the most important, part of that system. In that sense I build off, but depart from, most previous studies of health rights that center litigation, and instead focus broadly on questions of how constitutionalization impacts wellbeing and health policy processes. Bringing insights and tools from political economy to the study of the law and law-like rules can help expand the field of comparative constitutionalism—in this case bridging the gap between existing normative and doctrinal studies of socioeconomic rights and the large field of empirical research on health and social policy.

**An Institutional Theory of the Right to Health: hypotheses and concepts**

My hypothesis, for which I show empirical support in the chapters that follow, can be simply described in two parts. I describe these more fully in chapters 2 and 3, but a summary and explication of concepts is worth noting here.

First, constitutionalizing health—casting health as an enforceable right and embedding it in the basic law of a country—can benefit overall wellbeing of populations. This claim is not universal—as with any institutional formulation, health rights have a multitude of effects and, taken from different perspectives, geographies, issues, and populations, have attributes that are good, bad, and/or immaterial. On balance, however, I suggest constitutionalization is likely to improve wellbeing. Mortality and morbidity indicators are disproportionately driven by the poor and marginalized, who are saddled with much of the premature death and sickness in societies throughout the world. My hypothesis is that constitutionalization of health improves health in the aggregate, including by significantly improving the wellbeing of these poorer and marginalized populations.

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77 See Sabatier and Jenkins-Smith 1993 arguing for looking at policy change as a process over more than a decade.

78 Hirschl 2014.
segments of society even as it may do less for those with higher incomes, bringing equity benefits along with overall improvements.

Second, a constitutional right to health operates as an institution in the national political economy of health. It shifts the appropriate actors, venues, and actions in health policy with significant effect on the policy agenda and the eventual distribution of resources. Much of the concern about the right to health, I believe, stems from a base conceptualization of rights as “trumps” that will override the kind of complex public health policymaking necessary to weigh competing needs amidst limited resources and capacities. An institutional view, on the other hand, points us away from this conceptualization. Through this study I have come instead to conceptualize rights as “policy anchors”—borrowing a metaphor from fiscal policy to indicate an enduring and specific political commitment that is part of, rather than apart from, policy frameworks and is capable of plasticity to accommodate shifting conditions and countervailing, buffeting forces. The RtH can set new “rules of the game,” providing opportunities for which individuals and organizations evolve to take advantage.

The idea that judges and courts are applying legal reasoning to issue orders that end contentious health policy processes, for good or for harm, is simply not empirically accurate. Instead, bargaining over policy continues regardless of the rights environment. Under a right to health the institutional framework in which health policy operates is different in what are largely pro-health ways. The game is equally rigorous and challenging, but the field on which it is played changes. Constitutionalization unblocks policy change, which is critical in health policy that so often depends on adapting to fit new science and evolving conditions. The health system built before a major expansion of private insurance or for a less urbanized population, for example, must shift with economic and demographic changes. The system may have been effective in delivering penicillin and vaccinations but it has to change to fight AIDS. Health policy that implicitly assumes de jure or de facto racial, ethnic, or caste segregation has to evolve if it is to effectively tackle inequity.

Constitutionalization provides particular opportunities to open up the process of policy-making—allowing a shift in the venue for health policy to include courts and other rights bodies. Rights mobilization in this context holds the prospect of “expanding the conflict” to bring in powerful new actors including judges and lawyers. This changes the terms of debate in ways that destabilize the kind of closed bureaucratic policymaking systems that often characterize health policy and inhibit innovation, change, and improvement. In this context, rights change the policy landscape as much or more outside the courtroom, which explains why studies of litigation may miss the ways in which simply the possibility of going to court, and the framework of health as a right, changes the politics of health policy in issue areas that never even come before the judiciary. Fundamentally this opportunity changes the bargaining power of key actors including patients, civil society and non-governmental groups, and health actors inside the state vis-à-vis the rest of government.

Constitutionalization also puts critical new tools in the hands of health actors that can expand the information available to publics and governments and shift the structures of accountability that govern health. The idea of “voice” in health policymaking is much talked-about, largely in the context of democracy and transparency for improving wellbeing. The opportunities that come with legal mobilization—from discovery and subpoenas to the media coverage—can be critical to realizing voice in ways that are underappreciated. Finally, rights provide an important ideational shift in health policy—providing what Sen and Beitz both call “reasons for action” that are anchored in the national political bargain and undermine the ideas that often foster closed, static policy environments while enhancing the legitimacy of policy options focused on action and equity over inaction.

Constitutionalization can be especially important when dealing with health issues that primarily affect poor or marginalized people who often lack the power to move the levers of

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80 Schattschneider 1975 on the expansion of conflict in policymaking, and see Baumgartner and Jones 1993 for a discussion of policy monopolies as barriers to policy change, explored further in chapter 4.
82 Sen 2004; Beitz 2009.
democracy to change health policy in their favor. As Emily Zackin shows in a U.S. context, it is often not possible for unpopular political actors (stigmatized people living with HIV, for example) to make effective constitutional arguments and political change without courts, but engaging courts can actually promote public deliberation on issues that matter for them.\footnote{Zackin 2008.}

Similar processes are at work in a variety of countries and health policy issue areas. Perhaps the most well-known example of health rights in action is the South African Constitutional Court case on access to treatment for pregnant women to prevent HIV transmission to their children.\footnote{Minister of Health and Others v Treatment Action Campaign and Others 2002.} The Court’s decision was critical to shifting South African AIDS policy toward implementing antiretroviral treatment despite the President’s objections. As I describe in chapter 4, however, the court case itself was only one part of the opportunity structure created by the rights environment. Constitutionalization not only gave patients standing to sue, but also broke open policymaking around antiretroviral drugs well beyond the limited questions raised in the case by exposing information that was not available to the public despite a free press, shifting power dynamics within the ANC-led government toward pro-health leaders, and providing legitimacy to social movement groups and clinicians who had been opposing President Mbeki at the height of his power and popularity. The political question shifted toward how the government could justify not acting on the claims of rights-holders. In the end, a significant improvement in population health is attributable not to a court case alone, but to the shifts enabled by institutionalization of health rights.

A decade later, an entirely different set of circumstances saw the right to health mobilized in South Africa’s Eastern Cape on behalf of poor, black rural residents’ need for ambulances and EMS services to address leading causes of rampant maternal and child mortality. In an example as psychically far from the halls of the Constitutional Court as possible, the intervention of the South African Human Rights Commission forced local government officials to hear from communities, justify their policy choices, and reveal critical information to the public. It opened the door to badly
needed policy change and redistribution of resources that high profile media coverage, electoral competition, and social mobilization over a decade had failed to trigger.

In India, Supreme Court intervention on HIV resulted not in a landmark case but in a series of forced negotiations that similarly opened the door to pro-health policy shifts. In Thailand, rights instantiation inside the National Health Security Office has provided opportunities for individuals to bring claims on key health services that have re-shaped Thailand’s vaunted universal health programs.

These examples reflect a shift in the political economy of health and, where health is constitutionalized, it improves population wellbeing. As I show in chapters 3-6, these shifts increase the quality of health-related policy; increase health-supporting resource allocation—either growing expenditures, health workforce, and infrastructure, and/or allocating them to more health-impactful areas; and improve implementation of promised policies through greater information and accountability.

**Concepts & Conceptual Boundaries**

At the outset, it is critical to specify three concepts: the right to health, health-related policy, and institutionalization.

*The right to health (RtH):* While the idea of “positive” rights was out of favor among the drafters of many early constitutions in the global North—the U.S. Constitution, for example, famously omits them—framing social welfare and access as rights has a long history. The Carta De Foresta of 1217, sister document to the Magna Carta, set out economic and social entitlements directly affecting people’s daily lives, including a right of access to herbs and “vert” used in medieval medicines.85

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85 Van Bueren 2015.
Later in the French revolutionary period,\textsuperscript{86} and in the emergence of European welfare rights,\textsuperscript{87} health rights surfaced as well. The post-war international conception is concretized in the UDHR and appears in the constitution of the World Health Organization as the “enjoyment of the highest attainable standard of health.”\textsuperscript{88} It was not until recent decades, however, that we have seen a RtH incorporated in large numbers of national constitutions.

This project necessitates identifying when a right exists empirically—a deeply contested question.\textsuperscript{89} Joseph Raz’s oft-cited definition suggests rights exist if, all other things being equal, a person’s wellbeing (interests) is sufficient reason for holding others (including the state) under a duty.\textsuperscript{90} In this case the specific interest is in health—and drawing on the health capabilities approach, it is possible to both differentiate it from a right to \textit{be healthy}, which no state can guarantee, but also to denote a broader conception than simply a statutory right to access medical care.\textsuperscript{91} I believe it is appropriate, in this context, to consider that a right to health exists in a country when people can make a rights claim on the state and/or private actors, either individually or in groups, for feasible improvements in their health capability.

Following Sen, I do not argue a right does not exist if it is not perfectly enforced.\textsuperscript{92} As Goertz notes, however, a concept to which there is no negative pole is not empirically useful.\textsuperscript{93} Following my hypothesis, then, I will focus on the degree to which a country has \textit{institutionalized} a right to health. My assumption is that in some countries the state has no specific duty against which citizens can make claims and thus there is no institution of health as a right.

I am looking specifically to national constitutions as the starting point—whether they contain explicit language or have been clearly interpreted as supporting an \textit{enforceable} right to

\textsuperscript{86} Porter 1998, 56; Risse 1999, 302-05.
\textsuperscript{87} Ruggie 1982.
\textsuperscript{88} World Health Organization (WHO) 1946.
\textsuperscript{89} See, e.g. Dworkin 1978; Rawls 1999; Beitz 2009.
\textsuperscript{90} Raz 1984, 195.
\textsuperscript{91} Ruger 2010b; Sen 1999. Note this accords, albeit imperfectly, with the international conceptualization of a right to the “highest attainable standard of health.”
\textsuperscript{92} Sen 2004.
\textsuperscript{93} Goertz 2006.
health (i.e., not simply a value or policy principle). The growing number of constitutions that meet this standard is illustrated in figure 1.1. My focus here is on the constitutional RtH not because words on a page are decisive, but because the inclusion of an RtH in a national constitution is a clear, empirically visible move toward institutionalizing an RtH. I recognize that some societies without a constitutionalized form likely have strong health rights in practice. However, I believe a focus on constitutions is theoretically justified. While some worry about “sham constitutions”\textsuperscript{94} constitution-making is a uniquely decisive moment in the life of contemporary nation-states. Over time, the value and significance of written constitutions in the political life and policy-making of countries has only grown in most of the world.\textsuperscript{95}

As discussed below, in my quantitative analysis I will use specific forms of constitutional text to operationalize this broader concept for large-N analysis. In constructing a comparative study on the RtH, the constitutionalization of the right is not only an empirically legible starting point for study across time and space but it also represents a decisive move to law, which is important in the political process of institutionalization. It is, of course, an imperfect and noisy measure. However, for time-series large-N analysis I would suggest it provides at least comparable validity to other measures of rights instantiation used in scholarship on constitutions, international law, and political economy of development.\textsuperscript{96}

My qualitative work will use the existence of this constitutional text as a starting point for deeper analysis seeking to analyze the degree to which the RtH has been institutionalized. Since the ability to make claims are central to my concept of the RtH, meaningful and utilized opportunities to make claims for feasible improvements in their health capability will be key to the analysis.

\textsuperscript{94} Law and Versteeg 2013.
\textsuperscript{95} Ginsburg, Elkins, and Blount 2009.
\textsuperscript{96} Ginsburg et al. 2012; Simmons 2000; Law and Versteeg 2013, but see Choudhry 2012; Hirschl and Rosevear 2011 identifying such operationalization as best matched with qualitative study; and see measures of “institutions” in political economy in (Acemoglu, Johnson, and Robinson 2005) or democracy (Freedom House 2014).
Constitutionalization, Institutionalization, and Mobilization

A set of related concepts are relied upon throughout this dissertation that deserve clarification here. The concept of “constitutionalization” comes from studies in law and political science and reflects a political, not just a legal or jurisprudential, phenomenon in which key areas of policy are cast in rights terms and as a part of the fundamental national legal-political bargain, with an explicit enforcement mechanism—usually the courts. The related “judicialization” of issues, in which courts take up increasing power over policy outcomes and engage in complex back-and-forth with legislative bodies, is a piece of constitutionalization. It is judicialization that has most been the subject of increasing attention in health. However, as I argued above, looking primarily to courts and judges provides an insufficiently broad picture of constitutionalization. The bigger concept includes more fully the ways that a rights framework affects the politics of health as constitutionalization is both internalized and used as a tool by legal and non-legal actors—from bureaucrats to legislators to social movement groups. On the one hand, either action by courts or the threat of action by courts motivates other actors—legislators and bureaucrats—to act differently when the threat of court intervention exists. On the other hand, the framework of health as a right can both change the preferences of actors and shift the balance of power within the state, including over critical resource allocation decisions since “balancing competing priorities” and “fulfilling constitutional obligations” carry quite different implications. For the purposes of sections of this analysis, particularly the quantitative section in Chapter 2, I use constitutional provisions to serve as a practical marker of the constitutionalization of the right to health.

Constitutionalization, I argue, reflects a shift in the institutions governing the political economy of health, including critical distributional questions. Identifying the right to health as an “institution” helps further clarify the difference between text in a document and a real, empirically

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98 Shapiro and Sweet 2002; Tate and Vallinder 1995.
100 See, e.g. Béland 2005 on how the ability to successfully frame policy alternatives can be decisive in the policy process.
observable “enduring collection” of rules and practices that shape the options and incentives of the various actors in a given polity and remain relatively invariant to particular circumstances or the preferences of individuals. \(^{101}\) Stemming from political bargains, institutions dictate “appropriate” behavior and “structure conflict so as to privilege some interests while demobilizing others.” \(^{102}\) Institutions have been shown, for example, to set out the range of options for policy change in dealing with economic growth and crisis \(^{103}\) and restructuring social welfare systems \(^{104}\).

Creating an institutional environment that privileges the interests of individuals in achieving core health capabilities should improve health outcomes. In an environment of broadly weak institutions—as characterizes many low- and middle-income countries—elite capture of resources undermines provision of public goods that can improve health, especially for the poor and marginalized. As constitutions are rewritten or revised, these constitutional moments often reflect a “critical juncture” \(^{105}\) in which the seeds of a new institution may be planted.

I use institutionalization in this project as a matter of degree. I have in mind the degree to which a potential set of new rules and practices have actually become "locked-in." North describes how institutions come to provide increasing returns for compliance. \(^{106}\) Opportunities are increasingly created to participate in and to defend the institution. Organizations evolve to take advantage of new opportunities—from social movement groups choosing tactics to courts formulating decisions. In this case, we can judge the relative institutionalization of an RtH by the degree to which such opportunities exist—can patients go to court to affect health policy? Can civil society organizations make constitutional claims on health in venues that matter? Can health actors rely on a RtH as a reason for action? Without a constitutional right, the answer to these questions is no—but there is also a range of matters from legal standing rules to the density of rights-supporting organizations that affect relative institutionalization. These are similar to the way

\(^{101}\) March and Olsen 2008.  
\(^{102}\) Hall and Taylor 1996, 937.  
\(^{103}\) Hall and Soskice 2001, vol. 8.  
\(^{104}\) Pierson 2000b.  
\(^{105}\) Collier and Collier 1991.  
\(^{106}\) North 1990.
property rights and other rights-based institutions are analyzed in the political economy of development literature. A right to health, then, should be similarly considered to range from non-existent to strongly institutionalized. As described in the case study chapters below, South Africa has a highly institutionalized right to health as indicated by active judicial action on the right to health, multiple pieces of legislation and policy at national and provincial levels referring to the constitutional framework, wide penetration in public discourse, organizations rising to make use of the constitutional framework, etc. Malawi, on the other hand, has seen only limited institutionalization of the right to health and commensurately limited impact of constitutionalization. If my hypothesis is correct, then institutionalization of this type should increase the positive impact of the right to health; however, the alternative hypotheses above suggest that greater institutionalization might simply further distort health policy and undermine health. This is the empirical question at the heart of my case studies. I also hypothesize that the particular form of institutionalization likely matters. For example, it may matter whether a right to health was negotiated into the constitutional text explicitly (e.g. South Africa, Thailand) or has been judicially interpreted (e.g. India). These differences guide my case selections described below.

Health Policy

I am explicitly taking an approach that relates to the concept of “health capability,” which implies a broad conception of the aspects of policy and national decision-making that might impact people’s ability to functionally achieve health and to do so with agency. Jennifer Prah Ruger’s conceptualization more fully captures what matters for people’s lives than do explorations either framed around “opportunity” as the core concept or focused solely on “access” to medical services, capturing the complex processes that drive cross-national differences in health outcomes. I take a broad concept, on this basis, of what constitutes health-related policy. The health capabilities

\[\text{107} \text{ Kaufmann, Kraay, and Mastruzzi 2004.}\]

\[\text{108} \text{ Ruger 2010b.}\]
paradigm bridges debates over health care and the social determinants of health—recognizing the reality that both contribute to wellbeing without falling into nebulous debates in which every policy can be linked to health implications. It adds an important layer of complexity to epidemiologic and social determinants dialogues, recognizing that group-level factors may have individually heterogeneous effects. Focusing on identifying how well individuals can act within social and economic systems as agents of their own health to achieve health “functioning,” this framework draws important attention to how broader freedoms and power dynamics intersect with access and social structures to produce prospects for health agency. This is especially important for understanding the effect of constitutionalization, which changes how health policy is made, who the actors are, and how power is distributed in these processes.

In this context, I understand health policy to include health care services, public health including societal regulations intended to impact health, environmental health, medicines, health-related research, health education and prevention efforts, and other community and welfare-state programs aimed at improving health. Many other policy issues impact health (from education policy to income redistributive taxation), but I do not expect that the constitutional environment will have a significant effect on these issues that are largely governed by other constitutional elements.

As described below, the qualitative level of analysis in this project focuses on tracing policy issues where the right to health has been mobilized. There is a long history of rights mobilization on HIV/AIDS and it is not surprising that this figures prominently in my case studies. This matters for wellbeing since, led by countries in sub-Saharan Africa, HIV contributes significantly to the cross-national variation in health—for women aged 15-49 years, for example, HIV/AIDS is the leading cause of death worldwide. The area of essential medicines—policy and practice of which medicines will be available, to whom, at what prices, and under what intellectual property

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109 Ibid., 44.
110 Ruger 2010a, 146–7.
111 Mann 1996; Gostin and Lazzarini 1997; Galvão 2005; Mbali 2013.
112 Institute for Health Metrics and Evaluation 2016; World Health Organization (WHO) 2013b.
rules—has also been a major area of litigation, civil society mobilization, and international attention.\(^{113}\) This likely matters a great deal for health on two fronts: first, the degree to which medicines are available and affordable does have a significant effect on health outcomes—especially in the area of the major infectious disease killers like malaria, TB and HIV and to a lesser degree on non-communicable diseases. Of the 40 million annual deaths in developing countries (many among children), about 10 million are due to acute respiratory infections, diarrheal diseases, tuberculosis, and malaria—all conditions for which drugs can be life-saving if they are available and affordable.\(^{114}\) Apart from the direct benefit, there is also a major opportunity cost question—while spending on drugs is a small part of overall health expenditure in high-income countries it can be 25-66% of health spending in developing countries.\(^{115}\) In most low-income countries, pharmaceuticals are the largest public expenditure on health after personnel costs, and are the largest household health expenditure. Choosing to, for example, implement a strategic generic drug program instead of maximalist IPR rules can free up major resources for other urgent needs from paying midwives to drilling bore holes for water.\(^{116}\)

If constitutionalization only matters in these two areas, however, it would be difficult to see how it would substantially affect aggregate wellbeing. Therefore, part of this study aims to explore the impact not just of these two areas, but beyond, to test how far the effect of a right to health travels. If correlation with positive health measures is truly causal, we should be able to link a right to health with decision-making in other areas—budgeting, primary healthcare delivery, maternal & child health, and perhaps farther afield. Identifying whether these connections exist—whether the legal complex and rights-based claims-making matter here—is a key part of the process tracing level of analysis in chapters 4-6.

\(^{113}\) Hogerzeil et al. 2006; Krikorian 2009; Kapstein and Busby 2013; Maleche and Day 2014; Grover 2013.
\(^{114}\) World Health Organization (WHO) 2013a.
\(^{115}\) Ibid.; WHO and Cehraghali 2010.
\(^{116}\) Correa 2000; Correa and World Health Organization (WHO) 2002.
Mobilization

Finally, I follow legal mobilization scholars, who show that it is possible, in the course of broader policy struggles, to track when and how rights are mobilized. This is the process in which individuals and groups make claims about legal rights (theirs or others’) and engage the legal complex in formal lawsuits or less formal rights talk opportunities in order to defend or to develop those rights. When rights are mobilized, the institutionalization of the right to health becomes most visible. As such, in the case studies below I use interview data to identify sets of policy issues in each country on which the right to health was mobilized, and then engage in process tracing before and after mobilization to identify how constitutionalization affects policy and health outcomes.

Adjudicating Between Competing Theories

This study is designed to adjudicate between a set of alternative theories, each of which has support in academic literatures. The skeptical view suggests constitutionalization will have no real effect on population health. The pessimistic view instead worries that constitutionalizing health is actually a bad idea—introducing a framework that is too individualistic, governed by inexpert judges that will distort health policy and drive resources away from public health goods. Instead, as I described above, I see the constitutionalization of health as a move to institutionalize an “ethical” framework for health that is likely to change health-related policy and policymaking in ways that, on balance, benefit wellbeing. While the impact is likely to be different between countries and between population groups, I see the most significant mechanism in opening policymaking and shifting power balances in ways likely to have a positive effect in the aggregate.

These are hypotheses with implications that should be visible and empirically testable. If my hypotheses are correct then, contrary to the alternative theories in the literature, we should to be able to observe: better health outcomes in countries with an RtH, controlling for the dominant

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social science explanations for cross-national variation in health outcomes such as wealth, inequality, homogeneity, social determinants, and preferences of the dominant political coalition. Policymaking linked to those outcomes should be able to be credibly described as different from how it would otherwise have been without an RtH—in process, actors, and outcome. Second, we should also see positive outcomes from the involvement of the legal complex (and likely the interaction of the legal complex and social movements) that, over a substantial period of time, do not distort or divert resources from good public health or away from the poor.

**Research Design: Nested Analysis**

This study’s research design is structured to both adjudicate between competing hypotheses and, if my hypotheses prove correct, to generate sufficiently fine-grained data to uncover causal links. To do so requires analysis on at least two levels, illustrated in Figure 1.2. First, a high-level empirical relationship between an RtH and health outcomes. Then, at a second level, causal evidence about the mechanisms underlying this relationship.

I tackle this question using a “nested analysis” that combines a large-N regression with small-N fieldwork-based case studies. Chapters 2 and 3 go into greater detail below about the particular methodological choices made for each of these two levels. Combining quantitative and qualitative research, this strategy allows me to investigate the question at these two different levels of analysis and triangulate between the different types of causal leverage generated by each level of

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118 Lieberman 2005; the term “nested analysis” is proposed in the 1st edition of Collier, Brady, and Seawright 2010, 192.
analysis. While mixed methods are not appropriate for some types of studies, and nested analysis brings with it specific pitfalls, it is particularly well-suited for the question asked in this study for two major reasons. First, wellbeing in a nation is over-determined—with a broad literature that actually leaves relatively small unexplained variation in health outcomes, even as some “explanatory” variables merge multiple causal factors which are themselves explained by distal factors. In this context, a finding of significant impact for which we can be confident in generalizability is likely to only be observable across a large set of data. As discussed below, however, these same confounding factors make causal identification particularly difficult. So, following others who look at similar questions of policy, institutions, and welfare, I combine the forms of leverage at each level.

The large-N analysis helps me establish whether there is, in the world, a relationship between having an RtH and health outcomes—providing a high number of observations to overcome the well-known problem of many variables with too few cases. Comparative constitutional studies often suffer from a problem of external validity and selection bias due to over-reliance on a small set of much-studied cases—which can be overcome through large-N study. However, large-N statistical analysis alone is poorly suited for complex causal theories or uncovering causal mechanisms—which are required for this study to confidently adjudicate between theories that variously suggest an RtH will be immaterial, harmful, or helpful for population health. My hypothesis is not that words on paper do the work, but instead that constitutions matter insofar as they institutionalize rights in the political economy of a nation and therefore affect policy, which in turn affects health. The critical question, then, is how? We can only be confident that any large-N relationship in this context is causal if it is paired with evidence of the mechanism that is doing the work. Large-N analysis alone is also problematic in the study of

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119 Tarrow 2010a.
120 Rohlfing 2008.
121 e.g. Lieberman 2009; McGuire 2010; Lynch 2006.
123 Hirschl 2014; and on selection bias in cross-national cases, see Geddes 2003, 89-105.
124 Collier, Brady, and Seawright 2010; Mahoney 2007.
phenomena subject to *equifinality*.

In this case, there is ample evidence that similar health outcomes can result from different combinations of economic, social, and service-delivery factors. McGuire, for example, shows how an increase in GDP, a reduction in inequality, or a significant expansion of health services separately contribute to similar-sized reductions in child mortality in various contexts. My hypothesis is that an RtH acts similarly—it contributes to a specific causal pattern that results in improved health outcomes, but it does not act alone. As such, the task here is to discover the different causal patterns at work and whether the RtH emerges as truly important rather than just a spurious correlation. There is also a particular task in this research of establishing *directionality*. Research on the social determinants of health, for example, finds social structures drive health equity and, one might expect, would also contribute to the writing of constitutions that themselves do little work except reflecting an underlying predisposition.

In this context, revealing between-country effects and uncovering mechanisms are both critical—and best accomplished through a nested analysis.

At the first level, I assemble a panel dataset, focusing on the period 1970 to 2010 for which there is wide availability of data on each of the critical variables, and construct a robust model to reflect the major explanations for variation in mortality within the economics and social determinants of health literature. As described in the next chapter, this incorporates data including GDP, inequality, women’s education, ethnic fractionalization, urbanization, and other variables that have consistent support within the literature. I also test measures of democracy, to reflect the major well-studied political institution in the literature.

At the second level of analysis, I conducted fieldwork in four countries to uncover the plausible mechanisms through which an RtH impacts population health. By gathering “causal process observations” to augment the “dataset observations” in my large-N analysis, I am able to

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125 George and Bennett 2005, 161-2.
126 McGuire 2010.
127 Or see the opposite argument that constitutions are sometimes “shams” to protect poor-performing governments in Law and Versteeg 2013.
128 Perhaps most prominently Filmer and Pritchett 1999, who declare that between-country health differences can be explained by just five factors.
gain greater purchase on whether the relationship observed statistically is causal.\textsuperscript{129} My primary causal leverage at this level comes from within-case analysis, using data from over 165 in-depth interviews supplemented by archival research to engage in process tracing of recent health and health-related policymaking.\textsuperscript{130} I began by identifying health policy issues where the right to health was mobilized and traced the processes starting well before and continuing well after mobilization in order to understand whether and how the process and outcomes of policymaking shifted. Doing so, I show with empirical evidence the link between cause and effect and how the RtH acts through specific mechanisms to affect health-related policy, which in turn affects health outcomes. My theory operates in a world marked by multiple, complex interaction effects—with constitutionalization interacting with other political, demographic, and economic factors. Process tracing as a method is especially well suited in such a context, and helps me uncover what are path-dependent processes that lead to better health.\textsuperscript{131}

\textit{Country Case Selection}

The hypotheses and the implications for a right to health are global and so the dataset for the large-N analysis features the universe of cases is as well. The vast majority of premature morbidity and mortality, however, occurs in low- and middle-income countries, so the search for effective pro-health institutions is of particular practical importance there. Given the need to limit the population of interest for the small-N study, I focus on the global South—limiting the scope conditions for the study on that basis. The implicit presumption in most development literature is that Northern institutions are superior and should be emulated in the South—efficacious constitutionalization, innovation coming largely from the South, would provide the opposite.

In the nested analysis, the large-N statistical study is designed to illuminate between-case relationships between health and constitutionalization while the qualitative portion of the study

\textsuperscript{129} Collier, Brady, and Seawright 2010.
\textsuperscript{130} Mahoney 2012.
\textsuperscript{131} George and Bennett 2005, 206; Pierson 2000a.
builds on this relationship with a focus on collecting “within-case” data. This is gathered from countries that do have an RtH in order to show the mechanisms at work in health-related policy—whether a right to health can truly be identified as causal.

I focus on a paired comparison to allow “dual-process tracing”\(^\text{132}\) between similar cases, both of which have an RtH, yet have very different histories of institutionalization and judicialization—South Africa and India. With limited time for research and well-developed theory, random case selection is both inefficient and likely to produce an unrepresentative sample.\(^\text{133}\) Following Rohlfing, who suggests model-building cases as a first step in nested analysis, several processes in South Africa—specifically around the HIV response, explored in preliminary fieldwork and identified in literature—serve together as a “pathway case” and informed my initial hypothesis.\(^\text{134}\) In South Africa, the RtH has reached high-profile status and been mobilized by the legal complex, social movements, and political leaders.\(^\text{135}\) There is still significant debate, however, about whether the RtH in South Africa actually matters for health—whether, outside a few high profile Constitutional Court cases, health policy is different or better because of it.\(^\text{136}\) The South Africa case study, here seeks to delve deeper—to trace policy processes over a longer period and include less studied examples to add further data in this area. Following Lieberman, I draw on India as an “on the line” example for comparison.\(^\text{137}\) With a low residual in my quantitative analysis, India is seemingly well-explained by a theory that the right to health matters controlling for other factors and is most likely to reveal causal processes in small-N analysis.\(^\text{138}\) India also provides a well-matched pair to South Africa as a middle-income, highly diverse, highly unequal constitutional democracy governed by common law and featuring a strong judiciary. Yet in India the causes of ill-health are different (less HIV) and the history of the institutionalization of the right to health is also

\(^{132}\) Tarrow 2010b.
\(^{133}\) Seawright and Gerring 2008.
\(^{134}\) Rohlfing 2008; Gerring 2007.
\(^{135}\) Tushnet 2009; Young 2012; Heywood 2009.
\(^{136}\) Berger 2008; Pieterse 2014; Jones and Chingore 2014; Hassim, Heywood, and Berger 2014.
\(^{137}\) Lieberman 2005.
\(^{138}\) Ibid. 444-6.
quite different—judicially derived from constitutional interpretation rather than from constitutional drafting.¹³⁹

In addition, to test the theory I conducted field work for two additional cases—Malawi and Thailand, which are included here as brief shadow cases in the appendix. Malawi provides a low-income case with many similarities for comparison to South Africa including region, colonial history, a strong judiciary, and recent emergence from autocratic rule.¹⁴⁰ Thailand, for its part, provides a test outside a common law system and in a country in which the judiciary, while strong, is not "progressive" in the sense of actively courting socio-economic rights or supporting governments that do and thus constitutionalization is not judicialization.¹⁴¹ The basic concept in choosing these cases is to evaluate whether there are mechanisms that operate according to my theory in such diverse settings—that tie institutionalization of a right to health to better health-related policies and thus eventual improved health.

Outline and Summary Findings

I divide the empirical chapters into two sections: Quantitative and Qualitative.

Section 1 focuses on the connection between a constitutional right to health and indicators of wellbeing. Constructing a dataset of 144 countries over 40 years, statistical analysis shows that countries with the right to health have better health outcomes on average, even after controlling for the dominant explanations for cross-national variation in wellbeing from public health, economics, and political science literature. Using a measure for the gender ratio in under-5 mortality, I also show evidence that countries with a right to health have more equitable health outcomes. These findings are supported by further analysis that shows constitutionalizing countries provide more of what matters for the poor. They do not spend more on health overall, but a greater portion of health

¹³⁹ Case and Deaton 2005; Muralidhar 2008; Shankar and Mehta 2008; Parmar and Wahi 2011.
spending is public, with lower out-of-pocket expenses, and they achieve greater coverage of key health services such as immunization and skilled birth attendance.

Section 2 provides a next level of analysis about how constitutionalization works based on over 165 in-depth interviews with policymakers, judges, lawyers, activists, and elected officials in South Africa, India, Malawi and Thailand. This section has two goals: First, I seek to test whether the quantitative relationships uncovered in section 1 can be causally connected to constitutionalization through policymaking processes that would explain the significant health dividend the large-N data suggest. Second, understanding the causal mechanisms through which constitutionalization improves population health might enable us to identify ways to deepen those mechanisms and expand them to new issues and geographies. Chapter 3 provides an overarching explanation of the qualitative findings that outlines the mechanisms at work in constitutionalization drawn from the case studies that follow, which trace twenty different policy issues.

Chapter 4 focuses on South Africa—our best example of a strongly institutionalized right to health—showing that the constitutionalization has had a wide impact on health policy issues well beyond the handful of high profile court cases that have captured international attention. South Africa is hardly a success story on health, which is part of what makes it a particularly interesting example for study—overcoming huge barriers from the legacies of apartheid to the demographic youth bulge is a major social task. From HIV/AIDS to maternal mortality, prison conditions, user fees in healthcare, and the regulation of private insurance, the decision to include health as a right in the 1994 Constitution has had a significant impact on the wellbeing of South Africans. Chapter 5 turns to India, where the type of institutionalization of the right to health is quite different. A key set of decisions by India’s Supreme Court and lower courts have identified a right to health as judicially enforceable, which has triggered a large number of court cases throughout the country—tackling a host of different issues. India’s judicially-driven constitutionalization has given rise to a different politics of health rights than in South Africa, one which on some fronts has had lesser
impact. There are, however, important similarities in the mechanisms of just how constitutionalization affects health policy, which provides important evidence that these mechanisms are generalizable, while the differences in the details suggest ways that different settings might yield lessons for each other about maximizing health benefits.

I also make reference in this section to Annex D, which includes short case studies on Thailand and Malawi, which provide out-of-sample tests aimed at exploring how my findings from the core comparison of South Africa and India travel to very different contexts. Thailand, the non-common law example, which has a well-functioning universal health system, shows an example in a unique context of how constitutionalization plays out in a context where courts play a surprisingly small role yet cascading impact of rights instantiation is still seen in a set of bureaucratic and legislative initiatives. Malawi, meanwhile, reveal the limits of constitutionalization in spaces where insufficient “support structure” undermines institutionalization of health rights. Importantly, however, Malawi shows relatively high institutionalization of negative rights like freedom of expression and political association and my inquiry suggests investment in institution building could yield results in health rights as well.

In chapter 6 I conclude by highlighting the ways that my findings speak to debates in both scholarship and practice. Finding that the right to health matters—that by shifting the institutional environment in which health policy is made, constitutionalization can improve wellbeing—has implications for scholarship in political science, law, and economics. Challenging pessimistic accounts of “positive” rights, my findings contribute to scholarship that looks beyond the much debated, narrow set of institutions in development literature to address an innovation in institution-building that comes from the global South. Electoral democracy has received far more attention than it perhaps deserves when it comes to improving health and a turn to additional institutions, including constitutionalization, is warranted. Indeed, as I argue in the conclusion, there are important lessons for wealthy countries like the U.S.—most often positioned as the exporters of “good” institutions—about how rights frameworks that are showing impact in
complex, difficult health environments might be adapted to address some of the inequities and poor health outcomes experienced by many in the U.S. and countries like it. On a practical matter, I conclude by noting that foundations, international aid agencies, and United Nations bodies spend a great deal of money and time addressing rights and governance on the one hand and public health on the other. Truly connecting the two is today only in its infancy. These findings suggest, though, that constitution-writing is health policy work and that global health funders might get as much benefit by supporting lawyers, NGOs, and rights work as they do from building clinics and drug supply chains.
SECTION I: CONSTITUTIONALIZATION IMPROVES HEALTH
Chapter 2 Estimating the Effects of a Right to Health: Quantitative Evidence

Leave South Africa’s capital of Pretoria via the N4 highway north and in just over four hours you will arrive in Botswana’s capital of Gaborone. These two countries share a border and a complicated history in the Southern African region. Botswana has many of the ingredients for better health than its neighbor: higher GDP, stronger economic growth, lower economic and gender inequality, fewer ethnic divisions and electoral democracy that is both longer-standing and by several measures, as strong, if not stronger.¹ Yet South Africa’s under-5 mortality rate is 10% lower. The reasons behind this difference are multiple and complex, but one interesting difference between the two countries is South Africa’s constitutional protection of health as a right while Botswana provides no such constitutionalization. Does this matter?

This chapter outlines empirical evidence to address this question and suggest whether the right to health is beneficial, harmful, or simply a distraction. To do so, I model the effect of protecting health as a constitutional right using forty years of global health data.

The analysis below shows that countries with a constitutional right to health have better population health, controlling for the dominant explanations of cross-national variation in mortality from public health, political science, and economics literature. The effect is statistically significant and robust, showing an effect that is roughly equivalent, for example, to the difference between the United States and an “average” high-income country, or between Zimbabwe and its better-off neighbor Zambia. This positive impact is particularly important for questions of health equity as countries with a right to health show particular benefits in girls’ mortality rates compared to boys. Countries pursuing constitutionalization are similar to countries that are not in the total amount spent on health, which undermines both the suggestion that health rights are epiphenomenal to social commitment to health and that health rights will result in out-of-control spending. Instead, I present evidence that constitutionalizing countries invest more effectively in public health, resulting in significantly better coverage of several key measures of health service provision, in line with an overall finding of a small but significant mortality dividend from constitutionalization. While none of this data is perfect and causal identification necessarily relies on the nested qualitative evidence detailed in chapters 4 and 4, this chapter nonetheless presents strong pieces of evidence that institutionalizing a RtH has a beneficial effect on population health and, likely working through governance and health policy, is a net positive for the health system.

*The Right to Health in National Constitutions: Distinct Institution*

As described in chapter 1, the right to health takes a variety of forms—from international treaties conferring state obligation to ideational tools of social movements to culturally constructed expectations of private actors. This study uses one subset: an explicitly articulated right to health in a written constitution. This clearly under-identifies the right to health, but much as private property laws under-represent the institution of private property, I suggest constitutional provisions can serve as a valid, if incomplete, indicator for empirical evidence of a broader institution.

For the constitutional right to health variable, this study makes use of a dataset compiled by the Comparative Constitutions Project—a systematic catalogue of formal characteristics of
written constitutions, both current and historical, for most independent states since 1789. The dataset provides panel data for country years with over 13,000 country year observations. This project uses a subset of this data that codes a categorical variable based on whether the constitution includes an explicit reference to a seemingly enforceable right to health. This includes, for example, South Africa where Section 27 sites an explicit right to health but not Nigeria where a constitution from the same era included a policy directive toward health but not a right, as seen here:

<table>
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<tr>
<td>(1) The State social order is founded on ideals of Freedom, Equality and Justice (…)</td>
<td></td>
</tr>
<tr>
<td>(3) The State shall direct its policy towards ensuring that-</td>
<td></td>
</tr>
<tr>
<td>(c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;</td>
<td></td>
</tr>
<tr>
<td>(d) there are adequate medical and health facilities for all persons.</td>
<td>1. Everyone has the right to have access to</td>
</tr>
<tr>
<td></td>
<td>a. health care services, including reproductive health care;</td>
</tr>
<tr>
<td></td>
<td>b. sufficient food and water; and</td>
</tr>
<tr>
<td></td>
<td>c. social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.</td>
</tr>
<tr>
<td></td>
<td>2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.</td>
</tr>
</tbody>
</table>

Based on data reliability on other variables, observations are included from 1970-2010.

Given the expanding number of independent states with written constitutions, this provides annual observations for an increasing number of countries—118 in 1970 and 188 in 2010 (see figure 1.1).

Health rights in the constitutions of the world show great variation across time and space. In 1970 only 17% of written constitutions had an explicit right to health, while by 2010 that number surpassed 50%. Norms around constitutional construction clearly changed over the recent decades—in the

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2 Melton et al. 2013.
3 The one exception here is India where, in 1995, the Supreme Court identified health as a constitutional right. To my knowledge India is unique in having such a clear judicially derived right. In robustness checks dropping India does not change results below.
1970s only 35% of the over three hundred new constitutions written included a right to health but in both the 90s and in the 2000s 64% included a right to health. Clearly, though, there is still substantial variation—even in the most recent decade many constitution writers chose not to include a right to health. Given this clear trend all analyses below include controls for year effects and, in a robustness check, the impact of including the age and year of the constitutional system are tested, with models proving robust.

There is also relative diversity in adoption of a right to health geographically and economically. In 2010 just over half of all countries had a right to health, which included countries from every region of the world. As shown in Table 1, between 40 and 60 percent of countries in most regions had a right to health, though Oceana and Western Europe showed lower coverage while nearly all constitutions in Eastern Europe had a right to health. This supports the idea of diffusion effect between countries, though it is clearly incomplete. Countries at all income levels had adopted a constitutional right to health in 2010—60% of low-income, 58% of lower-middle and 62% of upper-middle-income countries, and 29% of high-income countries. It is reasonable to assume here that a country with higher health indicators has less need for a policy anchor in health.

Legal tradition is associated with the likelihood of adopting a right to health—68% of civil law countries compared to 26% of mixed and 15% of common law countries had a right to health. This is, however, not found to be an important confounding variable in regression analyses.

<table>
<thead>
<tr>
<th>Table 2.2</th>
<th>Polychoric correlations, 2010</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Right to Health</td>
</tr>
<tr>
<td>Income category</td>
<td>-0.16 *</td>
</tr>
<tr>
<td>Democracy</td>
<td>-0.05 *</td>
</tr>
<tr>
<td>Legal system</td>
<td>0.33 *</td>
</tr>
<tr>
<td>* .05 signif. in basic correlation.</td>
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The data shows countries across the democracy spectrum have largely split in adopting a right to health. Democratic countries, strongly democratic countries (customarily defined as those with a Polity-IV score at least 6), and autocratic countries each split nearly evenly between those which

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4 O’Connell 2010.
5 Legal system classification coded Muslim, civil law, common law, or civil/common law mixed based on University of Ottawa JuriGlobe University of Ottawa n.d.
do and do not have a constitutional right to health. Interestingly, strongly autocratic countries have slightly more often adopted a right to health—65% had done so in 2010.

In sum, while some categories of countries are somewhat more likely to have a right to health, there is substantial variation across all types of countries. Table 2 shows the correlation matrix between the right to health and these variables, illustrating low correlations. The right to health is not unduly tied to major political economy classes.

This suggests that the right to health is, as theorized, a distinct institution and that a cross-national statistical analysis is appropriate to evaluate the degree to which this institution matters.

Estimating Dominant Theories of Health: Wealth, Social Determinants & Democracy

To begin, this chapter first builds a model of the dominant theories of what matters for health and then tests whether, within that context, a right to health provides any analytic leverage.

The models here use under-5 mortality rates, the probability of death between birth and 5 years per 1,000 live births, as the major outcome measure of interest to represent health outcomes following Caldwell. Under-5 mortality is widely recognized as the most appropriate indicator of the cumulative exposure to the risk of death during early years of life. Using under-5 mortality also provides us with two important theoretical advantages. First, it is a measure of health likely to be affected by health systems more directly than some others given its limited timeframe. Unlike infant mortality measures, however, under-5 mortality captures the effect of multiple years of potential intervention in the health of a person. If institutions matter for health then they should act by ensuring provision of medicines when people are sick, doctors to care for them, healthier living conditions, etc., which are likely well-captured in the first five years of life. Mindful of Ross’s findings that missing national health data are not random and have a considerable biasing effect on

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6 Caldwell 1990.
7 Ahmad, Lopez, and Inoue 2000.
cross-national research, imputed child mortality estimates developed by IHME are used to provide wide geographic and time cover for the 1970-2010 period.

A series of models are assembled here with log under-5 mortality as the dependent variable to estimate the impact of having a constitutional right to health. There are strong time/progress patterns in the global dataset, which is addressed in two ways: by including the year as a control variable in the dataset (as a variable rather than a fixed effect, though both are tested) and by checking the robustness of the results with an auto-distributive lag model to account for these effects. As described in the robustness checks below, cognizant of the potential connection between RtH provisions and the age and year of constitution and the legal system, each is tested as a variable and neither holds significant predictive power. The right to health, on the other hand, is shown as a significant factor in all of the estimations.

Models 1 & 2: Wealthier is Healthier & Rights

Perhaps the most consistent finding in cross-national studies of mortality is the curvilinear relationship between higher national income and lower mortality—illustrated by the classic Preston curve. This influential theory cum stylized fact that “wealthier is healthier” suggests that national income is the most important explanatory variable in understanding mortality. It explains not only outcomes, but also state capacity, expenditure and inputs. As such, I make use of an IHME data set with among the widest available GDP estimates in dollars running from 1970-2010. Model 1 estimates the basic theory that GDP (logged) explains health outcomes.

Figure 2.1 shows the clear trend in both 1970 and 2010 that, indeed, wealthier is healthier. The labeled countries are those with a right to health. We can see, beyond the clear expansion of

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8 Ross 2006.
9 Rajaratnam et al. 2010.
10 Preston 1975.
13 James et al. 2012.
countries with the right to health, that while healthier is wealthier many countries fall well above or below the line and thus under- or over-perform the expectations of the reduced form model.

While the graphs do not tell a clear story of significance, it does seem that there are more over-performers among those with the right to health than there are under-performers—providing some initial support to the theory. This also shows up in model 2 reported below, which adds health rights to the equation showing the impact of health rights in the context of the restricted “wealthier is healthier” hypothesis.

Figure 2: Test of Wealthier is Healthier

Model 3: Economic & Social Determinants of Health

If growth in GDP were the only reason for improved health, countries would move along a fixed curve without substantial change to that curve over time. But we see that over time people live substantially longer at a given level of income—China’s income rise has not been nearly as large as what would have been needed several hundred years ago to reach the life expectancy it has today.\(^\text{14}\) Preston himself noted that income growth explained only a comparatively small part of the life expectancy differences through space and time.\(^\text{15}\)

A large literature has attempted to establish the set of other national assets that affect mortality cross-nationally that can better reflect the demographic and social determinants of health.

\(^\text{14}\) Cutler, Deaton, and Lleras-Muney 2006.
\(^\text{15}\) Preston 1975.
Several core variables including women’s education and ethnic fractionalization have consistently been shown to be associated with mortality, while others such as inequality have been debated. While the boundaries between theories are not always clear, much of the literature conforms to the expanded theory that these social and demographic factors differ between countries and cause a between-country gradient of health.\textsuperscript{16} Indeed, Filmer and Pritchett argue that they can explain nearly all variation in child mortality with just six economic and social factors.\textsuperscript{17}

While no consensus exists about the “right” set of variables that explain health, a set of often-discussed factors can be used to represent the social and demographic determinants of health. Theoretical explanations for including each variable are below along with basic measurement specifications. See Annex C for full sourcing and scaling.

**Female education** is among the variables most widely found to be associated with lower child mortality.\textsuperscript{18} As a variable it has been found to be encompassing—capturing a variety of individual and social determinants of health including fertility level, women’s empowerment, economic resources available to households, and general knowledge and beliefs about disease and prevention.\textsuperscript{19} It is also likely a good representation of important aspects of state capacity.\textsuperscript{20} Here, estimates of the age-standardized mean years of education for men and women developed in Gakidou et al. are used, which provide wide cross-national coverage between 1970 and 2010 for the mean years of education of women of reproductive age 15-44.\textsuperscript{21}

**Ethnic fractionalization** has been linked directly and indirectly to poorer mortality. The literature broadly suggests that ethnic fractionalization leads to an inability to coordinate
policy toward pro-health outcomes and reduces incentives for public goods creation.\textsuperscript{22} La Porta suggests that ethnic diversity leads to corruption and low government performance.\textsuperscript{23} Lieberman shows that, in societies with strong ethnic boundaries, political resistance develops to addressing intra-group stigmatized health conditions like HIV/AIDS and reduces effective response to epidemics.\textsuperscript{24} This paper makes use of the widely used measure of ethnolinguistic fractionalization, based on the 1985 measure as calculated in Montalvo and Reynal-Querol,\textsuperscript{25} which represents the probability that two randomly selected individuals in a country belong to different ethnolinguistic groups.

\textbf{Inequality} and its impact on mortality are hotly debated in the literature. Seminal studies have found a strong relationship between inequality and poor health outcomes on a variety of measures.\textsuperscript{26} Wilkinson & Pickett reviewed evidence showing that inequality was associated with low social capital and social mobility and more racism, along with higher rates of obesity, teenage birth, mental illness, and homicide.\textsuperscript{27} Others, however, have failed to find a direct relationship between inequality and health in a variety of measures and have suggested that other correlated factors are actually doing the work.\textsuperscript{28} Biggs et al. found a complex and contingent effect of poverty and inequality on health depending on the prevailing economic situation and that inequality and poverty exert independent, substantial effects on the relationship between national income level and health.\textsuperscript{29} The debate will not be settled here, thus inequality is included in the regression analysis. A robustness check of the regression without the measure shows it does not impact the analysis. One of the standard measures of gini coefficient is used here—the degree of inequality in national distribution of income among individuals or households, as

\begin{itemize}
\item\textsuperscript{22} Alesina, Baqir, and Easterly 1999; Easterly 2001.
\item\textsuperscript{23} La Porta et al. 1999.
\item\textsuperscript{24} Lieberman 2009.
\item\textsuperscript{25} Montalvo and Reynal-Querol 2005.
\item\textsuperscript{26} Rodgers 1979; Wilkinson 1992.
\item\textsuperscript{27} Wilkinson and Pickett 2007.
\item\textsuperscript{28} Judge, Mulligan, and Benzeval 1998; Deaton 2003.
\item\textsuperscript{29} Biggs et al. 2010.
\end{itemize}
calculated by World Income Inequality Database, which provides wide but imperfect coverage.30

**Urbanization and population density** both reflect geographic and societal factors that are linked to health and mortality in a variety of relatively intuitive ways, such as disease transmission and density of health services, which are unlikely to be reflected in any of the other control variables.31 Since, while similar, they are not likely to impact mortality identically (e.g. denser but less urbanized populations might have better reach of health services while avoiding negative disease-transmission effects of mega-cities) are likely important. As such, following standard practice, measures of both are included as control variables.32

**Conflict/Political Violence** is clearly a direct cause of excess mortality and a significant public health threat.33 A magnitude score of episodes of civil and ethnic violence and warfare developed by the Polity dataset34 was included in the original model. However, it fails to reach significance in any of the specifications and changes neither the model fit nor effect size of variables of interest substantially. As such, it is dropped from the base model. This comes as little surprise since other factors above including ethnic fractionalization and women’s education likely soak up the direct effect given the complex nature of political violence.35

**Region and year** are both also included in all the regressions, as is customary. Controls for time encompass a variety of factors including technological progress and scientific

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30 UNU-WIDER 2010.  
31 Cutler, Deaton, and Lleras-Muney 2006; Galea 2002. 
32 Filmer and Pritchett 1999; McGuire 2010. 
33 De Jong 2010. 
35 Pedersen 2002.
knowledge. Regional dummies help control for the effects of colonial history and region-specific differences in political stability.

Model 4: Institutions Matter—Democracy

Amartya Sen puts it clearly: “Individuals live and operate in a world of institutions. Our opportunities and prospects depend crucially on what institutions exist and how they function.” He suggests that examining both political and socioeconomic freedoms are critical. Yet while the connection between democracy and health has been much analyzed, the conception of a right to health as a critical institution shaping socioeconomic freedoms has been insufficiently examined. Both of these intuitions likely operate indirectly, likely through the provision of services and orientation of the state to health efforts.

A significant set of authors in several disciplines have argued democracy—conceptualized and operationalized to include the elements of both free, competitive elections and core political freedoms—reduces child mortality and improves life expectancy. As an institution Sen proposes that democracy has both an instrumental and a constructive role in health and development—proving a “hearing” for a population’s needs and allowing them to be understood in societal context. Building on this, some suggest that democracies’ responsiveness to public opinion and openness to social movements concerned with health lead to improved outcomes. Acemoglu and Robinson argue that the biggest change in democracy is who controls political power—the masses or the rich elite—with democracy favoring mass interests in public goods like health rather than private wellbeing. Bueno de Mesquita et al.’s work suggests that democracies encourage public health provision because, as opposed to small-selectorate autocracies, leaders in democracy are held

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36 Deaton 2013.  
37 Englebert 2000; Alesina et al. 1996.  
38 Sen 1999.  
40 Sen 1999.  
accountable by a large electorate, from which they must form a winning coalition that likely benefits from public health improvements.43

But other research has shown that whether democracy has a direct effect on health is much less clear.44 Ross finds, for example, there is no direct effect of democracy on infant or child mortality after filling in often-dropped but important countries and suggests this is due to a failure of benefits and spending to pass to the poorest sectors of society.45

Given the theory, Polity-IV is used here as a measure of democracy, which provides an 11-point scale from -10 (autocracy) to +10 (democracy) measuring executive recruitment, constraints on executive authority, and political competition. Of the available measures, it is most likely to capture the kind of democratic environment theorized in the literature to improve mortality.

Model 5: Constitutional Right to Health

Democratic governance, however, represents only half of the rights paradigm—so called “first generation” civil and political rights. The core research question is whether socio-economic rights, in this case the right to health, have an additional role in shaping the institutional milieu that affects health. Do constitutional health rights matter for people’s health, even controlling for wealth, social and demographic determinants, and democracy? Therefore, the final model includes the constitutional right to health variable alongside the variables for the three other explanations.

Estimation Strategy

The following model is estimated as the core “Right to Health” model:

\[ y_{it} = \beta_0 + \beta_1 \text{right to health}_{i,t-1} + \beta_2 \text{democracy}_{i,t-1} + \beta_3 \text{GDP per cap}_{i,t-1} + \gamma Z_{it-1} + \alpha_i + \epsilon_{it} \]

\( Y \) represents health outcomes, in this case log Under-5 mortality, while \( Z \) represents a matrix of additional controls for the expanded “wealthier is healthier” model. Here \( \alpha_i \) represents

43 De Mesquita et al. 2002.
45 Ross 2006.
time stable “unobserved heterogeneity” between countries not otherwise accounted for and \( \varepsilon \) is the error term.

Specifically:

\[
Z_{it} = \beta_4 \text{ female education}_{it} + \beta_5 \text{ ethnic fractionalization}_{it} + \beta_6 \text{ inequality}_{it} + \beta_7 \text{ urbanization}_{it} + \beta_8 \text{ population Density}_{it} + \text{ year} + \varepsilon
\]

A wide variety of estimation strategies are available for time series, cross-sectional panel data—none of which are perfect, which suggests the use of several alternative estimators. Variations on ordinary least squares is among the most widely used because of its ease of interpretation and strong efficiency performance. This model employs OLS for the core model conducted using Stata with standard errors reported (Table 2.3), with lagged independent variables. Conscious of the complex error structures that characterize panel data, however, a series of additional regressions using different estimators was also conducted for robustness checks that the findings hold. As Reed and Ye find, “estimators that perform well on efficiency grounds may perform poorly when estimating confidence intervals, and vice versa.”46 The core model is therefore fit with three additional estimators: FGLS, PCSE, and an ADL model. Parks’ Feasible Generalized Least Squares (FGLS) estimator is a common alternative to OLS, but is known to underestimate error terms in comparatively small and finite samples like those used in cross-national research.47 Beck and Katz suggest a version of OLS with panel corrected standard errors (PCSE) though this too has been criticized as inefficient in “practical research situations.”48 Variations on autoregressive distributed lag (ADL) models can also help account for a variety of weaknesses in standard OLS.49 ADL models, however, shift the analysis away from long-term process effects on levels to one of short term change and, in models like ours, is likely to substantially underestimate the effects of all IVs while

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46 Reed and Ye 2011, 986.
47 Parks 1967.
increasing the risk of falsely significant and insignificant coefficients due to measurement error. Focus on levels over annual change better fits this paper’s theory and also has the advantage of making the quantitative analysis comparable to previous studies that estimate the dominant theories used as a basis for this analysis. The core model uses a random effects model at the country level with time (year) as a continuous IV and fixed effects at the region level. Beck and Katz (1995) and others have argued for the use of country fixed effects specifications in order to deal with omitted variable bias, but since the theoretical function of a right to health is as much about between-country effects as within-country effects this is not ideal. A right to health is still significant in a fixed effects specification but, for these reasons, it is not used here for the core estimation. Perhaps even more importantly, the inclusion of unit dummies severely biases the estimates of the true effect of time invariant or slowly changing dependent variables such as ours. “In these cases, allowing for a mild bias resulting from omitted variables is less harmful than running a fixed effects specification.” To better check the effects of regional effects, a fully multilevel model is also fit in which countries are nested within regions. The results for each of these estimation strategies are included in Table A of the Annex—each supporting the core finding that the right to health has significant independent effect on health outcomes.

Results

Table 2.3 shows the main regression results. Each model includes both the coefficients of the regression results and a column in which all of the independent variables are transformed into standard deviation equivalents for easier comparability.

As expected, in the sample higher log GDP per capita was strongly associated with lower mortality rates. A first check in model 2 confirms that having a right to health in the constitution has a significant beneficial effect on mortality, even when considering wealth.

52 Plümper, Troeger, and Manow 2005, 334.
The variables in model 3, reflecting the fuller social and demographic determinants of health, show strong predictive value—together they provide a good model for under-5 mortality, with each of the values showing significance with the anticipated sign. As expected, income and women’s education have an effect that is both significant and large, with a clear but more moderate effect of ethnic fractionalization. In line with some of the debates in the literature, however, inequality is significant but has a much weaker effect, when controlling for the other variables in the model.

Columns 7 and 8 show that, in the sample, even after controlling for the broad determinants of health, democracy has a statistically significant beneficial impact on under-5 mortality. As we might expect from the literature, however, that impact is somewhat muted. A one standard deviation change in democracy score provides less than 5% of the impact that a standard deviation change in per capita GDP has in the model. Given the indirect nature of the theorized effect, and the inclusion of other factors that soak up much of the variation, this should not surprise us.

Columns 9 and 10 of the table show us that having a constitutional right to health is associated with a decrease in under-5 mortality, significant at the 1% level, even after controlling for the most common explanatory variables. Not surprisingly, the effect is small compared to, for example, income or women’s education that together account for much of the state and societal capacity to address health. But it is notable that the effect is the equivalent of a major change in polity score—as large as going, in 2010, from a country like Iran, Belarus or Libya (under Gaddafi) to one like Switzerland or Costa Rica. It has a similar effect as going from the ethnic diversity of Malawi or Colombia to that of the Netherlands. This suggests an important institutional effect, bolstering the theory that having a right to health is beneficial for health outcomes.
Table 2.3: Under 5 Mortality & The Right to Health

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DV: Log Under 5 Mortality (per 1,000 live births) 1970-2010</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wealthier Is Healthier</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Stand Devs</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wealth &amp; Rights Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand Devs</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Soc &amp; Econ Determin. Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand Devs</td>
<td></td>
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<td>Democracy</td>
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<tr>
<td>Stand Devs</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right to Health Health</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand Devs</td>
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<td></td>
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<td></td>
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<td><strong>-0.036</strong></td>
<td><strong>-0.036</strong></td>
<td></td>
<td><strong>-0.082</strong></td>
<td><strong>-0.082</strong></td>
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<td>(0.009)</td>
<td></td>
<td>(0.011)</td>
<td>(0.011)</td>
</tr>
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<td>Democracy</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td><strong>-0.002</strong></td>
<td><strong>-0.017</strong></td>
<td><strong>-0.002</strong></td>
<td><strong>-0.017</strong></td>
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</tr>
<tr>
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<td>(0.005)</td>
<td>(0.001)</td>
<td>(0.005)</td>
<td></td>
</tr>
<tr>
<td>Log GDP (pc)</td>
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<td><strong>-0.349</strong></td>
<td><strong>-0.242</strong></td>
<td><strong>-0.387</strong></td>
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<tr>
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<td>(0.008)</td>
<td>(0.013)</td>
<td>(0.008)</td>
<td>(0.013)</td>
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</tr>
<tr>
<td>Women's Education (years)</td>
<td><strong>-0.075</strong></td>
<td><strong>-0.280</strong></td>
<td><strong>-0.079</strong></td>
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<td></td>
<td>(0.006)</td>
<td>(0.023)</td>
<td>(0.006)</td>
<td>(0.023)</td>
<td>(0.006)</td>
</tr>
<tr>
<td>Ethnolinguistic Fractionalization</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td><strong>0.340</strong></td>
<td><strong>0.093</strong></td>
<td><strong>0.374</strong></td>
<td><strong>0.102</strong></td>
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<td></td>
<td>(0.130)</td>
<td>(0.036)</td>
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<td>(0.033)</td>
<td>(0.121)</td>
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<td><strong>0.026</strong></td>
<td><strong>0.003</strong></td>
<td><strong>0.026</strong></td>
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<td>(0.006)</td>
<td>(0.001)</td>
<td>(0.006)</td>
<td>(0.001)</td>
</tr>
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<td>Urbanization</td>
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<td><strong>0.107</strong></td>
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<td><strong>0.120</strong></td>
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<td>(0.001)</td>
<td>(0.018)</td>
<td>(0.001)</td>
</tr>
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<td><strong>-0.117</strong></td>
<td><strong>-0.000</strong></td>
<td><strong>-0.116</strong></td>
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<tr>
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<tr>
<td>Year Control</td>
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<td>yes</td>
</tr>
<tr>
<td>Regional Fixed Effects</td>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
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<td>Observations</td>
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<td>6,833</td>
<td>3,723</td>
<td>3,610</td>
<td>3,584</td>
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<tr>
<td>Number of Countries</td>
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<td>184</td>
<td>148</td>
<td>144</td>
<td>144</td>
</tr>
<tr>
<td>R²</td>
<td>0.814</td>
<td>0.832</td>
<td>0.881</td>
<td>0.896</td>
<td>0.892</td>
</tr>
</tbody>
</table>

**All independent variables are lagged one year. Standard errors are listed in parentheses. Constants not reported.**

**Absolute coefficients are reported in first model column. Second model column contains the standardized variables such that it has a mean of zero and SD=1 and therefore relative values are comparable (std dev change in DepV associated with a 1 std dev cha**
Additional Robustness

With the use of a variety of additional estimators described above (and in Annex A) these findings appear quite robust. In the full models (model 5) the data covers 144 countries through the use of imputed and estimated data on most variables. While not every country is covered and not for every year, the added coverage addresses Ross’s chief concerns of biased results by providing estimates for non-reporting countries across the democratic and economic spectrum. This 40-year dataset includes results for three times as many observations (3,584) as Ross reports in his 30-year panel and more than twice as many as Przeworski et al. in their 40-year dataset.\textsuperscript{53} Inequality data is the most incomplete data, a challenge this analysis shares with many studies and which is problematic to address through imputation beyond what is included here, so as a robustness check, regressions were re-run without the gini measure and also without the measure of democracy.\textsuperscript{54} This raised the number of countries observed to 161 and the observations to 6,013 but did not substantively change any of the findings.

To check the robustness of the findings the regressions were also repeated under a series of different conditions that might theoretically change the findings. None did. Because the majority of Eastern European countries have a right to health and comparatively few countries in the U.S./Canada/W. Europe group do, I re-ran the core mortality regression without each region and see no change in the effects. Clearly there is also a trend toward including a right to health in constitutions. To test whether there is some omitted effect of having recently written a constitution or simply of the era of the constitution in force, both the age of the constitution and the year in which it was written were tested in the regression. Neither was significant and RtH remained significant. To test whether the right to health is simply standing in for the legal system both a dichotomous civil/common law variable and a 5-level variable for legal system as outlined above was included as an IV. Neither is significant or affects the results.

\textsuperscript{53} Ross 2006; Przeworski et al. 2000.
\textsuperscript{54} Jenkins 2014.
Assessing Health Equity: The Sex Ratio Model

If the right to health works as theorized, then it should produce not just lower mortality rates, but greater equity in access to the services and conditions that enable wellbeing. Large-n data for cross-national comparisons in wellbeing across social cleavages is difficult to come by. One such measure, however, can be found in sex-differentiated mortality data. Under conditions in which girls and boys have the same access to resources such as food, healthcare, and living conditions, boys have higher mortality rates than girls owing to early-life biological advantages. Yet as Amartya Sen famously observed in many parts of the world this female advantage is eroded when girls are deprived of medical care and nutrition, resulting in millions of “missing women.” The “sex ratio” of child mortality rate is thus an important measure to help understand the degree of equity in national health and social systems. While some countries, notably India and China, experience overall sex imbalances due to selective abortion, ratios of under-5 mortality rates instead detect differential early access to health-enhancing resources.

On this basis, an additional model was constructed to estimate the effect of the right to health on the ratios of under-5 mortality of boys compared with girls. We used data developed by the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), which estimated annual rates of under-5 mortality for 153 countries. Each country had a maximum of three observations, one per decade, so our total N for this panel is significantly smaller. Nonetheless it provides an important, validated cross-national measure to assess health equity. An additional OLS regression was conducted using this data in two models: one (7b) that includes only health right by itself and another that includes the full base model used above. Each of the regressions

58 Hill and Upchurch 1995; Million Death Study 2010.
59 Sawyer 2012.
includes the overall under-5 mortality rate, taking note of epidemiologic impact of different overall levels of mortality on the sex ratio.\footnote{United Nations 2011, 66.}

The results are shown here in Table 2.3. In both models, the right to health is associated with a small but significant increase in the sex ratio of under-5 mortality. This holds even including a measure of women’s education levels that likely includes important aspects of discrimination and equity at work in differential mortality rates. This suggests greater equity in access to healthcare and health-enhancing resources in countries with a constitutional right to health. This adds support to the overall theory of a positive institutional effect of the right to health and confidence that the theorized mechanisms of action remain plausible.

All independent variables are lagged one year. Standard errors are listed in parentheses. Constants not reported.

\[ \text{Log GDP (pc)} = -0.349 \pm 0.803 \]

\[ \text{Democracy} = -0.018 \pm 0.061 \]

\[ \text{Women's Education (years)} = 1.214^{**} \pm 0.289 \]

\[ \text{Ethnolinguistic Fractionalization} = 2.877 \pm 2.521 \]

\[ \text{Inequality} = -0.030 \pm 0.048 \]

\[ \text{Urbanization} = 0.066 \pm 0.041 \]

\[ \text{Population Density} = 0.000 \pm 0.001 \]
Democracy & Health Services: evidence on the functioning of a right to health

The central claim of this chapter is that a right to health is a broadly beneficial institution for population health. If this claim is true we should be able to see its effects in the politics and policy of countries. Given the theory of the right to health relies on courts, social movements, and bureaucracies we might also expect to see that the right operates differently in more democratic environments. Evidence of both is presented below—quantitatively in this section and further developed qualitatively in section 4.

Democracy

Much existing literature has investigated whether democracy improves health, with mixed results as described above. In this context one might assume that constitutional rights and the attending institutional environment are not likely to matter nearly as much as the simple ability of populations to demand health and mobilize through the electoral process to demand government changes. The evidence in Table 2.3, however, undermines this presumption. The broader institutional environment—including the protection of health as a right—may actually help explain why democracy by itself seems insufficient to promote large changes in health.

Constitutional rights can operate in contexts weak in electoral democracy—especially in contexts where courts and/or bureaucracies are powerful and at least quasi-independent. Nonetheless, the operating of the right to health, as hypothesized above, is likely most effective where democracy is stronger. If it does represent a political institution that give rise to organizations and claims, those organizations and claims surely operate more effectively where political protest and electoral pressures can be used to articulate and enforce them. This would be what we might expect from Sen’s point that entitlements and political process are distinct but interdependent phenomena. Conversely, however, it might be that the right to health is simply a byproduct of democracy—simply reflecting the will of a pro-health governing coalition. To test this question, the

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main estimation is replicated with an interaction effect between democracy and a right to health included. The results in table 2.5 show that with this interaction the RtH remains significant, as does the interaction term, but democracy loses significance. This provides strong support to the contention that a right to health has an independent power, which is made significantly stronger in a context of democratic governance. This power does not seem to be simply a byproduct of democracy—and indeed we cannot reject the null hypothesis that democracy has no effect that is not accounted for by other parts of the political institutional environment. This is explored further in the brief case studies below.

Table 2.5: Right to Health & Democracy Interaction

<table>
<thead>
<tr>
<th>DV: Log Under 5 Mortality (per 1,000 live births) 1970-80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 6 Interaction Model</td>
</tr>
<tr>
<td>Health Right</td>
</tr>
<tr>
<td><strong>-0.075</strong></td>
</tr>
<tr>
<td>(0.011)</td>
</tr>
<tr>
<td>Health Right X Democracy</td>
</tr>
<tr>
<td><strong>-0.006</strong></td>
</tr>
<tr>
<td>(0.001)</td>
</tr>
<tr>
<td>Democracy</td>
</tr>
<tr>
<td>0.002</td>
</tr>
<tr>
<td>(0.001)</td>
</tr>
<tr>
<td>Log GDP (pc)</td>
</tr>
<tr>
<td><strong>-0.299</strong></td>
</tr>
<tr>
<td>(0.012)</td>
</tr>
<tr>
<td>Women's Education (years)</td>
</tr>
<tr>
<td><strong>-0.082</strong></td>
</tr>
<tr>
<td>(0.006)</td>
</tr>
<tr>
<td>Ethnolinguistic Fractionalization</td>
</tr>
<tr>
<td>0.344**</td>
</tr>
<tr>
<td>(0.121)</td>
</tr>
<tr>
<td>Inequality</td>
</tr>
<tr>
<td><strong>-0.002</strong></td>
</tr>
<tr>
<td>(0.001)</td>
</tr>
<tr>
<td>Urbanization</td>
</tr>
<tr>
<td>0.006**</td>
</tr>
<tr>
<td>(0.001)</td>
</tr>
<tr>
<td>Population Density</td>
</tr>
<tr>
<td><strong>-0.000</strong></td>
</tr>
<tr>
<td>(0.000)</td>
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<tr>
<td>Year Control</td>
</tr>
<tr>
<td>yes</td>
</tr>
<tr>
<td>Regional Fixed Effects</td>
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<tr>
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<tr>
<td>Observations</td>
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<td>Number of cowcode regional dummies</td>
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<td>144</td>
</tr>
<tr>
<td>r2</td>
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<tr>
<td>0.894</td>
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</table>

** p<0.01, * p<0.05

All independent variables lagged one year. Standard errors are listed in parentheses. Constants not reported.
Health Spending & Service Delivery

In thinking about a right to health, no one would suggest that it operates directly—courts cannot order that people become healthy any more than legislators can craft laws that do so. Specifying in detail the exact mechanisms through which a right to health operates is the subject of later chapters. However, there is significant qualitative and quantitative evidence that supports the mechanisms theorized above. This section presents data showing that countries with a constitutional right to health deliver more and better health services to their populations—just one part of improving health, but an important one.

The wealthier is healthier paradigm suggests a neoliberal policy agenda with very little priority for the project of public health and provision of health services—one that assumes health will inexorably follow improvements in economic situation. Many have challenged this paradigm, arguing that, regardless of income level, health spending, provision of health services, and prioritization decisions are essential for health outcomes. McGuire shows this empirically—demonstrating, for example, that to achieve a decline of 5 points in infant mortality a country might have to decide between a goal of increasing GDP per capita by $391, reducing inequality by 9.4 gini points, or increasing the share of births attended by a skilled attendant by 13%.

If the right to health operates as hypothesized, health service provision should be a critical part of the story and we would expect a clear direct effect of having a right to health on service delivery. To explore this, the right to health is tested on a series of spending and health service delivery measures. Several of the key variables from the previous regressions that are suggested in political science and economics literature to affect policymaking are also included as control variables. Specifically, spending, policy coordination, and expanded health service delivery have been linked to national wealth, ethnic boundaries, inequality, and democratic governance. State capacity is also clearly related to service delivery, which GDP significantly accounts for. The other measure that also partially accounts for state capacity in the dataset, women's education, is

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63 McGuire 2010.
problematic to use here since it is itself a service delivery measure—and, in fact, inclusion does not dramatically change the results and actually lowers the fit in several models and so it is not included here.

Table 2.5 shows the outcomes of the spending and service delivery regressions. There is a significant effect of having a right to health on two commonly-used measures of health services—the percent of births attended by a skilled health worker and the rate of DTP3 immunization of 1-year-olds. Both show a clear and significant positive relationship: 7.6% more children’s immunization and 3.8% more skilled birth attendance is associated with countries having a right to health, even controlling for wealth and democracy. Having a constitutional right to health is associated with higher public spending on health as a percent of GDP, but the finding does not reach statistical significance. However there is a significant relationship with higher public spending as a portion of total health spending. We cannot be sure that governments spend more overall, but they do clearly pick up a larger portion of the overall health tab in countries with a right to health—leaving people themselves less to spend. This is seen again in the lower percentage of health expenditures coming “out of pocket” for patients. Health spending is not an uncontroversial measure since the direct effect of spending on health outcomes is debated. Nonetheless, the finding that, controlling for other variables, people have to spend less on health in countries with a right to health could help explain the observed mortality differences. Especially among the poor, lower spending by patients is likely to increase use of preventive and curative health services.

The final measure is the median availability of common generic medicines (%) in the public sector, using data from the World Health Organization. This variable is included because of the strong case-study data explored below that the right to health may be seen most visibly in provision of medicine to people through court cases and government policy-making. The measure is only limitedly available, however, and should be taken with a note of caution (the regression includes 2004 data, which has the widest country coverage at 16 countries). The relationship, however, is

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Sachs 2001; Filmer and Pritchett 1999.
notable: 30% more medicines are available in the countries with a right to health and the finding is significant.

These data suggest that the right to health is strongly related to pro-health spending patterns and service delivery, with the medicine data suggesting that the pathway seen in case-study evidence may be widespread and significant.

Annex B includes results from the main regression using the under-5 mortality DV while controlling for measures of spending and service outcomes as IVs. As expected, the right to health still appears to decrease mortality, but the findings are not significant in four of five formulations and the magnitude of the coefficient is substantially reduced. This result supports the idea that the right to health is having its impact by working through the health system (rather than capturing some unrelated aspect of society), which follows findings by Rajkumar & Swaroop that governance institutions (health rights) are often the bridge between public health spending and health outcomes.66

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66 Rajkumar and Swaroop 2008.
Table 2.6: Health Rights Effect on Spending & Service Delivery (1970-2010, except medicines availability 2004)

<table>
<thead>
<tr>
<th>Health Right</th>
<th>Spending (GDP)</th>
<th>Spending (Total Health Expenditure)</th>
<th>Out of Pocket Expenditure (% Total Health Expenditure)</th>
<th>Public Health Expenditures (Total Health Expenditure)</th>
<th>Expenditures (% Total Health Expenditure)</th>
<th>Expenditures (% Total Health Expenditure)</th>
<th>Expenditures (% Total Health Expenditure)</th>
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<td></td>
<td>Attended (%)</td>
<td>% Total Health</td>
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<th>Yes</th>
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<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
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</tbody>
</table>

All independent variables are lagged one year. Standard errors are listed in parentheses. Constants not reported.

**p<0.01, *p<0.05, +p<0.1

Table 2.6: Health Rights Effect on Spending & Service Delivery (1970-2010, except medicines availability 2004)
Confirmatory Evidence: Healthcare Access and Quality

Finally, as an overall check on the findings in this chapter, two additional dependent variables were tested that measure amenable mortality and healthcare access and quality. Barber et al. used data from the 2015 Global Burden of Disease study to create estimates of mortality from a subset of causes like AIDS, diabetes, or appendicitis that is broadly amenable to effective and timely health care, removing much of the effects of local environmental and behavioral risks. They also construct a summary measure—the Healthcare Quality and Access (HAQ) Index. These measures provide significant benefit over other measures in that they get directly at the question of healthcare which, as discussed in the chapters that follow, is where much (but not all) of the activity of constitutionalization plays out. Unfortunately, estimates are only available for a limited number of years—meaning that when we use these measures as our DV there is insufficient power to test our full model against all the covariates. The right to health is, however, appears beneficial when the full model is run. In a paired down model where we test the right to health alone and include the most critical controls—GDP and Women’s Education—the right to health is significant and beneficial. Countries with a right to health have lower amenable mortality and score better on the index of healthcare access and quality.

Table 2.7: Testing Healthcare & Amenable Mortality

<table>
<thead>
<tr>
<th>DV:</th>
<th>Amenable Mortality (per 100,000)</th>
<th>Health Access &amp; Quality (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Right</td>
<td>-46.47** (11.49)</td>
<td>-22.56** (.85)</td>
</tr>
<tr>
<td>Log GDP (pc)</td>
<td>-84.36** (6.10)</td>
<td>5.84** (0.31)</td>
</tr>
<tr>
<td>Women’s Education (years)</td>
<td>-5.32+ (2.89)</td>
<td>1.46** (0.16)</td>
</tr>
<tr>
<td>Year Control</td>
<td>n</td>
<td>yes</td>
</tr>
<tr>
<td>Observations</td>
<td>835</td>
<td>771</td>
</tr>
<tr>
<td>Number of Countries</td>
<td>180</td>
<td>167</td>
</tr>
<tr>
<td>R²^</td>
<td>0.03</td>
<td>0.65</td>
</tr>
</tbody>
</table>

** p<0.01, * p<0.05, + p<0.10

All independent variables are lagged one year. Standard errors are listed in parentheses. Constants not reported.

Conclusion

Health data across four decades supports the contention that the right to health is good for people’s health. Estimating the most widely promulgated theories of the economic and social determinants of health and the connection between health and democracy provide a basis from which to empirically evaluate the effect of the right to health. While it is broadly true that wealthier, more equal, homogenous, and democratic countries are healthier, this chapter shows that even taking that into consideration, a constitutional right to health is a significant and beneficial institutional factor. More children survive until their 5th birthday in countries with a right to health, at least in part because the institutional environment shaped by a right to health encourages more and better delivery of health services.

It is clear, however, in the case-study evidence presented in subsequent chapters that rights can be an important institution for promoting health and that constitutional provisions provide a basis for action. Suggestions that a right to health might actually undermine health outcomes are not supported by the data from a recent forty-year period. Instead, the evidence suggests that health actors would be well advised to attend to constitutional drafting processes as they seek to improve the health of nations.
SECTION II: IMPROVING HEALTH THROUGH POLICY CHANGE
CHAPTER 3: CONSTITUTIONS & HEALTH POLICY CHANGE—QUALITATIVE EVIDENCE

In 1970, just a handful of countries had enshrined a right to health in their national constitutions. Fewer than fifty years later, just over half have done so. How does this matter for health policy?

Quantitative data presented in chapter 2 showed that countries with a constitutional right to health have better health outcomes, even after controlling for the dominant social, economic, and political explanations for cross-national variation in wellbeing. The impact after these controls is small but statistically significant—consistent with a relatively new institution in the political economies of health in countries. Those with a right to health do not spend more on health overall, but a larger portion of what they do spend is public—with lower out-of-pocket costs, wider availability of medicines, and better coverage of key health services. More evidence is needed, however, to establish the causal mechanism at work here—especially in the face of skepticism from

1 Kavanagh 2016.
scholarship in international development, judicial politics, and public health that variously ignores, dismisses, or expresses alarm at moves to constitutionalize health.

In this chapter I show how constitutionalization impacts wellbeing—describing evidence of important political institution-building. That this innovation is being led from countries in the global South is all the more reason to attend to its impact, including potential lessons for both similar countries and countries like the U.S., where health inequity remains a challenge and policy change is often blocked. Several important collections on the right to health have advanced our understanding of litigation and judicial action—with evidence of mixed and conditional impact.² Using a broader policy process approach that de-centers court orders to focus on policies that influence wellbeing and access to healthcare, I show it is in the “shadow of the law”—the process, language, and threat of litigation—where health rights matter most.³ In that context, it is notable that health-enhancing impact can be seen in countries with large and complex health challenges.

Based on fieldwork tracing policy processes in South Africa, India, Malawi, and Thailand, I find that constitutionalizing health creates an institutional context that is more health- and health equity-conducive. It is not only, or even primarily, a story about courts and legal orders—which some see as an anti-democratic way to tackle complex distributive issues. Instead, I show that, where a right to health is institutionalized, the process of health policymaking is different. The right to health acts as a policy anchor: for modern governments buffeted by a multitude of issues and countervailing pressures, constitutional rights can focus political power and attention to improve health policy. It acts through three mechanisms: 1) Unblocking policy change by dismantling closed, monopolistic policy processes: Even in strong democracies, complex issues in health policy are delegated to sub-systems of bureaucrats, experts, and interest groups that often exclude outsiders and defend the status quo. Anchoring health in the constitution gives the opportunity to “expand the conflict” by shifting some questions to courts and other rights venues, which destabilizes these closed systems and opens room for policy change; 2) Improving the bargaining endowments of key

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² Gauri and Brinks 2008; Yamin and Gloppen 2011; Flood and Gross 2014.
actors: Rights mobilization does not end bargaining over policy issues but puts a particular set of tools at the disposal of state and non-state actors seeking to spur health-enhancing policy change. Discovery can bring out information; subpoenas can call individual policymakers to account; reputational risk posed by litigation can raise the incentives for action by policymakers; and public/media narratives can legitimate change—all of which affects bargaining outside the courtroom, regardless of any court order; 3) Providing reasons for action: Anchored in the core national political bargain, constitutional health rights provide a discourse with the power to undermine ideas that legitimate closed policy monopolies while enhancing the legitimacy of policy options focused on action over inaction.

These mechanisms connect constitutionalization to policy and, through policy, to improved health outcomes—contesting the skepticism about the impact of constitutional health rights that can be seen in several contexts. For example, neither the World Health Organization’s Commission on Macroeconomics and Health nor its Commission on Social Determinants of Health recommended writing or amending constitutions to include health rights, even though the WHO Constitution was among the founding documents conceptualizing health as a right. U.S. and OECD-based health policy research can include a broader perspective on how law might impact policy by attending to innovations in health governance coming out of the global South. This also challenges international development scholarship to look beyond democracy and property/market institutions as the keys for development. These elements have proved powerful in oft-cited Nordic examples—where enviable health achievement without constitutionalization has been evidence for skeptics. A broader perspective, however, shows these standard institutions have proved insufficient to foster significant advances in population health and the health security of communities in many countries. The complex, diverse contexts where much of the world’s

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4 Sachs 2001; CSDH 2008; Marmot et al. 2012.
5 Law and health in much of the U.S. (e.g. Hacker and Skocpol 1997; Kersh and Morone 2002; Oberlander 2010; Peterson 2011) and comparative work (e.g. Immergut 1992a; Marmor and Wendt 2012; Fox 2014) is limited to OECD experience.
7 Hirschl 2011, 458.
8 Ross 2006; McGuire 2010; Powell-Jackson et al. 2011; Wullert and Williamson 2016; and see Ogata and Sen 2003 on human security.
preventable mortality occurs (e.g. low- and middle-income countries; regions of the U.S.) are replete with examples in which democratic pressures alone fail to deliver policy change needed to secure wellbeing. Scholars are thus increasingly exploring a broader set of health-supporting institutions that can “enable communities to press governments into action on a sustained basis.”

I show constitutionalization does just this. Finally, understanding a constitutional health right as a “policy anchor” also questions one of the most dominant metaphors in legal studies, which describes rights as “trumps.” This conceptualization helps explain the concern that rights will distort good public health policy if inexpert, unelected judges usurp power from policymakers, negate necessary trade-offs, and apply individualist frameworks. I show, however, that rights in these cases do not short-circuit the policy process—acting instead as institutions to increase the opportunities for, and likelihood of, health-enhancing policy change.

This chapter proceeds as follows: I begin with an overview of the methods used to trace the impact of the right to health on policy outcomes. I then describe in detail the findings of this study on the mechanisms through which constitutionalization impacts health policy. Later chapters in this section explore these mechanisms across a variety of health policy issues and contexts through case studies—beginning with a multi-part chapter on South Africa that details in depth examples on emergency medical services, HIV treatment, and tuberculosis in prisons and then explores an additional set of issues where the right to health was mobilized and then a chapter that explores issues similarly mobilized in India. The annex includes brief case studies on Malawi and Thailand that extend this work. Together, these cases reveal how the right to health operates in these countries as an important, beneficial part of the political economy of health in countries where it is institutionalized.

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9 Hall and Lamont 2009, 15.
Methods & Concepts: A Policy Process/Political Economy Approach

This chapter is based on over 165 semi-structured interviews conducted between 2013 and 2017 during fieldwork in South Africa, India, Malawi, and Thailand. As discussed in chapter 1, these countries were chosen to enable a paired within-case analysis of India and South Africa and then to test findings in different systems in Malawi and Thailand. The goal of the interviews was to reveal evidence on the causal impact of constitutionalizing health as a right through “process tracing.” Key informants in the interviews included elected officials, civil servants, judges, lawyers, activists, and academics with first-hand knowledge of policy processes under exploration. These interviews were supplemented with archival research from a variety of sources. A full methodological discussion appears in chapter 1; the interview protocol and list of interviews are in the appendix.

To understand the institutional effects of constitutional rights and assess their impact, we need to look at the whole policy system, of which courts and the legal complex are just one part. In this sense I build off, but depart from, important previous studies of health rights that center litigation, and instead focus on tracing the policy process over a decade or more. I place these processes in an applied political economy framework that identifies both the key structural features and relevant individuals and organizations, as well as how their motivations (financial, political, ideational) and relative power lead to eventual policy outcomes. Research began by identifying from initial interviews, a set of health-related policy issues during the past two to three decades in which multiple informants suggested the right to health had been “mobilized.” Since the goal of this portion of the research is to gain inferential leverage on what happens when the machineries of constitutionalization are engaged, we focus on tracing policies where rights are mobilized to understand whether this matters for the policy process and, if so, how. I use the term “mobilized” here following the work of legal mobilization scholars to indicate actors making use of rights as a strategic tool to change policy and/or practice—which might include litigation, threat of litigation,

11 Tarrow 2010; Bennett and Checkel 2014.
12 Sabatier and Jenkins-Smith 1993, arguing that “a decade or more” is needed to evaluate a policy process.
13 Hall 1997; Besley 2006; Bump and Reich 2013; Fox and Reich 2015.
filing complaints to a rights body, and using other legal tools to assert a rights-based claim. At any given moment, in each country under study, there were many active health policy issues—from insurance regulation to medicine safety to staffing clinics, etc. Many saw no rights mobilization. The health policy issues where rights were mobilized became the units of this study—and for each, I have worked to trace the policy process from a time at least several years before rights mobilization to several years after. Some might argue this reflects selecting on the dependent variable. The core question for this section, however, is how constitutionalization works. Does it, as critics argue, distort health policy and undermine democratic pressures? Or is it beneficial to health policy and outcomes? This effort builds off the large-N correlation-based evidence in chapter 2 which shows a mortality dividend from constitutionalization and tests whether there is a causal pathway that would support this result. This section therefore uses a different logic of “within case analysis” to generate greater and deeper causal leverage over the effect of institutionalized health rights—to directly link rights with policy change (or not) and rule out rival explanations. While it is tempting to instead try to pair policy issues with or without rights mobilization in a difference-in-difference design, this is unlikely to add to casual identification with a small universe of issues characterized by multiple interaction effects. Instead, using “causal process observations” provides the chance to augment the between-case data with mechanism-based evidence connecting rights with policy outcomes and health impact. I therefore sought to identify as many of the issue areas where rights were mobilized as possible—using multiple initial interviews to craft the issue list and reaching exhaustion in both South Africa and India. While my cases explore the universe of examples I identified, there may well be others. I am confident I have identified most of the major issues, but for my purposes the list need not be exhaustive. My goal in this section is not to quantify impact, but to gain analytical leverage over the causal processes at work and whether constitutionalization is positive, negative, or inconsequential for eventual health policy.

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14 McCann 1994; Scheingold 2004; Simmons 2009.
15 George and Bennett 2005, 170–8.
16 Collier, Brady, and Seawright 2010.
Table 3.1 lists the policy issues identified in South Africa and India where rights mobilization occurred, arranged roughly by the impact of constitutional rights on eventual health outcomes—policy issues traced in chapters that follow. This is a broad-strokes continuum of impact, more illustrative than quantitative, meant to show that while each issue saw rights mobilization, the degree to which rights mattered was not uniform—a reality returned to below.

<table>
<thead>
<tr>
<th>Impact</th>
<th>South Africa</th>
<th>India</th>
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<tbody>
<tr>
<td>High</td>
<td>HIV Treatment</td>
<td>HIV Treatment</td>
</tr>
<tr>
<td></td>
<td>Eliminate User Fees</td>
<td>Intellectual Property &amp; Access to Medicine</td>
</tr>
<tr>
<td></td>
<td>Drug pricing</td>
<td>LGBTI/Sodomy Laws</td>
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<td></td>
<td>Eastern Cape Emergency Services</td>
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<td>Private Sector Health Inquiry</td>
<td>Emergency Medical Care</td>
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<td>Silicosis &amp; TB in Mines</td>
<td>Maternal Health</td>
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<td>Migrants access to health</td>
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<td>Charitable hospitals</td>
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<td></td>
<td>Private Healthcare Regulation</td>
<td>Drug Pricing</td>
</tr>
</tbody>
</table>

*Source: Author estimations. Impact level is roughly nominal based on author estimation but is not systematically measured.*

In the South Africa and India cases below, I present results of a content analysis of nearly 1,500 newspaper articles from fifteen years dealing with the right to health, demonstrating that the constitutional right to health is addressed in the public and political discourse of the country. I call this *availability*, meaning the *idea* of a constitutional right to health is recognized beyond the discourse of lawyers, which is a precondition for mobilization.

My hypothesis in this section is that the right to health functions as an institution as theorized in political economy literature. That institution might be more or less well-established, and, if my hypothesis is correct, the right will have more effect where it is more institutionalized. For this purpose, I operationalize institutionalization loosely as a continuum based on the presence of the following: 1) a clear, enforceable right to health in the written constitution; 2) decisions by the national apex court enforcing the right; and 3) national legislation referencing the right. Each chapter below identifies countries’ degree of institutionalized right and distinguishes the degree of
institutionalization from the degree of impact on health policy. Table 3.2 shows it ranges from South Africa to Malawi (most to least). I note, and explore in greater depth in Chapter 4, that India is seemingly unique in the world in the degree of litigation on health rights based on a judicially derived right to health through a constitutional right to life.

<table>
<thead>
<tr>
<th></th>
<th>1. clear right in the written constitution</th>
<th>2. enforcement decisions by apex court</th>
<th>3. legislation referencing right</th>
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<tbody>
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<td>India</td>
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<tr>
<td>Malawi</td>
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Theoretical Framework: Policy Change, Democracy, and Rights

This section describes in greater detail the mechanisms across the various policy issues studied in South Africa, India, Malawi, and Thailand and the context for our conclusions. In brief, we can see that health policy change is often needed to improve health, but blocked. Democracy is the most widely studied political institution theorized to improve health policy, but examples from this research illustrate that democratic pressures are often insufficient to spur change. In practice, a variety of institutions and practices block policy change under democracy—most prominently, widespread policy monopolies that prevent policy entrepreneurs from disrupting the status quo. Such monopolies are regular features of policy environments since policymaking attention is inherently limited and delegation to sub-systems is necessary as policy agreements are reached and attention moves on. Securing policy-change to improve health, however, requires overcoming the stability of equilibriums which will be easier in some institutional environments than in others.

In this context, scholars have drawn attention to the broader need to understand institutions of “successful societies” beyond electoral democracy that promote population health
and ensure health security for their people.\textsuperscript{17} The constitutionalized right to health should be seen in this context—it functions as a distinct institution, and its impact on health outcomes can be linked directly to its role in policy change. As outlined below, constitutionalizing health makes health-enhancing policy more likely by destabilizing policy monopolies and increasing bargaining power of policy entrepreneurs, while providing “reasons for action” as ideational resources that support these mechanisms.

**Policy Change & Improving Health**

Through tracing policy areas in which the right to health is mobilized, I find that a key piece of the power of constitutionalizing health comes in how it unlocks opportunities for policy change. In health, policy change is necessary to improve outcomes and equity over time. Knowledge, technology, and capacity drive progress in health, yet all require political action to move from idea into impact. As Angus Deaton traces, significant differences in health outcomes up to the present day can be directly attributed to the translation of basic medical and scientific knowledge into practice—translation mediated by politics, policy, and state capacity.\textsuperscript{18} The specific element of “change” is important. Without opportunity to depart from the status quo, health and sanitation 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 demographics; social determinants are not tackled with new responses; and local institutions are not required to adapt to changing national priorities.

Where policy change is blocked, the prospects for improving health are limited. In particular, addressing health inequities, which requires addressing historical legacies in healthcare and social determinants, is especially dependent upon policy change.\textsuperscript{19}

\textsuperscript{17} Evans 2009.
\textsuperscript{18} Deaton 2013, 93–100.
\textsuperscript{19} Smith, Hill, and Bambra 2015; Navarro 1995; Beckfield and Krieger 2009.
While on some health issues the best policy is contentious and unclear, answers for many of the biggest health issues driving cross-national differences in wellbeing are not particularly complex or controversial. AIDS treatment saves lives; ambulances and midwives are critically important for rural areas; rampant TB epidemics inside prisons have to be controlled. I find that where rights are being mobilized, the policy change needed is most often 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 on the frontlines; and d) ensure tools and resources for implementation are made available. I use the term “better” or “improved” health policy below largely in this vein, albeit not uncritically, and try when possible to link policy to outcomes.

Policy change is, of course, not inherently positive. Indeed, there are some examples below in which pro-health actors sought to limit change. On the whole, however, with the advance of knowledge, I show it is often blocked policy change in South Africa, India, Malawi, and Thailand that inhibits health. My point is that there is every reason to expect that “policy stability” is a barrier to improving health and equity.⁴⁹

Is Democracy, Not Rights, Spurring Change? Empirical & Normative Arguments

In this project, one of the biggest challenges is distinguishing between the effects of life under a constitutional democracy—with electoral competition, open media, social movements, and some degree of separation of powers—from the effects of constitutionalizing health as a right. They are of course inter-related and, as shown in chapter 2, there is significant interaction between the two concepts. My goal in this section, however, is to seek to separate the effects—to trace the effects of constitutionalizing health as distinct from the effect of these other freedoms. Theoretically, the right to health is a “positive” right and content-specific—framing health-related obligations of the state in terms of individuals and duty-bearers. As I explain further below, constitutionalization of health has the effect of “anchoring” health policy and expanding the set of actors engaged in the

⁴⁹ I use the term policy stability from (Tsebelis 2002) to particularly connote systematically blocked policy change.
policy process—providing new tools in the service of realizing health capabilities. One challenge to
this narrative is the suggestion that what is actually being observed is the effective deployment of
the mechanisms of electoral democracy—that the improvements in wellbeing observed in chapter
2 can in fact be better explained by electoral competition, party ideologies allowed to compete for
influence, social movements free to demand accountability and gain attention in open media, and
the other freedoms of life under more open government.\(^\text{21}\)

It is therefore worth briefly reviewing the literature on health and democracy as context
before proceeding to explain the mechanisms through which the qualitative case studies suggest
the right to health acts on population wellbeing—which, I find, include some of the same elements
that are theorized to matter under democracy but, in practice, often fail to unblock needed policy
change.

There is a significant body of thought—most prominently described by Amartya Sen—
suggesting the electoral pressures and political freedoms of democratic regimes contribute to
improved health and longer lives.\(^\text{22}\) These claims have empirical support in political science,\(^\text{23}\)
economics,\(^\text{24}\) and public health.\(^\text{25}\) The connection is distal—working largely, though not exclusively,
through policy change. Many find the link between democracy and health to be missing, small, or
highly contingent, as I will return to later. Nonetheless, there is a well-developed set of four broadly
constructed mechanisms from literature that analysts suggest link democratic governance and
greater likelihood of pro-health policy change—which might be shorthanded as *incentives,*
*information, accountability, and association.* Political economy work finds governments facing
popular elections have greater incentive to provide public goods, including public health. Elected
leaders are forced to respond to the “median voter” who benefits from redistributive public health
efforts, while autocrats who depend on a small, identifiable “selectorate” have the option of

\(^{21}\) I ground this discussion 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.
\(^{22}\) Sen 1983; Sen 1999.
\(^{23}\) Moon and Dixon 1985; Przeworski et al. 2000; Navia and Zweifel 2003; McGuire 2010; Wigley and Akkoyunlu-Wigley 2011;
Gerring, Thacker, and Alfaro 2012.
\(^{24}\) Besley and Kudamatsu 2006; Kudamatsu 2012.
2012; Mackenbach and McKee 2013; Patterson and Veenstra 2016.
targeting club goods instead.\textsuperscript{26} Others find electoral democracy shifts incentives by allowing emergence of Left parties committed to health and welfare expansion.\textsuperscript{27} Information has been shown to be critical—a flourishing press and opposition politics under democracy can ensure both health information for the public and information to government about how to calibrate policy. Democracy encourages provision of data and explanations for policies, as “democratic elections (with choice of parties) forces the party in power to justify its policies or reform them in accordance with people’s needs.”\textsuperscript{28} Electoral competition also provides the accountability mechanism through which voters can punish leaders who fail. Democracy raises the expectations of equity, demand for health services, and the expectation that health will improve, to which politicians must respond if they do not want to face the wrath of “retrospective” voters. Freedom of association under democracy also encourages health policy change. Civil society and social movements demand greater public action on health and spread health information directly.\textsuperscript{29} The development of knowledge networks of experts, officials, and interest groups can drive pro-health policy change. These key mechanisms of electoral democracy suggest that democracies should encourage policy change toward improving public health.

Democracy is also seen as a normative good for health—electoral democracy provides not just empirical short-term health benefits but a just model for health policymaking that gives voice to the population, including those worst off, and promotes polycentric policymaking able to balance different needs and interests.\textsuperscript{30} Elections change the preferences of rulers which changes policy—and by extension policy change that cannot be explained by elections and related freedoms lacks democratic legitimacy. Rights enforcement is thus suspect in such distributive politics: if they act as a “trump” and bring an inappropriately “strong” and individualistic framework to health

\textsuperscript{26} Meltzer and Richard 1981; De Mesquita et al. 2002; Boix 2011; Acemoglu and Robinson 2005.
\textsuperscript{27} Huber and Stephens 2012, 105, 148; and see Moon and Dixon 1985; but see Haggard and Kaufman 2008 who find a more contingent role for Left parties.
\textsuperscript{28} Ruger 2005, 301, and on voters demands see Powell Jr and Whitten 1993; Berry and Howell 2007; Hobolt, Tilley, and Banducci 2013.
\textsuperscript{29} Haggard and Kaufman 2008, 16; Cordner, Brown, and Morello-Frosch 2014.
\textsuperscript{30} Ruger 2005.
policy that needs cooperation and balancing it could undermine the “public” in public health.\textsuperscript{31} Hirschl suggests resort to law primarily serves to preserve hegemonic dominance against more democratic redistribution of resources.\textsuperscript{32} The “countermajoritarian difficulty” of courts may be especially problematic in such a context with limited resources in which the health needs of the few could very directly undermine the health of the many if inexpert courts distort health policy.\textsuperscript{33}

There is, however, increasing challenge to the empirical link between health and democracy—with many studies either challenging the link or finding it has very significant scope conditions.\textsuperscript{34} While democracy may often work as theorized (see e.g. McGuire’s work showing democratic pressures in South Korea and Indonesia triggering policy change\textsuperscript{35}) evidence suggests democracy is insufficient to ensure large-scale public health advances. While idealized democracy should result in improved health, politics often prevents the translation of knowledge and evidence into policy and practice.\textsuperscript{36} The United States provides a key example in which, despite a much-touted democracy, health policy change has remained blocked for decades at a time. Scholars have linked this failure to political culture, class structure, powerful interest groups, and political institutions that diffuse power and create myriad ways for interest groups to block health-enhancing change.\textsuperscript{37} The particular role of the wealthy in blocking policy change favored by, and beneficial to, majorities is notable.\textsuperscript{38} The core question for wellbeing, then, may well be less about deliberation and more about whether political institutions can effectively support diffusion of a normative commitment to wellbeing taken forward in policy change.\textsuperscript{39}

In tracing the impact of the right to health, there are two particular questions that need answering: First, is constitutionalization as I have framed it doing the work or is policy change

\begin{itemize}
  \item \textsuperscript{31}Dworkin 1978; Siegler 1980; Kapur 2013. 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.
  \item \textsuperscript{32}Hirschl 2004.
  \item \textsuperscript{33}Bickel 1962. \textit{But see} Graber 1993 arguing judicial review can actually increase accountability and Scheppel 2005 arguing that under some conditions courts can be \textit{more} democratic than elected officials—a theme I return to below.
  \item \textsuperscript{34}Gauri and Khaleghian 2002; Shandra et al. 2004; Ross 2006; McGuire 2010; Powell-Jackson et al. 2011; Chuang et al. 2013; Batniji et al. 2014; Mackenbach and McKee 2013; Wullert and Williamson 2016.
  \item \textsuperscript{35}McGuire 2010, 223-7-73.
  \item \textsuperscript{36}Smith 2013a.
  \item \textsuperscript{37}Morone 1990; Hacker and Skocpol 1997; Oberlander 2007; Steinmo and Watts 2008; Marmor and Barer 2012.
  \item \textsuperscript{38}Bartels 2009; Hacker and Pierson 2010; Page, Bartels, and Seawright 2013.
  \item \textsuperscript{39}Ruger 2007.
\end{itemize}
actually attributable to other democratic pressures? And second, is constitutionalization giving courts too much power and distorting health policy by “trumping” a balanced public health approach—ending important policy debates with court orders focused on the needs of the few?

**Beyond Democracy: Institutions and Policy Change**

There is a robust literature in political science and economics that finds that political institutions, democratic and undemocratic alike, often support the status quo. Literature on veto players, for example, shows that policy change is often blocked if there are many veto players with significant ideological distance between them who are internally cohesive, resulting in “policy stability.”40 Historical institutionalists have also shown that in any given policy battle, prior decisions limit options for the very kind of policy change that may be needed to enhance health.41 Policies become “locked in” as path-dependent processes create new constituencies, administrative capacities, and expectations among policymakers and the public, which work to sustain policy equilibriums in self-reinforcing political cycles.42 Institutions act as filters for knowledge translation—selectively favoring only certain interpretations of policy goals and the possible means to achieve them.43 Meanwhile, officials facing electoral uncertainty and expecting their political rivals to reverse their policy decisions have plenty of room in democratic systems to take proactive steps to protect those decisions by insulating agencies and programs from the future exercise of public authority.44 In this sense, there is every reason to expect that even in democratic politics, there will be major barriers to health-enhancing policy change.

Scholars have increasingly shown how institutions can shift—both dramatically at “critical junctures” and through endogenous, incremental changes over time.45 Competing institutions that

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42 Pierson 2000.
43 Weir 1992; Smith 2013b.
44 Moe 1990; Moe 2005.
45 Mahoney and Thelen 2009.
provide new venues for policymaking can be a critical part of overcoming institutional limits to policy change—which is a key element of constitutionalizing a right to health.

Kingdon’s influential framework notes that policy change is driven by “policy entrepreneurs”—individuals and groups pushing new ideas.\textsuperscript{46} While some literature assumes democratic pressures will trigger preference shifts in rulers—by convincing those in office or by replacing them—this often does not hold.

In practice, a great deal of health policymaking occurs not in the macro-political sphere of elected officials but instead in what Cobb & Elder call “systems of limited participation.”\textsuperscript{47} These systems have been well described in political science literature—variously called policy monopolies, policy sub-systems, iron triangles, and sub-governments.\textsuperscript{48} Punctuated Equilibrium Theory (PET), pioneered by Baumgartner and Jones, identifies these systems as the reason why even clearly disadvantageous policy equilibriums and stability are maintained for long stretches with only small changes.\textsuperscript{49} The critical idea is that modern governments throughout the world must address a wide variety of policy issues simultaneously and, in the regular course of policymaking, delegate many to sub-systems in which a smaller group of officials, bureaucrats, experts, and interest groups do much of the work of policymaking.\textsuperscript{50}

These sub-systems often become “policy monopolies” that seek to exercise exclusive control over both the decision-making and political understanding of a policy issue and can block (or enact) change. They may do so for a variety of reasons: Bureaucratic agents are often risk averse; caught in a complex web of competing interests in which any change is likely to rouse the ire of some powerful constituency, bureaucrats are often the enemies of change.\textsuperscript{51} Prospect theory explains why a variety of actors in these sub-systems, worried about the unknown implications of upsetting the current policy equilibrium, may similarly act to maintain the status quo.\textsuperscript{52} Others,

\textsuperscript{46} Kingdon 2003.
\textsuperscript{47} Cobb and Elder 1971.
\textsuperscript{48} Adams 1981; Berry 1989; Sabatier and Jenkins-Smith 1993; Weible, Sabatier, and McQueen 2009.
\textsuperscript{49} Baumgartner and Jones 1993; Jones and Baumgartner 2012.
\textsuperscript{50} Walt et al. 2008; Shiffman 2007; Timmermans and Schollen 2006; Green-Pedersen and Walgrave 2014; Ohemeng and Anebo 2012; Liu and Jayakar 2012; Tosun 2013; Lam and Chan 2015; Chan and Zhao 2016; Baumgartner et al. 2015.
\textsuperscript{52} Kahneman and Tversky 2000; Mercer 2005.
meanwhile, are motivated more directly by financial or personal gain. As a result, in practice, policy monopolies are recognizable and common:

“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.

A key point here is that monopolies deflect the attention of the macro political sphere—high-level politicians and officials—who lack both interest 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). By marshaling a politically resonant central idea, they justify both the content of the policy and the continuation of their existence. Actors conduct “maintenance” of the monopoly—taking small actions that deflect criticism while bolstering the idea at the core of the monopoly and, through “communicative discourse” aimed at macro political actors, give the impression the monopoly is acting appropriately and taking criticism into account.

Monopolies thus create a mechanism for “negative feedback” in which challenges to the status quo do not grow into significant policy change but instead are dealt with inside a closed system where cosmetic changes maintain overall stability. Policy entrepreneurs, especially those lacking substantial political power, are not able to mobilize the macro political stream to attend to their reframing of problems and solutions. Monopolies often explain the lack of policy change where democratic pressures were applied and failed.

A good example can be seen on the issue of Emergency Medical Services in the Eastern Cape of South Africa, which I take up in depth in Chapter 4.1. For decades, EMS services were basically nonexistent in much of the rural province due to policy legacies from the Apartheid era, and policy change was blocked by a small monopoly of self-interested actors—some directly

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53 Baumgartner and Jones 1993, 7.
54 Schmidt 2008 on discourse and Mondou, Skogstad, and Houle 2014; Wyszomirski 1998 on monopoly maintenance.
55 Shiffman and Smith 2007.
benefiting, some just risk averse—protected by a few powerful regional politicians. Media exposés, patient complaints, and even pressure from national government were all defected into bureaucratic change management plans that went nowhere, shielded by the idea that “transformation” would take time but people should have faith in the ANC, party of liberation and Nelson Mandela.56

These insights about policy change give structure to my findings. Centrally, what I show in the qualitative studies of policy issues in the following chapters is this: constitutionalization creates important opportunities to disrupt policy monopolies and open space for policy change.

**Constitutionalizing Health: Rights as a Policy Anchor**

Constitutionalizing health as a right, in this study, shows an appreciable effect on policy in ways that enhance health and health equity. It does so because a constitutional right to health acts as a “policy anchor.” For contemporary governments buffeted by a wide variety of countervailing political currents and winds, it focuses political attention and power in health-enhancing ways. In monetary policy, an “anchor” refers to a long-term policy commitment (e.g. money supply or exchange rate targets) used to achieve price stability. Policy outcomes independently and flexibly take shape around the nominal anchor, as a wide array of market and public sector actors change their expectations to address economic conditions in ways that result in inflation control.57 A policy anchor thus sets background assumptions that remove certain important questions from the day-to-day political and economic vicissitudes. It encourages progress toward a goal while setting the power of the state against actions that would undermine it. The cases explored below in South Africa, India, Malawi, and Thailand suggest the right to health operates in this way—providing a stable anchor point in a sea of competing forces that legitimizes a particular direction for state action and provides a point of leverage for policy entrepreneurs. In this way, the constitutional right

becomes an institution governing the political economy of health—part of the “rules of the game” that create a logic of “appropriateness” for specific actors to engage in specific actions in specific venues.\(^{58}\) While it is tempting to see the right to health as simply instrumental rhetoric for political actors, an institutional view understands that law and constitutions constrain some actors, empower others, and privilege a certain range of policy options.\(^{59}\) As I document below, constitutionalization anchors health in a particular politics that encourages weakening of policy monopolies that block change and unlocks specific tools which increase the bargaining power of pro-health actors, while providing reasons for action that prove powerful in health policy debates.

Given the relative ubiquity of institutional barriers to health-enhancing policy change, the search for alternative institutions that support pro-health policymaking is important. Ruger argues that a normative right to health is best understood through a health capacity paradigm as an “ethical demand for health equity.”\(^{60}\) It should not simply be a legal principle for courts to enforce access to healthcare, but instead is a claim for social organization toward redistribution of resources to provide people the capacity to be healthy, requiring diffusion of a norm throughout society and concomitant political action in legislation and regulation. Recognizing that this norm is far from sufficiently diffused in most societies, however, I argue constitutionalization is doing the work of advancing this norm across multiple venues inside and outside courts.\(^{61}\)

Norm diffusion happens because the right works as an anchor, not as Dworkin’s metaphor of a “trump.” Looking at the whole policy cycle on issues where the right to health is mobilized, rather than starting with litigation, shows how a right to health works differently. I show that in nearly all cases described below, policy processes that feature right-to-health mobilization do not end in court decisions. Bargaining that \textit{does} take account of balancing needs and weighting priorities continues, but with power relationships and normative frameworks that are different from how they would be without the rights mobilization. Court cases while important, play a largely

\(^{58}\) March and Olsen 1983; Chang 2011.

\(^{59}\) Smith 1988; Burgess 1993; North and Weingast 1989.

\(^{60}\) Ruger 2010, 118.

\(^{61}\) See, e.g. work on norm diffusion in Finnemore and Sikkink 1998; Risse-Kappen, Ropp, and Sikkink 1999, though whether the source of the norm in this case is international is less important here than the effects of constitutionalization.
indirect role. Few policy changes are attributable only to court orders; many are 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 make use of outside the courtroom—and in so doing advance a norm. Rather than standing in tension with Ruger’s focus on norm diffusion over legal enforcement, I find evidence that the right to health in practice provides new actors and venues an opportunity to get involved, a reason to do so, and a normative framework for that engagement.

Deconstructing Health-Related Policy Monopolies

By anchoring health in the core national political-legal agreement, a constitutionalized right to health helps open policy cycles—drawing the attention of the macro political sphere to critical health issues and destabilizing problematic policy equilibrium. The institutional environment under constitutionalization makes a specific “venue shift”—going to court—a clear recourse for actors excluded from policymaking. In this way, it opens new opportunities to, in the words of Schattschneider, “expand the conflict” to include others who may be more favorable to their policy change and shift the power dynamics that allow some perspectives to be ignored.  

These “losers” in health policy are often those whose shorter lives and higher rates of illness drive poor health statistics and who are depending on some form of policy change to better address their ill health. Alongside them are the policy entrepreneurs inside and outside government who are promoting policy ideas that are not taken up and policy change that does not happen because of exclusive cycles and spaces. These policy entrepreneurs are, under a rights framework, also “norm entrepreneurs” seeking to promote a new ethical framework for health policy decisions. In health,

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62 Schattschneider 1975; Mortensen 2007, 347.
63 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 from attracting attention to destroy a policy monopoly.
these may include government public health officials and bureaucrats with ideas that challenge the status quo, civil society groups and activists, academics, and opposition politicians.

Both the idea of rights and the possibility of going to court bring a powerful actor 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 entities such as human rights commissions, ombudsman offices, and others, which exercise some of the key power and capacity of other judicial bodies.

In the example mentioned above in the Eastern Cape, entrepreneurs inside government (including the short-lived head of the health department) and outside (e.g. NGOs and AIDS activists) offered policy solutions to a widely recognized public health problem but came up against strong interests in maintaining the status quo. As detailed in the chapter below, the Human Rights Commission (HRC) became an alternative venue to address blocked health policy on emergency medical services. Leveraging the legitimacy of the HRC brought powerful new allies from the Commission into the policy issue, who dealt with the question of EMS on rights terms and actively brought the voices of rural Black South Africans into the policy sphere alongside those who had traditionally exercised exclusive authority.

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 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

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64 Karpik and Halliday 2011.
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 to 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 to legitimately do just that.

There has been a significant push by the executive and sometimes the legislatures in each of the case studies to try to weaken the courts—but little of that seems to be tied specifically to judicial engagement in health rights cases, but it does explain why the court in several cases seem wary of going further than they do. What we can see here, though, is that court intervention is important but bargaining and venue shifting is more important than court orders as the major driver of change, thus constitutionalization does not rest alone on any court’s enforcement of a particular minimum core obligation alone.

*Increasing Bargaining Endowments of Health Policy Entrepreneurs*

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 more standard civil matters is not what happens in court decisions and enforcement, but “in the shadow of the law.” Such is the case in the health rights policy issues observed in South Africa, India, and Thailand. In different but parallel ways, law and rights protection in each context shows the 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.

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65 Shapiro 2002.
66 Mnookin and Kornhauser 1979; Galanter 1983.
On the other hand, mobilizing the right to health can bring a far wider set of “action repertoires” than just enforceable court orders to open health-related policy issues to attention.\(^{67}\)

While I use terms that come from law and the judiciary, they play out in various spheres under constitutionalization by changing the relative power of players in broader policy negotiations. These include:

- **Discovery** of information, as judicial and quasi-judicial bodies have the power to compel the sharing of evidence. This enforced sharing can have significant impact on destabilizing policy monopolies that thrive on selective sharing of information. Democratic theorists value information flows as a key mechanism—informing leaders about problems to be solved, voters of the performance of their government, publics about health threats—and they are key to policy change. Exclusive control over information is thus an important force for policy stasis. As doctors and AIDS activists in South Africa shifted their fight to the courts it was publicly shown that each of the Mbeki government’s reasons for not rolling out antiretrovirals was based on false or misleading information.

- **Subpoena** of officials is a key part of the accountability function of legal institutions and a key way rights can drive improved health policy—increasing transparency and encouraging coordination across divisions.\(^{68}\) That high-level officials from Eastern Cape government were forced to show up, listen to testimony of affected communities, and present their response in front of the public changed the power dynamics between the state and communities. In interviews, officials themselves identified that experience—more than the HRC report and recommendations themselves—as the reason for changes in policy since “…I was forced to explain certain things that had been standard practice and, in fact, some of them I could not explain.” (Interview SA-29; and SA-27)

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\(^{67}\) By action repertoires I mean here a broader conception that just political campaigning or social movement literature but the full range of tactics deployed by a wide variety of political actors, most similar to how the term is used in Kriesi, Tresch, and Jochum 2007.

\(^{68}\) Gloppen, Gargarella, and Skaar 2004.
• **Reputational risks** associated with being the subject of judicial or quasi-judicial inquiries change the incentives of policymakers—officials prefer not to be ordered into court and take action to avoid it. In India, interviews with government officials showed how on HIV, maternal health, and other issues action and attention came when senior officials realized they would have to directly connect themselves to the existing policy status quo through appearances or affidavits. “Somebody comes running to me saying that, ‘Sir, we have to do something. Otherwise on the 13th of next month you have to appear before this judge.’ Then all the stops will be pulled out and something would be done. (Interview IN-42)

• **Media narratives** that come from rights-based venues improve the bargaining power of entrepreneurs. The law requires a certain kind of language and argumentation that, while often inaccessible in its details, can also provide clearer narrative about the need for policy change. Whether they are exonerated or condemned in the end, the spotlight turned on health policies challenged as producing rights violations is bright and can be especially important where arcane, technical-seeming issues are couched as such to preserve a policy monopoly. In the Novartis case the narrative shifted, under the spotlight of the case in the public view. The multinational pharmaceuticals industry sought to keep the conversation focused on technical details about the WTO and increased efficacy as an appropriate standard in Section 3(d) of the Indian Patent Act, but it quickly became about whether the State could achieve its obligations to provide essential medicines without placing limits on excessive patenting by multinational pharmaceuticals.

Policy researchers have shown that actor power is a critical factor in policy change in health and development issues.69 Together, the set of resources described above shifts the bargaining endowments in health policy in favor of change over inaction and entrepreneurs over those invested in the status quo. Increased information flows, personal accountability of officials, and increased incentives to act are all products of rights mobilization that, even without a court order,

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69 Shiffman and Smith 2007.
shift negotiations—with the potential to change the goals and framing of policy, the process of policymaking, and its implementation.

**Ideational Tools & “Reasons for Action”**

Rights are also, of course, ideas. Work in the area of discursive institutionalism has provided increasing clarity on how ideas function on multiple levels to affect policy and both shape and are shaped by institutions.\(^70\) Much of the anxiety about constitutionalizing health lies in the power of rights as an idea. Dworkin reportedly worried that a rights framework would be too strong and absolutist for use in South Africa in policy areas such as health.\(^71\) Looking at rights in the context of a broader policy process approach in South Africa, India, Thailand, and Malawi, however, shows the idea of health rights has mostly been used instead as “reasons for action.”\(^72\)

Within institutions that change slowly, ideas are central tools for promoting policy change. Rights provide a new language that legitimizes claims making by individuals and groups. “This is our right” as an idea is quite different from “we want” or “we need”—and its discursive power lies in being able to disruptively inject the capabilities of individuals and groups into policy discussions framed only in aggregates and budgets.\(^73\) Specifically, health rights as “reasons for action” are a mechanism to improve health in several ways:

Most obviously, the idea of rights provides the legitimacy for a venue shift and the deconstruction of policy monopolies. Rights, as ideas, are far more easily mobilized by policy entrepreneurs than by policy monopolies. In South Africa, the constitutional provision in Section 27 that explicitly mentions not just a right to health, but specifically emergency services, provided the reason for the HRC to act when requested. Meanwhile, as Baumgartner and Jones note, ideas used to legitimate monopolistic policy cycles are impenetrable in certain venues but less so in

\(^70\) Schmidt 2002; Schmidt 2008.
\(^71\) Dworkin 1978; Sachs 2009, 168; Tushnet 2009.
\(^72\) Sen 2004; Beitz 2009 share this framework of reasons for action.
\(^73\) Ruger 2006.
In health, concepts like “cost-effectiveness analysis” or “sustainability” or “financial risk protection” have walled off key decisions as technical, bureaucratic areas of authority when they are, in reality, issues of distributive politics. Thinking in rights terms, the legal complex brings a new set of standards for judging acceptable conduct. As an 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.

Secondly, rights provide an ideational framework that encourages change and contributes to the bargaining power of policy entrepreneurs. Institutions impose constraints on what ideas agents may take into consideration—and rights can shift this ideational scope. South African courts, for example, have disrupted the powerful idea that limited resources in health-related policy is an endpoint of health policy debates. They have instead used a discourse in which “progressive realization” and “reasonableness” require attention to time—how and when health services will be provided, not whether. In this way, ideas can operate on policy at multiple levels—from the most simple type of policy solutions to broader macro philosophies. The effect of conceptualizing health as a right can be seen in the case studies here not just in courts, but in the actions of government officials, bureaucrats, civil society actors, and others. The right to health in these cases operates as a mid-range idea—a framework or “program” that underpins policy and policy cycles. The result is not jettisoning complex balancing of public health, but instead an infusion of urgency and specificity into that balancing, which lends particular weight to policy options that emphasize action and delegitimizes those that focus on stasis.

Finally, ideas also shape coalitions as “magnets” that attract some while repelling others. In this Eastern Cape this included the creation of a wide-reaching coalition ranging from legal service groups to former anti-Apartheid activists committed to the constitution.

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74 Baumgartner and Jones 1993.
75 Constitutional Court of South Africa 2002.
76 Schmidt 2008.
77 Béland and Cox 2016.
Support/Opportunity Structures & International Factors

Building on work in judicial politics, I find that “opportunity structures” often dictate how and whether constitutionalization will have a meaningful effect on a given issue. The ease of filing cases and the degree to which the judiciary takes note of, rules on, and enforces health rights drives both demand and supply of litigation and affects the impact. Charles Epp, in a comparative study, showed that activist judges and rights-promoting constitutions are insufficient alone to trigger “rights revolutions” and that “support structures” are necessary—organizations committed to establishing rights, able lawyers who will mount cases, and sources of financing for litigation. I find evidence supporting these as necessary for policy impact of health rights as well.

This is not quite the same as saying that strong, organized civil society matters for policy change or that ‘high levels of social mobilization’ advances population health. Instead the claim here is more specific—it is in the interaction between the legal complex and health policy entrepreneurs that constitutionalization most clearly takes shape. Those policy entrepreneurs often include social movements and NGOs from organized civil society, but also include government officials (as we see in cases in both South Africa and India) and public health physicians, academics, and activists that are not particularly connected to organized civil society. In fact, quite a few of the issues identified are narrow and have little or no social mobilization behind them. But it is the availability and accessibility of lawyers, legal aid groups, and legalistic actors that span the inside and outside of government like the Human Rights Commission that act as a bridge to connect policy entrepreneurs to decision-makers through rights venues and rights claims.

As illustrated in broad strokes in Table 3.1 above, there is a spectrum of the degree of impact that the constitutional rights framework has on eventual health outcomes, in part attributable to those support structures. In Malawi, this becomes especially clear: interviews with judges in Malawi’s highest courts show great willingness to consider cases and acceptance among

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78 Gauri and Brinks 2008; Yamin and Gloppen 2011.
80 Evans 2009.
some that health might be judicable under the constitution.\textsuperscript{81} Yet while there is significant rights mobilization on political freedoms, that mobilization is missing on health—in part because cases are not easy to bring, but largely because there is a very limited supply of able human rights lawyers, and the financing for rights cases comes almost exclusively from political actors like political parties interested in speech and elections but not health and socioeconomic rights. This stands in contrast to South Africa and India, where strong support structures drive cases.

A policy process approach, though, provides a further insight: the degree of impact on policy change is also conditioned by the nature of that issue’s policy space. The cohesion of the policy monopoly, the power of the idea maintaining the status quo, and the political strength of both the policy entrepreneurs and the monopolists all affect impact. This is perhaps best illustrated by the issue at the bottom of Table 3.1 for South Africa—TB in prisons. A landmark ruling handed down by the Constitutional Court was an apex moment of a long effort by doctors and activists that finally drew macro political attention to cycles of TB infection that had long been ignored with severe consequences for prisoners and the communities to which they returned. Yet when Justice Edwin Cameron returned to the prison a few years later, he found very little changed.\textsuperscript{82} As explored in depth below, this stemmed not from lack of judicial openness or sufficient resources and support structure lawyers, but directly from the strength of the policy monopoly exercised by Department of Corrections officials and its capacity to absorb and deflect challenge.

International factors are also important to mention—both as a source of text and concept in contemporary constitutions and as an important set of pressures and ideas in health policy.\textsuperscript{83} Beth Simmons has shown that treaty ratification can affect domestic politics in ways not dissimilar to what I find in the right to health.\textsuperscript{84} It is notable, however, how infrequently interview and archival data shows international institutions (e.g. UN, WHO, World Bank, etc.) as major players in these policy processes or international instruments (e.g. WHO Constitution, ICESCR in this case) as the

\textsuperscript{81} Interviews MW-10-18.
\textsuperscript{82} Cameron 2015.
\textsuperscript{83} Elkins, Ginsburg, and Simmons 2013; Mehta 2010; Birn, Pillay, and Holtz 2009; Marmor, Freeman, and Okma 2005.
\textsuperscript{84} Simmons 2009. Posner critiques insufficient attention to treaty/constitution relationship (2012), which is also needed here in future work.
source of rights claims. Part of this is attributable to research focus; tracing international-level processes was not a major part of the design of this study. It is also true, however, that while diffusion of policy ideas and international pressures impact health politics, this has not changed the reality that national-level actors and institutions shape policy change. It is national actors that must adapt and implement transnational ideas and that mediate international forces. We do see international factors mattering for the support and opportunity structures, however. Funding for rights “support structure” organizations came from abroad. Transnational networks provided additional power, ideas, and inspiration for policy entrepreneurs in civil society and government as well as judicial actors, in ways predicted by existing literature. International aid group MSF, for example, provided information used by NGOs pushing for reform in the Eastern Cape—and the third HRC panel member was a South African doctor formerly employed by MSF. This shows how the policy anchor provided by constitutionalization can provide legitimacy for domestic actors to leverage international ones.

Conclusion

In the chapters that follow I trace a series of policy issues—starting in South Africa and building out to a comparison with India, Thailand, and Malawi. In each, the power of the right to health comes in providing this institutional and ideological anchor that significantly changes the policy cycle outside the courtroom. In this institutional landscape, policy monopolies are harder to maintain, and ideas that sustain policy stasis in the face of poor health outcomes are delegitimized—which opens new space for health-promoting policy change. The opportunity to shift the venue of policymaking out of the closed space of a small group of risk-averse bureaucrats and self-interested actors can make way for a new ideational framework and new actors. By anchoring health in the constitution, the right to health can deconstruct the policy monopoly blocking change, increasing

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85 Campbell 2004; Béland 2010; Ban 2016.
the bargaining power of key actors inside and outside government, and providing reasons for action that drive significant reforms. In each of the cases below, constitutionalization often triggers mechanisms related to information, incentives for public goods, and accountability theorized to improve health under democracy—but which electoral pressures and political freedoms prove insufficient to activate.

These findings are, of course, based on the empirical evidence from the African and Asian cases below; further work is needed to see how these dynamics play out in places like Latin America or Europe, where particular institutional factors such as a civil law system may change the effects.

Tracing the secondary effect of international rights norms and ideas on the proximal domestic policy processes in health remains an area ripe for further exploration.

The evidence gathered for the case studies here directly connects the right to health to changes in health policy—which is, in turn, directly related to the drivers of poor health and mortality. This provides significant evidence of a causal pathway for the effect we observe in the large-N analysis that showed countries with right to health are healthier than similar countries without. For countries with a basic right to health, the evidence in this chapter suggests that the effect of this right might be deepened by more opportunities for rights mobilization. Expanding the support and opportunity structure for actors inside and outside government to do so through increasing legal services, for example, or expanding the venues like human rights commissions and increasing their capacity to take on health cases could have impact.

Meanwhile, countries like the United States facing significant health problems and health inequities might also learn from these mechanisms. Most recent judicial action on health in the United States has been about challenges (largely unsuccessful) to the expansion of the state’s role in health; these are not the only way to think about health and constitutional law. Even where amending the written constitution seems unlikely, further research might help us understand how moves to create judicial and quasi-judicial venues to deal with health and broaden the legalized

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87 See, for example, Ferraz 2009 and Landau 2012 expressing worry about Brazil and Colombia’s high-volume court systems. But see Biehl et al. 2012; Biehl 2015 whose detailed empirical work suggests some of these concerns are misplaced. Their work hints that some of the same mechanisms I find may be at work in Brazil.
framework might affect health policy and whether the mechanisms described here might have potential to improve health policymaking in this country.
CHAPTER 4: HEALTH & RIGHTS IN SOUTH AFRICA

South Africa is not, by most measures, a success story on health. Mortality rates are far higher and (public) health services far poorer than one would expect for an upper-middle-income country. South Africa’s child mortality rates are closer to those of Eritrea and Bangladesh—each with a fraction of South Africa’s GDP per capita—than those of similarly wealthy countries. Given the discussion in Chapter 2, however, South Africa’s poor health outcomes are not such a mystery. From a broader perspective, South Africa’s economic and demographic endowments would predict poor health outcomes. Legacies of colonialism and Apartheid leave South Africa among the countries with the most unequal wealth distributions and highest ethnic/racial fragmentation on the planet.¹ From these two factors alone, we might expect serious challenges in coordinating effective policy as well as direct negative effect on health. In addition, South Africa has seen rapid urbanization since the fall of Apartheid and is facing significant challenges in education, violence, 

¹ World Bank 2017; Lieberman 2009.
gender equity and state capacity. We should expect South Africa to face serious health challenges and difficulty driving policy change to improve wellbeing and equity.

In addition to demographic factors, South Africa faces a series of challenges with governance. Many of the intentions and promises of the post-Apartheid government have not materialized. The reasons behind this are many and include: low public spending on health, limited capacity and poor quality in public sector health services, strongly embedded interests in the private health sector, multiple competing levels of government authority over health, provincial political fiefdoms that encourage poor management and corruption, limited political power of rural people and those living in poverty, and dynamics within the governing coalition that undercut health.

What, then, has been the role of changing political institutions in addressing this challenging demographic, economic, and governance context? South Africa is widely lauded for its successful transition to multiparty electoral democracy and protection of political freedoms—ranked among the most robust democracies in the world by most measures. Yet as I show below, on critical issues in South Africa, the mechanisms through which democracy is theorized to improve health have not had that effect.

South Africa also is one of the highest-profile examples of constitutionalization of health in the world—with the right to health embedded in the country’s famed 1996 constitution and a series of health rights cases at the Constitutional Court that have drawn global attention. Skeptics, however, are quick to point out that these court cases have been relatively few and the outcomes, from a jurisprudential perspective, have been decidedly mixed. Touching on only a handful of key health issues, it is hard to see how the decisions of apex courts have made significant improvements in the wellbeing of South Africans on the whole.

In this chapter I show how the framework I laid out in chapter 3 provides a fuller picture of constitutionalization in South Africa. Starting from a wide-ranging set of health policy issues where the right to health has been mobilized in the country, I show that the effect of constitutionalizing health in South Africa has been to directly address several of these widely recognized barriers to better health. Exploring the right to health as a “policy anchor” in the political
economy of health in South Africa points, for example, to how the engagement of rights actors in the Eastern Cape has opened political space to address a decades long failure of management in the EMS sector and the legacies of Apartheid in one of the countries most challenged provinces. We can see, too, how incentives and actors shift in a variety of contexts far from the Constitutional Court. At the competition commission, for example, constitutionalization has helped slash the price of medicines and secured access to information critical for addressing the realities of South Africa’s two-tiered public/private health system. In the most well-known court cases, too, including Minister of Health v. Treatment Action Campaign, which opened access to AIDS drugs, rights and the judicial decision act not as a “trump” but instead as a piece in a broader policy process that is distinctly different because of the constitutionalization of health. There are other issues where constitutionalization has a far smaller effect—including the issue of tuberculosis in prisons, a massive unaddressed health problem for the country, where the evidence suggests significant rights mobilization has not moved the needle on policy change. Exploring the limits of impact, though, teaches a lot about the mechanisms of action and suggests where and how rights-based-work takes hold. On the whole, I find evidence of a wide-ranging impact of constitutionalization of health policy that shifts incentives, moves resources, and ultimately improves wellbeing through addressing critical questions in the governance of health in South Africa.

Health of South Africans

South Africans today live significantly shorter lives than similar countries as illustrated below—well over a decade shorter than citizens of other BRICS countries, for example. Much of this is directly related to HIV rates and the country’s initially poor response to the AIDS crisis. Over 20 years since Nelson Mandela became president, South Africa still has far higher rates of infant, child, and maternal mortality than would be expected for its income and relative level of development.

Indicators over time show a mix of good news and bad. As shown in Figure 4.1, South Africa saw a significant decline in life expectancy beginning in the late 90s that has only reversed
itself in recent years—putting South Africans today only about as well off in longevity as they were thirty-five years ago. This reality reflects South Africa’s “quadruple burden” of disease, experienced only in the Southern African region: hyper-endemic HIV and TB epidemics, high maternal and child mortality, high levels of violence and injuries, and a growing burden of non-communicable diseases.

Table 4.01 South Africa Health Indicators Compared to Similar Countries

<table>
<thead>
<tr>
<th></th>
<th>GDP per capita (PPP, current int'l $)</th>
<th>Life expectancy at birth (years)</th>
<th>Under-5 Mortality (per 1,000 births)</th>
<th>Maternal mortality (per 100,000 births)</th>
<th>HIV prevalence (% ages 15-49)</th>
<th>People living with HIV*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya</td>
<td>3,089</td>
<td>62.1</td>
<td>49.4</td>
<td>510</td>
<td>6</td>
<td>1,500,000</td>
</tr>
<tr>
<td>India</td>
<td>6,105</td>
<td>68.3</td>
<td>47.7</td>
<td>174</td>
<td>0.3*</td>
<td>2,100,000</td>
</tr>
<tr>
<td>Namibia</td>
<td>10,411</td>
<td>64.9</td>
<td>45.4</td>
<td>265</td>
<td>13.6</td>
<td>210,000</td>
</tr>
<tr>
<td>South Africa</td>
<td><strong>13,195</strong></td>
<td><strong>57.4</strong></td>
<td><strong>40.5</strong></td>
<td><strong>138</strong></td>
<td><strong>19</strong></td>
<td><strong>7,000,000</strong></td>
</tr>
<tr>
<td>China</td>
<td>14,451</td>
<td>76.0</td>
<td>10.7</td>
<td>27</td>
<td>0.1*</td>
<td>501,000</td>
</tr>
<tr>
<td>Brazil</td>
<td>15,474</td>
<td>74.7</td>
<td>16.4</td>
<td>44</td>
<td>0.6</td>
<td>830,000</td>
</tr>
<tr>
<td><strong>Global Avg</strong></td>
<td><strong>15,691</strong></td>
<td><strong>71.7</strong></td>
<td><strong>42.5</strong></td>
<td><strong>216</strong></td>
<td><strong>0.8</strong></td>
<td><strong>36,700,000</strong></td>
</tr>
</tbody>
</table>

Source: 2015 data from World Development Indicators, World Bank *UNAIDS † NACO ‡ National Health and Family Planning Commission of the People’s Republic of China
In recent years, however, life expectancy has been on the rise and both child and maternal mortality have turned sharply downward. Just since 2010, child death from pneumonia has been nearly halved. This reflects a decade of significant progress but much more work to do.

With over 7 million people currently living with HIV, South Africa has the largest epidemic in the world. Both the drop in life expectancy and significant rise in infant and child mortality during the late 90s and early 2000s were caused by an out-of-control epidemic of untreated HIV. Until recent years, patients admitted with HIV-related illnesses occupied more than half of the beds in many South African hospitals. Tuberculosis, long a problem of its own in South Africa, exploded as the HIV epidemic left millions with weakened immune systems. Today, TB kills more people than any other cause, though HIV/AIDS is the underlying reason as reflected in Table 4.02. HIV has been both an immediate and proximal cause of South African’s poor health as the disease devastated the health workforce, undermining efforts to expand and strengthen the post-Apartheid health system. Today, even as both deaths and transmission rates of HIV are dropping, population growth and “youth bulge” in the country mean the absolute numbers of both remain significant.

High child mortality rates reflect striking levels of preventable deaths. HIV plays a role through both pediatric AIDS deaths and by leaving children without healthy parents to care for them. Meanwhile, main causes of death among children—respiratory tract infection, diarrheal

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2 Massyn et al. 2016.
4 Long et al. 2016.
6 Seekings 2014; Whiteside 2014.
disease, sepsis and tuberculosis—are preventable and curable. Indeed, the bulk of childhood death is the result of avoidable factors, as much as 61% of which are direct health system failures. Maternal mortality has been similarly damaging with rates as illustrated in Figure 4.1 that remain far higher than in the early 1990s when data became available—much of it avoidable. In addition to devastating levels of violence, South Africa faces a large and growing problem of non-communicable diseases. If HIV and TB were to be controlled, then the major deaths from disease in the country would be from stroke, diabetes, and heart disease. Rates on NCDs are going in the wrong direction even as progress is being made against HIV and TB.

A key point here is that much of South Africa’s mortality and ill health is amenable to change through basic preventative and curative health services. Expansion of those services in the last decade has contributed significantly to the positive turn in health indicators, even as progress remains fragile.

**Political and Racial Economies: Historical Legacies**

The poor health of South Africans is a direct product of its particular history—with the twin legacies of mining and Apartheid structuring the country’s contemporary challenges. Since the discovery of diamonds in Kimberley in 1867 and gold in the Witwatersrand in 1886, the mining sector has become a cornerstone of South Africa’s economy. At its height in the 1980s, minerals extraction constituted 21% of the economy and employed 763,000 people—and while it has fallen to the 6th largest industry in the country, it remains among the most politically dominant. With mining came a political economy that determined disease patterns that persist—creating a set of companies able to exercise incredible power to move both people and policy. Massive migration, along with coercive laws, taxes, and restrictions on land use, moved cheap, migrant, male labor out of agriculture and into mining towns. Migration came from both within South Africa and from other countries in the region—at its height in the 1970s, nearly half a million men from Botswana,

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8 Whiteside 2014, 181.  
9 Stats SA 2017.
Lesotho, Swaziland, Malawi, and Mozambique migrated to South Africa’s mines. These migration patterns have had a major effect on the health of South Africa through nearly all facets of life; patterns of violence, the construction of slums, the structures of Black South African families, sexual practices, the provision of public and private healthcare, etc. provided fertile ground for the spread of infectious diseases and construction of a fractured, ineffective health system for the majority population. Hundreds of thousands of black people working in South Africa’s cities were pushed into single-sex hostels that were overcrowded and poorly ventilated, with male hostels often served by sex workers. This oscillatory migratory pattern—living temporarily in cities or mining towns, with regular visits to rural homelands in and outside South Africa—was key to the spread of tuberculosis and STDs in the first half of the 20th century. HIV came to South Africa likely through migrant workers from Malawi and it is due in no small part to migrant mining labor that the Southern African region is today home to the highest rates of disease in the world.

The Apartheid system built off the political economy of mining, the periods of Dutch and English colonialism, and of the segregation that preceded it. The system of rigid racial hierarchy classified South Africans into categories—White, Asian/Indian, Coloured, or Black/Bantu—that determined where a person could live and work, whom they could marry, whether they could vote, and which system they could access for school, healthcare, and social protection. The 1945 Urban Areas Consolidation Act crafted the rules of legal segregation while the 1952 Abolition of Passes and Coordination of Documents “Natives” Act required all black South African adults to carry a “pass book” in white neighborhoods. These laws were reinforced by draconian repression from a state that denied Black people citizenship, removing millions to rural Bantustans. Apartheid South Africa was governed for the benefit of the white population, with massive inequality, racial division, and widespread poverty among the majority. The country was divided into multiple layers of administrative units that were never particularly viable—white-ruled provinces, “independent”

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10 Whiteside 1986.  
11 Marks and Andersson 1987; Coovadia et al. 2009.  
13 Whiteside 2014.  
14 Clark and Worger 2016.
Bantustans or ethnic homelands, “self-governing” areas like KwaZulu-Natal; and separate administrations for Coloureds, Indians, and Whites.\textsuperscript{15}

The African National Congress (ANC), which formed in 1912 and opposed the formation of the South African republic, was banned and went into exile after police killed protesters against the pass laws in Sharpeville in 1960, sparking unrest and a national state of emergency. Anti-Apartheid organizing inside and outside the country became militant and multiple civil society networks mobilized on a massive scale through the 1980s, which saw widespread protests and state-sponsored violence in response. Eventually, pressure from social movement organizing along with reform efforts within the white ruling class, facing a major economic downturn, resulted in the first national democratic elections that brought the ANC to power in 1994.\textsuperscript{16}

The two-tier health system under Apartheid included a publicly financed public sector serving the majority of the population and a private sector funded primarily through medical aid schemes for a small white minority. The public system was highly inequitable, with few facilities in rural areas, and was broadly designed to provide very limited health services to women, children, and farm workers. It was racially fragmented into fourteen different operating authorities—10 Bantustan health departments, three racial “own affairs” health departments, and the national Department of Health.\textsuperscript{17} The private sector, meanwhile, consumed the majority of resources to serve less than a quarter of the population with private insurance and focused services on expensive tertiary hospitals and in the major urban areas around Johannesburg, Cape Town, and Durban, creating vast geographic and population inequalities.\textsuperscript{18} Privatization and deregulation led to massive resource misalignment—with an 87% increase in private for-profit hospital bed availability, for example, between 1988 and 1993.\textsuperscript{19} As a result, whiter, wealthier communities were often over-serviced in terms of healthcare by most estimations—leading to high spending with little health impact, a trend that has proved hard to reverse. Meanwhile, apart from the health system,

\textsuperscript{15} Price 1986.
\textsuperscript{16} Wood 2000.
\textsuperscript{17} Schneider, Barron, and Fonn 2007.
\textsuperscript{18} Coovadia et al. 2009.
\textsuperscript{19} McIntyre et al. 1995.
the social, economic, and environmental conditions under Apartheid were deeply damaging to the wellbeing of Black South Africans—overcrowded squatter settlements, migrant labor, poor access to water and electricity, malnutrition from both income poverty and being forced onto infertile land, and un- or underemployment.\textsuperscript{20} By the end of Apartheid in 1994, the inequity was deep: infant mortality was ten times higher in the black population than among whites and massive numbers of maternal deaths among Black women were going largely uncounted by the government, which refused to collect statistics.\textsuperscript{21}

\textbf{Contemporary Socioeconomic Context}

The legacies of both the chaotic governance structures and the racial hierarchies remain—ethnic boundaries and inequality drive poor health both directly through deprivation and indirectly through challenges in setting effective health policy.\textsuperscript{22} A decade after the fall of Apartheid, the legacies of this system were still quite clear with life expectancy in 2004 ranging from 64 years for white people to 49 years for black people—reflecting both deep inequality and poorer health even among whites than should be expected for a country of South Africa’s wealth.

\textsuperscript{20} Seekings and Nattrass 2016; Jinabhai, Coovadia, and Abdool-Karim 1986.  
\textsuperscript{22} Lieberman 2009; David and Collins 2014; Wilkinson and Pickett 2009.
Since the fall of Apartheid and until very recently, South Africa has enjoyed strong economic growth except at the height of the global recession in 2009—largely matching or beating the global average. As seen in Figure 4.2, the significant deterioration in health in the 1990s and 2000s caused by HIV occurred at a time when economic growth should have been fostering improvements. Poverty rates in South Africa increased slightly in the late 1990s, likely undermining health, but have seen a steady decline since then—even through the 2008-09 recession. Rates of hunger followed roughly the same trajectory. Nonetheless, poverty rates remain markedly high—with somewhere between 20% and 46% of the population living in income poverty depending on the cut off—its rates are far higher than similar countries.23

South Africa has, by several measures, the most unequal distribution of income and wealth in the world.24 It also has one of the highest unemployment rates, with a quarter of the population out of work and far higher rates among young people.25 The historical legacy of state repression has left the country with a vast police and prison complex and the highest rate of incarceration in Africa by far, twice that of Zimbabwe for example.26 Gender inequity and violence against women and against LGBT people remains a far more significant factor in health outcomes than in most countries. This mix of unemployment, poverty, gender inequity, and incarceration has been a driver of the country’s HIV and TB epidemics with which the health system has been unable to cope.

South Africa also faces distinctive demographic realities that undergird the health challenges. Continued population growth and urbanization are both linked to the inequality and poverty figures. The combination of rapidly declining fertility rates and mortality due to HIV have resulted in a population “bulge,” with the largest cohort of South Africans currently in their 20s and early 30s. This population bulge combines with significant urbanization—with urban provinces of

\[\text{Seekings and Nattrass 2016.}\]
\[\text{See, e.g. World Development Indicators gini score}\]
\[\text{Seekings and Nattrass 2016.}\]
\[\text{Institute for Criminal Policy Research 2016.}\]
Gauteng and the Western Cape growing 57 and 47 percent respectively between 1996 and 2011 while the rest of the country grew just 17 percent.27

Together, the social and economic determinants of health explain much of the poor health outcomes experienced in South Africa. The health system, while struggling to keep up, is distorted in ways that have proved very hard to address and, as such, has struggled to rectify these realities.

**Democracy**

Since 1994, South Africa has been hailed as a successful democracy and so, as we consider the effect of constitutionalizing health we must also consider both the possibility that electoral democracy is actually doing the work on health, or that constitutionalization is actually undermining democratic governance on health. In the measures widely used by political scientists to measure electoral democracy and political freedoms, South Africa scores a 9 (out of 10) in Polity and a strong designation of “Free” by Freedom House.28 For most of the last decade The Economist Intelligence Unit has ranked the country among the three strongest democracies in the global South, with scores roughly equal to France.29

The African National Congress (ANC) has, since the fall of Apartheid, been the leading party in South African electoral politics—winning large margins at the national level and exercising continuous control over the Presidency since transition. These electoral victories have led some to label South Africa a “dominant party system” in which the lack of alternation in apex politics may reflect a far weaker democracy than the international comparisons capture.30 As Southall and others argue, however, this mischaracterizes the nature of ANC power, which is constrained by constitutional, political, and economic realities.31 While the ANC peaked at 69.7% of the national vote in the 2004 election, South Africa has been characterized by fierce electoral competition including local and provincial electoral losses for the ANC and multiple parties—

27 Seekings 2014.
29 Economist Intelligence Unit 2017, though it has seen a significant dip in the last year under the cloud of the Zuma presidency.
30 Giliomee and Sinkins 1999; Southern 2011.
31 Southall 2017.
from the Zulu Inkatha Freedom Party early on to the DA today—that capture significant vote-share and major public attention. Meanwhile, the ANC itself has been a place of significant internal debate and contestation—famously including the open competition between leaders representing different national constituencies that culminated in the ouster of President Mbeki at the Polokwani ANC conference.\(^{32}\) Since the democratic opening, the ANC has also ruled as part of a tripartite alliance between the ANC, South African Communist Party, and the largest union confederation, COSATU. The Alliance, while criticized as overly dominated by the ANC and perhaps contrary to the interests of South Africa’s working class, has also provided an additional layer of complexity to South Africa’s democracy.\(^{33}\)

Components of democracy identified by Sen and Ruger as keys toward realizing the freedoms that improve health are largely present both \textit{de jure} and \textit{de facto} in South Africa:\(^{34}\) vibrant multiparty democracy exists with highly contested elections even as ANC exercises “weak dominance”;\(^ {35}\) free media including 47 daily and weekly newspapers in multiple languages and widely watched public and private TV news as well as widespread internet use;\(^ {36}\) open public discussion leading to flows of information about health, including an entire media outfit dedicated to health policy and information;\(^ {37}\) guaranteed freedoms of assembly, association and expression actively protected by legal and political branches, albeit controversially; and the practical ability to voice complaints and opposition perhaps best illustrated by the several hundred service delivery protests (including health services) of varying sizes that occur each year.\(^ {38}\)

**Post-Apartheid Governance of the Health & Welfare State**

The election of Mandela brought great hope and expectations; since as far back as the 1955

\(^{32}\) Piper and Matisson 2009; Booyzen 2017.
\(^{33}\) Habib and Taylor 2001; Piper and Matisson 2009.
\(^{34}\) Sen 1999; Ruger 2005.
\(^{35}\) Southall 2017.
\(^{36}\) Mokgata 2013.
\(^{37}\) https://www.health-e.org.za/about/
\(^{38}\) Alexander, Runciman, and Ngwane 2016.
Freedom Charter, the ANC had been focused on a program to build a health and social security system that worked for all. A self-proclaimed social democratic party working to build a “developmental” state, the ANC’s ideological commitments suggests the kind of left-leaning, ambitious party that many have linked to successful welfare states and improvements in health.39 Meanwhile, the ruling tripartite alliance of the ANC, SA Communist Party, and the major labor confederation COSATU have modeled their political alliance on a socialist-grounded corporatist alliance between state, labor, and capital. Rhetorically, health and welfare policy have reflected this outlook. In practice, however, the South African health system has not achieved universalism, equity, or quality. As I describe below and in detail through the case studies in this chapter, low spending, limited capacity, poor accountability and management, powerful vested private and political interests, complex multi-level authority over health, limited power of rural and poor people, and particular dynamics within the ANC have undercut transformation of health and welfare systems. These challenges are important to understand as one explores the impact of rights on health because it is in this real context, with particular barriers to success, that the shift toward a constitutionalized politics of health is occurring.

The ANC, through successive administrations, has repeatedly declared a commitment to creating a “comprehensive system of social security” built around a concept of solidarity.40 In some ways the post-Apartheid welfare state moves toward this ideal. South Africa today spends a larger portion of its GDP on social welfare programs than any major developing economy with coverage that is without peer in the world—moving from 2.4 million people receiving social grants at the time of the 1994 elections to 16 million by the 2014 round, with major redistributive and anti-poverty effects.41 As Seekings and Nattrass show, however, moves toward a more universal social security and health system have largely been blocked. The dramatic expansion has been parametric—an expansion of eligibility, including across racial and geographic lines—rather than

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39 The party has a complicated relationship with the idea of a “welfare state” but broadly subscribes to a social democratic rather than liberal welfare state as described in Seekings and Nattrass 2016. It also, though, is focused on building a developmental state, limits the decommodification that the party is willing to support. There is, however, little question of the party’s left/socialist history and leanings, which have been linked by thinkers like Navarro et al. 2006; Huber and Stephens 2001 and others to improved wellbeing.
40 South Africa 1997a.
41 Seekings and Nattrass 2016, 143.
a departure from the Apartheid-era “liberal” welfare state characterized by means tested programs. There is not, for example, a universal pension or unemployment program and the idea of national health insurance is still only in the planning stages two decades after the government declared its intention to build such a program. “South Africa's social safety net has a very loose weave,” writes Michael Samson. While government has repeatedly committed, as the 2012 Treasury Budget Review pledged, to a “major restructuring of South Africa's social protection arrangements” to “eliminate gaps” and ensure “all South Africans will benefit from new arrangements and risk will be shared,” reforms have largely been blocked. Policy hangover from the Apartheid government and path-dependent effects including strong constituencies for the status quo along with some limited fiscal space have gotten in the way of major reform efforts.

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<tbody>
<tr>
<td>Life expectancy at birth (years)</td>
<td>61.37</td>
<td>55.84</td>
<td>51.56</td>
<td>54.39</td>
<td>57.18</td>
</tr>
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<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>62</td>
<td>85</td>
<td>112</td>
<td>154</td>
<td>140</td>
</tr>
<tr>
<td>Under-5 mortality (per 1,000 live births)</td>
<td>62.1</td>
<td>75.3</td>
<td>75.2</td>
<td>53.8</td>
<td>41.4</td>
</tr>
<tr>
<td>AIDS-related Deaths</td>
<td>190,000</td>
<td>345,607</td>
<td>320,000</td>
<td>180,000</td>
<td></td>
</tr>
<tr>
<td>Incidence of tuberculosis (per 100,000 people)</td>
<td>585</td>
<td>932</td>
<td>948</td>
<td>834</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health System &amp; Financing</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Health expenditure, total (% of GDP)</td>
<td>8.3</td>
<td>8.1</td>
<td>7.8</td>
<td>8.5</td>
<td>8.8</td>
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<tr>
<td>Public Health expenditure (% of total health exp)</td>
<td>41.4</td>
<td>40.8</td>
<td>42.7</td>
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<td>48.2</td>
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<tr>
<td>Public Health expenditure (% of government exp)</td>
<td>13.0</td>
<td>13.6</td>
<td>13.0</td>
<td>14.1</td>
<td>14.2</td>
</tr>
<tr>
<td>Public Health expenditure (% of GDP)</td>
<td>3.4</td>
<td>3.3</td>
<td>3.3</td>
<td>4.0</td>
<td>4.2</td>
</tr>
<tr>
<td>Private Health expenditure (% of GDP)</td>
<td>4.9</td>
<td>4.8</td>
<td>4.5</td>
<td>4.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Physicians (per 1,000 people)</td>
<td>0.59</td>
<td>0.69*</td>
<td>0.77*</td>
<td>0.78*</td>
<td></td>
</tr>
</tbody>
</table>

Source: World Development Indicators, Statistics South Africa, UNAIDS
*Data from year prior based on availability

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42 Ibid., 142–52.
43 Samson 2002, 73.
44 South Africa 2012.
The health sector in particular has seen these dynamics clearly at work. The system inherited by the new government in 1994 was actually comparatively well-resourced, with among the highest total spending on health among middle-income countries, at 8.5% of GDP.\textsuperscript{45} It was in South Africa that the first human-to-human heart transplant was performed by Christiaan Barnard in December 1967, signifying a health system that served a white minority quite well.\textsuperscript{46} The key challenge was not funding, but the massive inequalities in the distribution of resources. More than half of doctors, 93% of dentists and 89% of pharmacists were in the private sector serving the minority with access.\textsuperscript{47} There was also a major imbalance in the system toward hospitals and only very meager resources for primary care services, especially in Black areas.

The ANC’s 1994 manifesto health plan and 1997 “White Paper For the Transformation of the Health System” fit into the broader ANC macroeconomic proposals under the Reconstruction and Development Programme (RDP) with a broad focus on ensuring “the health of all South Africans must reflect the wealth of the country” through addressing both health service delivery and the social drivers of ill health from poverty and clean water to women’s education.\textsuperscript{48} These founding documents placed responsibility for healthcare firmly at the door of the state and pledged to dismantle the inequity of the two-tiered health system through an integrated, democratic, decentralized, and equitable national health service.

Inequity, however, has persisted. Today, the lowest socio-economic groups bear the largest burdens of ill health—including both infectious and non-communicable diseases.\textsuperscript{49} Yet these same groups have the lowest level of health service utilization and derive the least benefits from these services when they are used.\textsuperscript{50} This has been significantly exacerbated by the HIV and TB epidemics, which hit the health workforce particularly hard and exacerbated human resources shortages that, in turn, left the public system incapable of offering either HIV or primary healthcare effectively. The disparities in expenditure between the public and private sectors relative to the population they

\textsuperscript{45} McIntyre et al. 1995.
\textsuperscript{46} Hunt 2006.
\textsuperscript{47} McIntyre et al. 1995.
\textsuperscript{48} African National Congress 1994; South Africa 1997b.
\textsuperscript{49} Ataguba, Akazili, and McIntyre 2011.
\textsuperscript{50} Marten et al. 2014; Ataguba and McIntyre 2013.
serve have widened over time.⁵¹

As shown in Table 4.03, public health spending did not change much as percent of GDP in the first decade after Apartheid and has risen significantly since then—both in real terms and as a portion of government spending. There has been significant movement toward redistributing resources between geographic areas and levels of care. The gap in spending per person dependent on public sector health services, between the best- and worst-resourced provinces, declined from a five-fold difference in 1992/93 to a two-fold difference in 2005/06 and spending on primary health care increased to over 22% of total public-sector health-care expenditure.⁵²

However, substantial inequities and efficiencies remain. Public spending overall remains only 4.1%, which is lower than the average of 6% among other middle-income countries. The national public health sector, staffed by just 30% of the doctors in the country, remains the sole provider of health care for more than 40 million people.⁵³ Many public-sector hospitals and clinics are in a state of crisis due to underfunding and mismanagement—with run-down infrastructure, stock outs of essential medicines, and staffing shortfalls that undermine quality patient care. Up to 25% of those who lack health insurance pay out of pocket for private sector care in order to escape the poor quality available in the public sector.⁵⁴

Rural communities have seen significant expansion in health services with a great many new clinics built since 1994 to serve the roughly 40% of the population living in rural areas. Expenditure continues to be lower per-capita in rural provinces and in rural districts. In Eastern Cape, for example, per capita spending in the major urban Nelson Mandela Bay district was double the expenditure in rural districts. This has a direct relationship to health service quality and outcomes. Rural Eastern Cape province, for example, has double the case fatality for children with Pneumonia as Gauteng province.⁵⁵

On the other hand, private spending remains 50% of total health expenditure, which is

⁵¹Ataguba and Alaba 2012.
⁵²Coovadia et al. 2009.
⁵³Mayosi and Benatar 2014, 1345.
⁵⁴Ibid., 1346.
⁵⁵Massyn et al. 2016, 125.
among the highest in the world.\textsuperscript{56} There are 83 private insurance plans funding the health needs of only 16.2\% of the population.\textsuperscript{57} Spending through these plans in South Africa is the highest in the world and is six times higher than in any OECD country and represents more than six times the 2013 OECD average of 6.3\%.\textsuperscript{58}

At its 2007 policy conference the African National Congress (ANC) renewed its resolve to introduce a National Health Insurance (NHI), which would aim to achieve universal access to health care. The plan, however, has been slow to appear. There is a multitude of powerful actors invested in the status quo—ranging from health insurance companies to the 8.8 million people who have private health coverage, including nearly all of the leaders in government, business, and even the NGO sector. It also reflects a major challenge challenges in financing. Modeling of the resources needed suggests that although total expenditure on health care would not have to increase very much, spending from public funds would need to increase dramatically—from around 4\% of GDP to more than 6\%.\textsuperscript{59}

Governance in the health sector has been a major challenge—with multiple competing levels of authority and significant issues in poor performance and corruption. The immediate focus in the Mandela government was consolidating the health system and by 1995 the government had re-structured the fourteen different departments of health in to nine provincial health departments and one National Department of Health. While South Africa is not technically a federal state, the relatively powerful provincial governments have significant control over the health sector under the National Health Act, which defined both the district health system and primary healthcare as provincial responsibilities. The National Department of Health has overall responsibility for setting health policy and crafting guidelines and regulations, but provincial authorities develop their own policies in relation to these national policies. In the late 1990s, national funding for health shifted from allocations made by the Minister of Health to block grants based on the Treasury’s complex

\textsuperscript{56} South Africa 2017.
\textsuperscript{57} Council for Medical Schemes 2015.
\textsuperscript{58} South Africa 2017.
\textsuperscript{59} McIntyre and Ataguba 2012.
“Equitable Shares” formula based in part on the size of the population not covered by private health insurance. These unconditional grants are disbursed directly to the provinces to cover all social spending and provincial authorities allocate health spending from within them, along with some additional “conditional” transfers for key disease programs. Overall the National Department of Health directly controls just 2.5% of government health expenditure. This governance structure has created several challenges including centralization of power among provincial authorities, which vary significantly in their capacity and their outlooks, resulting in notable differences in service delivery and outcomes. Many of the provincial administrations have significant vulnerabilities inherited from their evolution from Apartheid-era Bantustans and other structures, which were characterized by divisive politics, poor governance and corruption. Rispel et al. show how today, the complexity in the health system, together with a high degree of centralization of decision-making and authority, have led to high levels of corruption and poor performance in some provinces. Stuckler, Basu, and McKee, meanwhile, have shown that provinces with greater capacity and infrastructure to provide health services have captured a greater portion of national health resources creating political “infrastructure-inequality traps” for higher need provinces. Divided authority has limited what National Department of Health can do to address the problems.

Constitutionalization of Health in South Africa

South Africa’s post-Apartheid constitution-making process reflected not only the final process toward democracy and the elimination of legalized racial hierarchies, it also reflected a revolution in South African law—shifting from parliamentary sovereignty to constitutionalism. The core decision to create a judicially enforceable constitution was among the most important agreements in the negotiated interim constitution and the basis for the constitutionalization in South Africa on a wide variety of fronts. Well before the ANC was unbanned and the constitution-
writing process began, there was significant debate on the question of whether the inclusion of socioeconomic rights was appropriate as part of the new constitutionalism of the republic.\textsuperscript{66} The ANC argued forcefully for their inclusion, suggesting in one submission to the process that they explicitly envisioned the kind of “policy anchor” I argue has been created in practice:

“The ANC believes that the wide-scale injustices and inequalities of the past require the inclusion of particular socio-economic rights in a South African Bill of Rights. The inclusion of such rights within a Constitution records a country’s vision and aspirations for the future. The new Bill of Rights cannot therefore shy away from including within the scope of its protection, fundamental rights, which while posing difficulties in enforcement reflect important principles in the promotion of a society based on justice and equality, a society which seeks to redress the imbalances of the past.”\textsuperscript{67}

The right to health was a prominent part of the rights argued for by the ANC, drawing explicit inspiration from international instruments including the African Charter on Human and Peoples’ Rights and the International Covenant on Economic, Social and Cultural Rights.\textsuperscript{68} Albie Sachs, later a Constitutional Court Judge, was among the early advocates of including health rights in the constitution—inspired in part by international conversations that bridged the Atlantic.

“We believed there was a need not just for procedural justice but for substantive equality and we had to break new ground. It was through engaging not just with each other but with thinkers in the U.S., Brazil, parts of Asia, with the two Marthas—Minnow and Nussbaum—and with Jonathan Mann, Roberto Unger that we crafted a clearer idea of the transformative power for health that could be found in the law.”\textsuperscript{69}

The ANC had a number of reasons to support the inclusion of socio-economic rights but among these was a concern to prevent an overly-expansive reading of the right to property that might challenge future policy goals like restructuring a health system dominated by private health

\textsuperscript{66} The two sides summarized nicely in Sachs 1992 and Davis 1992.
\textsuperscript{67} African National Congress 1995.
\textsuperscript{68} Ibid.
\textsuperscript{69} Interview SA-02, Albie Sachs, October 22, 2015.
schemes. In this way, including the right to health was both a statement of values and insurance against future moves by private interests to limit the policy space for transformation.\footnote{Dixon and Ginsburg 2011 call the inclusion of socioeconomic rights in the SA constitution an "insurance swap"—health and such socioeconomic rights in exchange for property rights protection, inclusion of which was a dealbreaker for the National Party.}

The 1992 draft Bill of Rights put forward by the ANC included a section entitled “right to health” that declared, “a comprehensive national health service shall be established linking health workers, community, state institutions, private medical schemes and individual medical practitioners so as to provide hygiene education, preventative medicine and health care delivery to all.”\footnote{African National Congress 1992.} During the negotiations on the interim constitution, however, socioeconomic rights were shelved due to resistance from the National Party until the process under the elected assembly where the ANC had a freer hand.

Section 27 of the final text of the constitution states, in part:

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.

The Constitution also includes sections rights to health services for children (§28(1)(c)) and prisoners (§35(2)(e)). While these sections focus on healthcare alone, the public health responsibility of government is arguably also influenced by its duties under the Constitution’s broader range of socioeconomic rights including to water (§27(1)(b) and housing (§26).

As I use it in this section of the project, however, constitutionalization reflects something more than just the existence of a right in constitutional text. For it to matter in the way I am arguing, it must truly be “available” in the society—institutionally prominent enough to be picked up and used by actors. Two indicators help identify the degree to which that is the case: first, whether the right to health exists in public discourse; and second, whether courts are using the right to health on a variety of different cases. In South Africa both are true.
As shown in table 4.04, the right is an active idea in public debate. I coded a sample of articles from South Africa’s 10 largest newspapers, which included over 80 articles explicitly dealing with the constitutional right to health. While internationally the discussion tends to focus on HIV treatment, the articles in the sample dealt nearly as much with maternal and child health as with AIDS and also focused on reproductive health, basic health services, and the price of medicine. Importantly, the “major actors” in these articles were most commonly activists and were as often doctors as they were lawyers, lending support to my contention that constitutionalization has as much to do with what happens outside court as inside.

The constitutional provision has also been the basis for a range of key legislation including the National Health Act of 2003, which provides the legal backbone for the South African health system and is the legislative source of current public health powers, cites Section 27 extensively in its preamble as the source of authority for key policies. In addition both the Choice on Termination of Pregnancy Act 92 of 1996 and the recent White Paper on National Health Insurance for South Africa draw their legal source and mandate from health rights in the constitution.

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72 See discussion in Pieterse 2014.
Meanwhile there is ample evidence that South African courts are taking up the right to health in cases. The first reported decision came not under Section 27, but under a claim on the Section 35 right of detained persons to “the provision, at state expense, of adequate… medical treatment.” The first Section 27 case reached the Constitutional Court in 1998 in Soobramoney v. Minister of Health (Kwa-Zulu Natal).\footnote{1998 (1) SA 765 (CC).} In that case the Constitutional Court upheld a decision to deny Mr. Soobramoney access to renal dialysis based on state hospital rules, finding that the state’s good faith decision not to extend dialysis to all, reached rationally after considering cost and demand, did not violate the state’s constitutional obligation. Probably most important case came a few years later in 2002 with Minister of Health and Others v. Treatment Action Campaign, which sidestepped the logic in Soobramoney to clearly show courts would enforce the constitutional right to health.\footnote{2002 (5) SA 721 (CC).} Explored in greater detail in the case study below, this case took place amidst the dramatic battle over the Mbeki government’s refusal to roll out HIV/AIDS treatment in the public health sector. Here the Court found the government’s position denying access to Neverapine to prevent the transmission of HIV from mother to child (MTCT) was unreasonable and held that the state had an obligation not to ignore urgent health needs, especially those of excluded segments of society that could not afford medical services. The Court ordered the government to devise and implement a comprehensive MTCT plan and remove restrictions on the drug Nevarapine.

From there over a dozen cases have reached the apex court dealing with the right to health. The cases have been varied and complex, showing the right to health inspires robust activity in the courts. Several of these cases are taken up in the case studies of policy issues below. Alone, they do not necessarily suggest an ultimately widespread impact on population health. I outline below, however, how they fit into a broader set of policy issues where rights mobilization never reaches a major court decision yet still has a significant impact on the eventual health outcome.
Constitutionalization in a Complex Health Context

A constitutional right to health is not a magic bullet—it cannot simply make people healthier. This is nowhere more obvious than in South Africa where the challenges facing the health sector are immense. Despite relative wealth and high democracy, the demographic challenges alone present health authorities with a steep climb to addressing historical inequities and improving health overall. Low public health spending, along with highly-entrenched and politically powerful private systems, undercuts health for the majority. Meanwhile, complex and competing levels of authority mean that some provinces still lack basic service delivery despite the availability of financing and commitment at the national level. All this is visible before we even delve into the specifics of key policy areas like HIV, where disastrous decisions have had long-lasting effects.

What a right to health does do is to change the “rules of the game” in the politics of health. Seen in the context described here, constitutionalization matters because it acts on several of these key barriers to better health. As I describe in Chapters 4.2 through 4.5, the right to health has been mobilized on a wide set of health issues and there is evidence it has helped address some of the stickiest challenges in the health in the country. In teasing out the impact of this mobilization it is clear that the effect has been far from universal in this complex environment, but on the whole, there are clear, observable benefits to the wellbeing of South Africans.
4.2: Emergency Health Services Policy in the Eastern Cape

“We understood that there are these things called an ambulance that government has sent out, but we had not seen them here. When we are very sick or when women are in labor, then we hope: that we can walk some kilometers to the public road and that there are cars coming; or that that our family has enough to hire a car. If not, then that is when people die waiting.” —Community leader, Xhora Mouth, Eastern Cape (Interview SA-23)

“In short, our health emergencies are financially devastating. They 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

In this section I explore the particular case of emergency medical services in the Eastern Cape province as a first example of constitutionalizing health policy. Access to emergency services is both a question of equitable expansion and of basic health security as it affects vulnerability to catastrophic health crisis. This is in many ways a least-likely case for rights-based policy change to actually have an impact, given expectations in much of the literature. The Eastern Cape is a large rural area, and the beneficiaries of policy change in this case are poor, Black people living in an impoverished rural area. Given expectations in the literature that rights and courts will serve the interests of the elite, or at least the middle class, many would not expect impact. In this case the policy issues at stake are also complex and involve multiple, competing trade-offs—exactly the sort of policy area some believe cannot be handled effectively in rights terms. As such, it is a good test of the hypothesis that rights can be beneficial to population health. The region I focus on here is also extremely distant, both geographically and psychologically, from the Constitutional Court’s home on Constitution Hill in Johannesburg. As a case that features no apex court decision, it also provides a most interesting test of the theory I laid out in the preceding chapter.
Of Ambulances & the Social Determinants of Health in the Eastern Cape

“You’ve got the poorest people in South Africa paying R7-800 rand [about US$65] that nobody had for a private car to get them to hospital. It was killing people, just all the time.” —NGO leader, Xhora Mouth (Interview SA-22)

South Africa’s Eastern Cape (EC) Province is the second largest in South Africa—home to over 6.5 million people. Under Apartheid, much of the province was part of two vast Xhosa-speaking “Bantustans” (Transkei & Ciskei) that were profoundly and intentionally underdeveloped. While most such Apartheid-era homelands were smaller and divided into many parts, aiding their eventual incorporation into the new South Africa, the Transkei was larger than Switzerland and presided over by a series of authoritarian leaders who left little governance infrastructure. After the fall of Apartheid, the Eastern Cape combined these homelands with the areas around the white-controlled urban centers of Port Elizabeth and East London. Two decades later, the province remains deeply challenged; it is home to more unpaved roads considered “poor or very poor,” for example, than most of the rest of the country combined. At the time of democratization, healthcare expenditure was at R250 ($20) per person in the previously white part of the Eastern Cape, but R70 ($6) in the former Ciskei and just R40 ($3) in the Transkei.

For much of the past decade, public health experts, elected officials, community leaders, activists, and the media have bemoaned the poor state of the EC health system—from major staffing shortages to crumbling infrastructure, unpaid bills, mismanaged hospitals, and drug shortages. Petty corruption and graft have been a significant problem—reflecting management failures on a large scale.

Emergency Medical Services (EMS) has been a particularly consistent failure in the province—with stories sparking regular outrage. In one eight-month period, for example,
newspapers reported that 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 magistrate’s court after waiting 90 minutes for an ambulance.79

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, especially maternal and child wellbeing. Given the rural nature of the EC, the poor road infrastructure, deep poverty, and the high costs of private transportation, this is a major barrier to healthcare. In South Africa as a whole, the neonatal mortality rate is strikingly high, at 15 per 1,000 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.80 Maternal mortality is similarly common—with estimates as high as 400 of every 100,000 births ending in the mother’s death.81 The EC, in particular, 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 children die from basic causes such as diarrhea and pneumonia.82 Researchers have shown that more than half of these deaths are preventable with basic interventions in the health system.83

A critical challenge in the Eastern Cape, then, is getting people into the system. The province has the lowest rates of attendance at antenatal clinics for prenatal care—often because parents cannot arrange transportation. As shown below in Table 4.05, year after year the EC has had the lowest portion of children who are born in facilities, often leaving mothers to give birth without any trained birth attendant. While in the United States, fewer than 1% of babies are born while women are trying to get to medical facilities, in the EC that number is upwards of 7-10%, while many others never actually try.84 Problems with emergency health services are a key factor.

“Mothers here in the rural areas are lucky if they can get a kombi [shared taxi van] out at the main

79 Baby stillborn after 40-hour wait for help 2003; Eastern Province Herald 2004; Call for probe into 6-hour ambulance wait 2004.
80 Wang et al. 2014.
81 South Africa Every Death Counts Writing Group 2008.
82 Massyn et al. 2014; Udjo and Lalthapersad-Pillay 2014.
83 South Africa Every Death Counts Writing Group 2008.
84 Alabi et al. 2015.
road,” noted one interview respondent. “But if you can’t walk the long distance to the main road, or it’s nighttime, or there’s just no one coming, then you have to hire a private car—which means asking all your neighbors to borrow. Most people just don’t go.”

Table 4.05: Births in facilities (%)

<table>
<thead>
<tr>
<th>Province</th>
<th>2002</th>
<th>2006</th>
<th>2010</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>58.4</td>
<td>68.4</td>
<td>66.2</td>
<td>78.6</td>
</tr>
<tr>
<td>North West</td>
<td>59.4</td>
<td>70.5</td>
<td>69.1</td>
<td>74.4</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>60.5</td>
<td>84.9</td>
<td>73.9</td>
<td>80.4</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>62.2</td>
<td>74.0</td>
<td>73.5</td>
<td>81.7</td>
</tr>
<tr>
<td>Western Cape</td>
<td>65.0</td>
<td>88.2</td>
<td>84.1</td>
<td>88.1</td>
</tr>
<tr>
<td>Free State</td>
<td>65.6</td>
<td>73.4</td>
<td>89.6</td>
<td>86.3</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>67.4</td>
<td>81.3</td>
<td>86.2</td>
<td>88.2</td>
</tr>
<tr>
<td>Gauteng</td>
<td>70.1</td>
<td>98.0</td>
<td>94.4</td>
<td>95.6</td>
</tr>
<tr>
<td>Limpopo</td>
<td>71.2</td>
<td>89.5</td>
<td>85.6</td>
<td>91.6</td>
</tr>
</tbody>
</table>

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

Strikingly, studies have linked lack of transportation to health facilities and between facilities (when a higher level of care is needed) to up to one-quarter of deaths and severe complications related to birth for both mother and baby. This results not only in death and injury, but also in HIV transmission—which is almost entirely preventable during birth, but only with HIV testing and timely administration of antiviral drugs by a clinician. With HIV and related TB, still the leading killer in South Africa, millions of women giving birth are HIV positive.

While those in childbirth are among the most obvious, many others need transport. Emergency transport is critical for the elderly and for the young—with many stories of infants and young children dying waiting for an ambulance because their parents had no way to get them to a hospital. Meanwhile, “planned patient transport” (PPT) 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.

“In this wheelchair, there is no way for me to get to the main road,” shared one respondent whose

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85 Interview SA-23.
86 Department of Health 2015.
87 Velaphi et al. 2011.
88 Statistics South Africa 2016.
hilltop home was only accessible by vehicles with four-wheel drive. “When I got TB, I know I was supposed to go regularly to the clinic. They said if I didn’t, I could develop resistance, but how do I do that?”

Healthcare for many is inaccessible for practical purposes.

Equally important is the economic toll of the lack of EMS. An analysis done by 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 their main source of income—grants that usually run about 1,200 rand per month (about $100). Incomes for many workers are not much more. In this context, an emergency requiring a taxi that often costs 700-800 rand (about US$66) means spending as much as 50% of household income, at the expense of other needs like food and shelter that also impact health. Disability, chronic illness, or repeated emergency needs means medical transport costs push people into debt, building on the cycle of social determinants that connect income, inequality, and poor health.

Limits to the Pressures of Democracy for Policy Change

“We have been talking with those seeking to be elected or who have been elected. They always agree with us and say, ‘we need a clinic’ or ‘we need ambulances,’ but it never happens.” —Community leader Folokwe, Eastern Cape (Interview SA-24)

Over the past decade, there have been waves of pressure for change—marked at various points by the kind of “focusing” events described in the literature as opening the possibility for policy change. From headline-grabbing deaths and the resignation in protest of Dr. Trudy Thomas, the first post-Apartheid Member of the Executive Council (MEC) for health (equivalent to the provincial minister), to strikes by EMS workers over deplorable conditions, none of these

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98 Interview SA-30.
99 Goudge 2015.
100 South African Human Rights Commission 2015, 86.
101 Interview SA-26.
102 Shiffman and Sultana 2013 provide a health policy example of the concept of “focusing events” from Kingdon 2003.
potential “focusing events” have opened windows for the kinds of policy change needed. Instead, a strong, quickly-adapting policy monopoly has maintained several conditions: insufficient sustained investment for EMS in the province along with concentration of the investment that does occur in the major urban, formerly-white areas. A specific policy that ambulances must be based at public facilities with a certain level of infrastructure has been particularly pernicious—meaning communities with no clinic (and thus greatest need for transport) also have no ambulance, while formerly white communities that benefitted from an over-building of clinics under Apartheid have more than their share.

<table>
<thead>
<tr>
<th>Table 4.06: Advantaged vs. disadvantaged districts in the Eastern Cape</th>
<th>Sarah Baartman District</th>
<th>O.R. Tambo District</th>
</tr>
</thead>
<tbody>
<tr>
<td>People per ambulance</td>
<td>8,502</td>
<td>34,124</td>
</tr>
<tr>
<td>People per district hospital</td>
<td>45,058</td>
<td>151,660</td>
</tr>
<tr>
<td>% Population white &amp; colored</td>
<td>45.9%</td>
<td>0.7%</td>
</tr>
<tr>
<td>% Population Black</td>
<td>53.3%</td>
<td>99%</td>
</tr>
<tr>
<td>% of households with piped water</td>
<td>79%</td>
<td>39%</td>
</tr>
</tbody>
</table>


A set of overlapping groups has helped prop up the policy status quo: risk-averse bureaucrats, whiter/wealthier communities, politicians supported by patronage, and self-interested public and private sector actor-supported stability of policy that has thoroughly failed rural, Black South Africans. The relative power of residents of Port Elizabeth, East London, and similar areas keeps some level of ambulance services there (albeit of questionable quality at times) at the expense of expansion to the former Transkei and Ciskei. “Advantaged communities are actually very afraid of losing services, so powerful politicians in this province would call up DOH at the first sign of rationalizing services,” one official reported. A comparison of two districts in the province illustrates the disparities: as table 4.06 shows, there were four and a half times as many people per

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94 ECDoH 2007; Medical strike stalls SOS line 2012; Eastern Cape EMS wildcat strike could be over by next week 2012; Thomas 2013.
96 Interviews SA-6, SA21, SA38; and see Integrated Support Team 2009; Colm et al. 2004.
97 Interview SA-29.
ambulance in the O.R. Tambo district, formerly part of the Transkei, than in the richer and significantly more white and colored district municipality of Sarah Baartman, which surrounds Port Elizabeth. It is notable that these are based on the total number of ambulances, but the South African Human Rights Commission (HRC) found that serious mismanagement resulted in 30-40% being out of service for various reasons. Nonetheless, the EC Department of Health (ECDoH) has, at least in theory, posted sufficient ambulances to the wealthier, whiter district to meet the national standard of 1 per 10,000, while they are far from that level in O.R. Tambo.

African National Congress (ANC) powerbrokers have used the EMS as patronage jobs to secure voting blocs—meaning, here, electoral pressures actually fomented club goods. Others seem to have simply believed reform was nearly impossible and focused on simply concealing the effects to avoid the ANC being blamed. Owners of private ambulance services had close ties to ANC political leaders and benefited from fallback business from both individuals and public-sector hospitals when EMS was unavailable. There is also some evidence of officials receiving kickbacks from contractors who did not adequately perform. Meanwhile, even capable and honest civil servants were nonetheless highly risk averse—finding that inaction was less likely to upset the balance of power and that justifying the status quo was good for their professional lives. “It was, of course, always easier to just continue what had always been done—pay the doctors in the high-level hospitals and don’t worry when there’s no money left to expand EMS or other services,” a relatively new official reported of his predecessors. All of this was exacerbated by exit to private care among the wealthy and upper-middle classes, meaning many of the decision-makers are not reliant on public sector ambulances.

Responsible actors have justified the current state of affairs as the unavoidable effects of Apartheid—claiming the moral high ground for the ANC as the party of liberation, working at “transformation” as quickly as possible under difficult circumstances. “They just say: we are the party of Mandela and ‘a better life for all.’ These are troublemakers spreading lies,” reported one

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98 Interview SA-6.
99 Interview SA-17, Colm et al. 2004.
100 Interview SA-27.
activist. Officials also pointed to limited resources—both financial and human—as a powerful reason for inaction, with petty corruption and poorly trained staff difficult to change quickly. “They told us they couldn’t put ambulances in Xhora Mouth because there were bad roads, which was a problem for [Department of] Roads and Transport. There was no secure place to park it because the community was poor and there was no infrastructure. Meanwhile, they could not hire competent workers from the communities to drive or to answer emergency calls because education is bad in the area,” reported one health activist from the EC. This idea, or “policy image” in Baumgartner and Jones’ terminology, was powerful—it allowed ECDoH to portray its funding decisions and their outcomes as reasonable, passing blame to other departments, to national government, and to the former regime. Like any powerful idea, this has elements of truth to it: funding was insufficient, and fixing the EMS problem was multidimensional. Yet outside experts, former leading national health officials, and others all expressed the same consensus in interviews: getting ambulances to Xhora Mouth and the rest of the province was possible and urgent.

Looking over two decades, it becomes clear that failure to coordinate on policy for change, both intentional and negligent, prevented doing so.

Electoral pressures that should incentivize change have largely failed to achieve serious policy change in the Eastern Cape for a variety of reasons. A set of ANC leaders has been part of supporting outsourcing of EMS services, defending insufficient budgeting for EMS, and covering up mismanagement and under-spending of existing resources. The ANC 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. Opposition parties have controlled some municipal governments since 2000 and, beginning in the 2004 election, the ANC began to drop below 50% in substantial areas of the province but maintained pluralities in multi-party elections, losing several districts in subsequent elections in 2009, 2014, and 2016. Opposition parties including the Democratic Alliance, United Democratic Movement, Economic

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101 Interview SA-21.
102 Interview SA 26.
103 Interview SA-6, SA-53, SAS-57, SA-5, SA-7. And see Meents and Boyles 2010; Where there are no ambulances 2015.
Freedom Fighters, and Congress of the People hold a significant minority bloc of seats in the provincial legislature, and the opposition regularly highlighted the failures of EMS and the broader health system in their drive get votes. Some might misinterpret ANC electoral success as evidence of limited electoral competition, but South Africa’s proportional representation electoral system has ensured vote-seeking is aggressive, as the ANC competes strongly for votes to offset other regions of electoral weakness. Meanwhile, information has been widely available—both information for voters and information to government about the performance of the system. A series of high-profile newspaper stories in the province has revealed health system failures and, in particular, the collapse and inaccessibility of EMS—with headline-grabbing stories of babies, mothers, and elders dying while waiting for an ambulance. A documentary film about the shocking state of public ambulances aired on local television. A Human Rights Watch report brought international attention, documenting failures of ambulances and inter-facility transport leading to deaths among mothers and children. And a respected journal published reports on how a many-hours wait was both common and directly linked to avoidable perinatal death. Some legislators responded with grandstanding and the sharing of informational reports of their own—but seemed unwilling or unable to change things. 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 EMS that ECDoH seemed incapable of filling, but changes failed to materialize.

In one particularly notable episode, an award-winning 2007 investigation by the Daily Dispatch showed how public emergency services and maternal health linked to Frere Hospital were all but collapsing—revealing negligence, staff shortages, incompetence, and lack of equipment; even

104 Zille 2009; Waters 2008; Government wins battle for cheaper AIDS drugs 2012; Cope calls for national intervention in key Eastern Cape departments 2012.

105 Colomer 2016, 440–51. Perhaps the best illustration of this is a visit by the full ANC leadership led by Pres. Zuma in July 2015 aimed at shoring up its base.


107 EMS Blues 2009.

108 Odhiambo 2011.

109 Meents and Boyles 2010.

110 Report of the Standing Committee on Health ‘to investigate the general state of hospitals in the province,’ 18 Sept, 2001

a case of a cleaning worker delivering a baby.\textsuperscript{112} The national Deputy Minister of Health Nozizwe Madlala-Routledge responded by visiting and declaring the situation a “national emergency,” calling for change.\textsuperscript{113} She went in part because of stories of pregnant women dying while waiting for ambulances to get to the clinic—and also because she heard that the MEC for health was actually part owner in an ambulance service and she worried about the political ramifications (a story later substantiated this).\textsuperscript{114} But instead of change, the provincial MEC for health accused her of lying, and national Minister of Health Manto Tshabalala-Msimang used that as a convenient excuse to get rid of her deputy, with whom she had clashed on HIV.

Throughout this period and beyond, there were multiple attempts to use the levers of democracy to address the issues. Advocacy group Public Service Accountability Monitor (PSAM) issued a damning report in 2004 on the Eastern Cape DoH’s accounting and spending practices.\textsuperscript{115} Describing what they called the “Emergency Medical Services Fiasco,” they revealed that 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, and 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 change was short-lived, and PSAM and other civil society groups largely found themselves frozen out of decision-making.\textsuperscript{116} EMS workers went on strike at least twice in the post-Apartheid period because of working conditions, without significant effect. There was even a march to the provincial parliament in Bhisho. Yet for years, there were no meetings between organized civil society and ECDoH officials.\textsuperscript{117} Most importantly, service delivery did not improve.

Even when the national government was clearly aware of the problems, change was largely blocked by the power of local elites in the broader ANC structures. A confidential internal report

\textsuperscript{112} Why Frere’s Babies Die 2007.
\textsuperscript{113} Chambers 2007.
\textsuperscript{114} Interview SA-7.
\textsuperscript{115} Colm et al. 2004.
\textsuperscript{116} Interview SA-17.
\textsuperscript{117} Interview SA-21, SA-38.
commissioned by national Minister of Health Barbara Hogan in 2009 found that “On the basis of
the norm of one ambulance per 10,000 population, the province should have a fleet of 700 vehicles.
In fact, there are only 180 available.” The report found that contracts for ambulances were
inappropriately negotiated and both far too expensive and failing to deliver services. In 2010, the
new national Minister of Health Aaron Motsoaledi responded to advocacy by groups by appointing
Dr. Siva Pillay as Superintendent-General of the ECDoH with a reform mandate that included EMS.
He fired the entire regional leadership of the ambulance service, along with 1,284 other staff, and
began to reorient the department. But powerbrokers in the Eastern Cape clashed overtly with him—
including leaders in the provincial ANC who were critical national players in the party and its
electoral strategy. He was quickly pushed out, despite the Minister of Health’s strong backing.

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 under-
spending 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, it is clear that the planned
expenditures were far too insufficient to reach even the basic levels of EMS services of 1 ambulance
per 10,000 people. The department essentially planned to fail—leasing some ambulances, claiming
other ambulances were on the way, procuring ambulances without four-wheel-drive 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 continued.

118 Integrated Support Team 2009, 94.
119 Interviews SA-38, SA-21, SA-06.
121 Treatment Action Campaign and SECTION27 2013.
Mobilizing the Right to Health

“The testimony was very moving. I mean, I sat there listening to the testimonies and the pain that people were going through; it was actually very—was very kind of intense… I felt that I was there responding to the communities as an accountable officer.” —Senior Official, Eastern Cape Department of Health (Interview SA-29)

“The Human Rights Commission was helpful because it called Department of Health but it also called Treasury, it called Department of Transport, it called others to come and account. When we went for the budget bid this year, we then had to be saying how we will actually implement… this we have known was important for quite some time but maybe we couldn’t make happen with all the political players.” —Senior Official, Eastern Cape Department of Health (Interview SA-27)

Beginning in 2012, a set of actors began mobilizing the health rights framework in a much more substantive way. Rights bodies had previously taken note of the failures of the EC health systems and had written reports. But in 2012, things changed, as legal aid organization SECTION27 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 AIDS treatment clinic in the country set up by MSF (Doctors Without Borders)—profiled in a widely read book by Johnny Steinberg. The ECDoH decided to stop paying its relatively low rent for the building that housed the clinic, for reasons that are still not clear, and instead moved it into a large tent in an open field. Because of connections with MSF, the Treatment Action Campaign, and SECTION27, 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 itself is a notable case of rights mobilization dealt with in Chapter 4, but I raise it here because by 2012 there was a significant “support structure” that had already successfully mobilized the legal complex for health policy change on a small level. Shifting focus to the EMS problem, the rights-based groups joined together with health workers’ unions and some

123 Steinberg 2008.
older anti-Apartheid era groups to create a new coalition—the Eastern Cape Health Crisis Action Coalition (ECHCAC). The rights frame helped structure this coalition, bringing in Black Sash, for example—a women’s anti-Apartheid and human rights group that was not largely involved in health policy. The coalition began by writing a series of letters to provincial health leaders—which at first went unanswered. After litigation began, responses were quick in coming.

On March 12, 2013, the Eastern Cape Provincial Office of the Human Rights Commission received a complaint from the Nqileni Village community in Xhora Mouth. Xhora Mouth is a rural community with high rates of TB from its dependence on migrant mining labor—and where the nearest clinic is a two-and-a-half-hour walk, involving at least one river-crossing via boat. 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 health—and emergency healthcare in particular—as a basic right, which was denied their community, where there were no ambulances or planned patient transport. The local HRC conducted an investigation and substantiated the claim—finding available ambulances, response times, essential equipment, staffing, and ability to navigate rugged rural terrain were all lacking. A few months later, the ECHCAC 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.124

Highlighting this issue in their report, legal aid group SECTION27 had begun to compile a founding affidavit 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 material to push the Human Rights Commission national office to take the complaint up as a critical set of questions for the HRC’s mission. The commission, with prodding from the ECHCAC groups, agreed to conduct a series of consultations with communities to gather more and more evidence on the failure of the EMS.

124 Treatment Action Campaign and SECTION27 2013.
After an initial request for information went unanswered by the ECDoH, the HRC subpoenaed a series of documents from the department relating to the size of the ambulance fleet, plans to increase the size, the state of ambulances, response times, and under-spending of the emergency medical services budget.\textsuperscript{125} The response of the ECDoH provided highly unsatisfactory and contradictory information, while claiming that this issue was not appropriate for rights-based inquiry.

In response, the HRC launched hearings. In addition to two commissioners from the HRC—Deputy Chairperson Pregs Govender and Commissioner Bokankatla Malatji—Dr. Prinitha Pillay, a former MSF doctor working for the Rural Health Advocacy Project, was appointed to provide expertise on the subject, since neither commissioner was fully conversant in rural health systems.\textsuperscript{126} The HRC asked the ECHCAC to identify four communities where they could gather testimony. Lusikisiki, Xhora Mouth, Chintsa East, and Hamburg were chosen, each of which then elected a representative to attend the formal hearing.

Even before the hearing formally occurred, very significant bargaining had begun, as the ECHCAC groups made it clear they would work with SECTION27 to consider a lawsuit on EMS and support the HRC process. As a result, ECHCAC groups were finally granted meetings around this time with local officials—meeting once with the MEC and twice with the superintendent-general in 2013/14. They demanded increased spending on EMS and coverage in rural areas.\textsuperscript{127} Under pressure and attention, the EC government revised its EMS budget for 2013/14 upward to R812m. In November 2014, as preparations were getting under way for the hearing, supplemental funding was again made available for the EMS service—R83.4 million; R62 million of which was allocated for leasing ambulances in order to increase the size of the current fleet, and R21.3 million to fund the employment of additional staff.\textsuperscript{128} Health expenditure on EMS had been hovering around 4% of total provincial health spending for many years. Figure 4.3 below shows that trend

\textsuperscript{125} South African Human Rights Commission 2015, 20.
\textsuperscript{126} Interviews SA-22, SA-23.
\textsuperscript{127} Interview SA-20.
\textsuperscript{128} South African Human Rights Commission 2015, 43.
was broken beginning in 2013/14—with EMS taking a notable increase in its share of EC health expenditures, inside a total budget that itself increased.129

At the hearing, 200 people were in attendance. The ECHCAC bused in 20 people from each of the communities, while the Treatment Action Campaign brought out their members from the urban communities. The subpoena is a critical power held by the HRC—an institutional tool enabling them to compel government to appear. When Treasury did not show up on the first day of the hearing to join representatives of Health, Planning and Roads & Transport, the threat of a subpoena quickly encouraged them to send a representative. By convening all the parties, the Commission changed the accountability dynamic that had previously existed, in which each department blamed the others 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, it uncovered critical details—that ECDoH had regularly failed to spend its limited EMS budget and that, contrary to the official narrative, current plans did not put the ECDoH on track to meet even its own targeted number of ambulances. During the two-day-long hearing, government officials who had been reluctant to meet with civil society groups were compelled not only to present reports and data, but also had to listen to the community 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. Here 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’ in some of the provinces thwarting the orders from national government and courts, so this was critical.”130

130 Interview SA 17.
This also empowered change-agents *inside* the ECDoH. As illustrated in the quote that opened this section, some ECDoH officials—including a few brought in specifically to fix the problems raised by the HRC complaint—found they now had winning arguments.131 Where previous efforts to increase and shift the budget, add EMS staff, and buy ambulances that could actually reach rural areas were blocked in either DoH or Treasury, they now gained new traction.

**Policy change outcomes**

The outcomes of this case will continue to roll out over the coming years, but several outcomes can be observed. The first is increased resources for the EMS—which took a distinct jump following rights mobilization, hitting its highest level since apartheid in both total rand and portion of health expenditures in 2015/16. It will reportedly rise again this year. In addition, recent years have seen significant under-spending—especially on planned patient transport. For the first time in recent years, EMS is on track to have zero or close to zero under-spending.

In addition, the ECDoH reports additional shifts: procuring 141 new four-wheel-drive capable ambulances and creating a new policy on response time that explicitly sets the target as fifteen minutes in urban areas and forty-five minutes in rural areas.132

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131 Interview SA-27, 29.
132 Interviews SA-27, SA-29.
At a national level, the national Department of Health has moved to regulate ambulances—long neglected, despite clear direction in the Health Act of 2003. While the first draft focused largely on the private sector, after extensive comments and lobbying from ECHCAC groups, the promulgated regulations deal with public sector delivery and speak directly to the EC example.

Finally, it is notable that a new MEC for health took office in 15 and hired a new EMS director. For the first time ever, the ECDoH superintendent-general and the director of EMS visited Xhora Mouth in 2015 and met with residents to hear more about their concerns.

Most importantly, perhaps, Xhora Mouth now has an ambulance stationed much closer. At least three times since the hearing, an ambulance has been called and has shown up to ferry patients to hospital. It has taken far longer than the promised 45 minutes, and most people are still quite wary of trusting the ambulance will show up for life-or-death moments, but there is clear progress. In October, officials report, there will be a new four-wheel-drive ambulance based in the parking lot of the organization that helped residents file a human rights complaint.\(^{133}\)

\(^{133}\) Interviews SA-28, SA-29.
Figure 4.4: Leaders from Xhora Mouth and surrounding villages meet with the head of the EMS in Bisho, 2015. Figure 4.5: The new ambulance parked near Xhora mouth, 2016.
4.3: HIV/AIDS AND THE POLITICS OF LITIGATION

“We do have a constitution. It has its own limits. But that constitution is the most important thing. We have a constitution that guarantees the right to health. Without that I think we would be in a different state” –Treatment Action Campaign Leader living with HIV (Interview SA-43)

“I think the Right to Health is the indispensable start, it gets things moving that otherwise might not. I’m not sure how it matters after that but it does open things up to where we can take a look and see…” –Justice, Constitutional Court of South Africa (Interview SA-03)

“I think people began to take note of what the constitution means in the context of health policy implementation… at the beginning it was all about [Mbeki] asserting his authority and closing the question on AIDS, but in the end South Africa is a country with a right to health clause and that was what caused it to tip toward what people needed even against his authority, if I may put it that way.” –Former Senior Health Official (Interview SA-07)

We turn now to a case that contrasts in many ways with that of the EMS in the Eastern Cape. Perhaps the most internationally known case of the constitutionalization of health lies in the high-profile fight over AIDS treatment in South Africa—an example that pitted activists and the Constitutional Court against the country’s President and Minister of Health. Where the Eastern Cape example illustrates the possibility of rights mobilization through quasi-judicial bodies to affect the health of the rural poor, in a case that has garnered little notice outside South Africa, the AIDS treatment struggle played out on a global stage. Drawing the attention of heads of state and media throughout the world, legal scholars have both celebrated and critiqued the case. Kapczynski and Berger call it “one of the most celebrated human rights cases in the world,”134 and Bilschitz notes it “demonstrates that socio-economic rights can offer important protections to the vulnerable against unreasonable government policies,” even as he worried at the time, that it “may well amount to very little” because the court lacked an enforcement mechanism.135 The EMS and AIDS treatment cases, different as they are in scale, follow a similar path in which policy change was blocked by monopolies that were ultimately only disrupted by health rights mobilization that changed the

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134 Kapczynski and Berger 2009, 46.
135 Bilschitz 2003b, 1, 25.
actors, interests, and ideas at play. Together these contrasting cases illustrate well how constitutionalization effects policymaking.

In 1996 scientists at the International AIDS Conference in Vancouver announced definitive evidence that combination therapy with antiretrovirals (ARVs) was effective against HIV. Brazil announced it would begin public distribution of ARVs to those living with HIV immediately that year. Yet in South Africa—despite a similar economic, social, health and political context—it would take years before ARV roll out began. A conservative estimate found that failure to implement an even minimally effective program resulted in 3.8 million “person-years” lost over 5 years. That policy decision, however, was reversed, and today South Africa has the world’s largest ARV treatment program and one of the most progressive policy frameworks for the use of antiretroviral medicines to prevent HIV transmission. This turn around happened not because of a change of heart among officials, a breakthrough in scientific evidence, a change of government or officials in charge of health, or successful international pressure; the turning point came because of the institutional opportunity structure created by the constitutionalization of health, which enabled organized activists and human rights lawyers to destabilize the closed policymaking system on AIDS treatment and secure sufficient political power to override the persistent will of the President and Minister of Health.

The Early Political Challenges of AIDS in South Africa

In 1982, AIDS claimed its first two South African lives while the country was deep in the control of the Apartheid regime. While the government in the 1980s took some basic steps to address HIV, including securing the blood supply, the Apartheid government lacked both the will and the credibility to effectively address HIV. The real force of the epidemic, however, became clear at the same time the transition to democracy began. In 1990, the first national surveys of women attending antenatal clinics found an HIV prevalence of 0.8%. A year later the rate had doubled to

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See Lieberman 2009, Chapter 4 for a remarkable comparison of the two countries including similar economic power, complicated federal politics, comparatively strong public health systems facing strong pressures to expand/change, and an epidemic that was actually larger in Brazil in 1990.

Chigwedere et al. 2008.

UNAIDS 2016; Registrar of Medicines 2015.
1.5% and it became abundantly clear that South Africa was in the early stages of a rapidly growing
HIV epidemic.¹³⁹

For a time, it seemed AIDS might be a health issue that could be effectively tackled by a
new, pro-active democratic government. Returning from exile in countries that were already well
in the throes of HIV epidemics, ANC leaders were well aware of the potential crisis. The Health
Secretariat began discussions on a plan before the ANC was unbanned and, in 1990, met in Maputo
at a conference with representatives of the internal struggle which produced a statement on the
urgent priority of addressing the disease.¹⁴⁰ Two years later, in a rare show of unity, the ANC and
the Apartheid government together hosted a conference inside the country and began crafting a
strategy to address AIDS before a date had even been agreed for elections. They launched NACOSA
(the National AIDS Committee of South Africa), an umbrella body meant to coordinate the AIDS
response, which created the AIDS Plan—a two-year strategy that was lauded both in the country
and internationally for its progressive and comprehensive approach.¹⁴¹ It is worth noting that two
of the eight members of the drafting team would go on to become health ministers in the new South
African government: Dr. Nkosazana Dlamini-Zuma and Dr. Manto Tshabalala-Msimang.¹⁴²

The government that came to power in 1994 brought not only a strong plan but a clear
picture of what inaction would look like. Their health manifesto showed this clarity:

“HIV/AIDS is emerging as a major public health problem, with over 2,000 reported
cases at the end of 1993, and 500,000 people infected with HIV. Forecasts to the
year 2000 predict that there will be between 4 and 7 million HIV-positive cases,
with about 60% of total deaths due to AIDS, if HIV prevention and control
measures remain unaddressed. Similarly, credible predictions indicate that by the
year 2005, between 18% and 24% of the adult population will be infected with HIV,
that the cumulative death toll will be 2.3 million, and that there will be about 1.5
million AIDS orphans.”¹⁴³

This worst-case projection is a chillingly accurate picture of what came to pass over the

¹³⁹ Schneider and Stein 2001.
¹⁴¹ Fourie 2006, 106.
following decade, at the end of which roughly 2.4 million people had died of AIDS.\textsuperscript{144} How did this happen?

Despite an initially promising start, the Mandela government stumbled quite dramatically in implementation. The AIDS Plan, adopted as one of the first steps of the government of national unity, designated AIDS as a “presidential lead project” giving it access to preferential funds. Unfortunately, in practice implementation was left almost entirely to the newly formed Department of Health under the leadership of Nkosazana Dlamini-Zuma, which was also at the time laboring to create a single bureaucracy from the fractured and under-resourced structures left by the previous government. This sapped both energy and resources from the AIDS plan that had been designed as a multi-sectoral effort. Unfortunately, the government also engaged in a series of “disastrous high profile ‘quick fix’ solutions.”\textsuperscript{145} First the Department of Health commissioned a stage sequel to the popular anti-Apartheid film called Sarafina II meant to spread anti-AIDS messaging. The 14 million rand effort was a complete failure—the tender process was violated resulting in accusations of mismanagement of funds, the script was widely panned, and the project was scrapped.\textsuperscript{146} This was followed shortly thereafter by statement from a cabinet meeting announcing the development of Virodene P058—a new South African-created treatment for HIV that was immediately decried by other experts.\textsuperscript{147} The Medicines Control Council (MCC) found out only after the announcement and promptly banned further testing of the substance, which over the course of a year-long scandal was revealed to be an industrial solvent, dimethylformanide, which had no impact on HIV.\textsuperscript{148}

These early missteps not only undermined progress against HIV and cast the government response in a very poor light, but it set up a dynamic that would continue—pitting activists and NGOs who publicly spoke out about the poorly-managed response against an increasingly defensive government.

\textsuperscript{144} Cumulative death toll was approximately 2.4 million people by 2005 (based on calculations from UNAIDS 1998; Chigwedere et al. 2008). 5.5 million people were living with HIV and the prevalence rate estimated between 16.8-20.7% (UNAIDS 2006).
\textsuperscript{145} Nattrass 2004, 44.
\textsuperscript{146} Schneider and Stein 2001, 727.
\textsuperscript{147} McNeil 1997.
\textsuperscript{148} Myburgh 2009.
Political leadership also did not appear as it had been hoped and expected. Nelson Mandela, consumed by the vast demands on his time, did not place AIDS high on the political agenda of his government—delegating to his deputies F.W. De Klerk and Thabo Mbeki who brought neither his power nor charisma.\textsuperscript{149} Mandela first spoke about AIDS in 1997 at the World Economic Forum in a powerful speech that was unfortunately not repeated inside South Africa. Indeed, one particularly harsh assessment suggests that “measured minute by minute, during his presidency, Mandela probably spent more time with the Spice Girls and Michael Jackson than he did raising the AIDS issue with the South African public.”\textsuperscript{150}

While leadership has been a central factor in the AIDS response, structural factors undergirded the broader challenges and magnified the importance of leaders’ (in)actions. There was a broad “institutional logjam” in reorienting the South African public service from the goals of control, constraint, and regulation towards new social goals.\textsuperscript{151} The AIDS Plan envisioned a strong central policymaking and coordination role, but under the quasi-federal system of South Africa’s new constitutional structure, it was the provinces that were meant to actually execute the program and the complexity of competing authorities and conflicting roles was very significant. Provinces allocated the centrally-distributed funding as they saw fit, resulting in major differences in the prioritization of HIV—ranging from just R2.5 million in one province to as much as R55 million in another in the 1998/99 fiscal year.\textsuperscript{152} Meanwhile, a system of “sunset clauses” kept civil servants in their jobs and bureaucracies largely in place, including both Apartheid officials and divisive Bantustan authorities, meaning that there was little innovation, accountability, or bottom-up pressure to address the AIDS pandemic.

The growing crisis in South African AIDS policy might well have righted itself with either strong political leadership or a public health system bureaucracy with unified commitment and capacity. Lacking the latter, however, the problems in Pretoria were amplified with few political openings to address them.

\textsuperscript{149} Cameron 2005, 124–6.
\textsuperscript{150} \{Citation\}
\textsuperscript{151} Schneider and Stein 2001, 726.
\textsuperscript{152} Marais 2000, 17.
Failure in the Era of ARV Treatment—Rise of a Policy Monopoly

A few months after the ANC was elected, results from a study were published in the *New England Journal of Medicine* showing that the use of the drug AZT could drastically cut the transmission of HIV from mother to child and, within a few years, new medicines and dosages made prevention of mother-to-child transmission (PMTCT) possible on a wide scale, including in the global South. In 1997 scientists announced a breakthrough at the International AIDS Conference in Vancouver—that a combination of highly active antiretroviral drugs could reverse the course of AIDS—bringing people back from edge of death. It was also quickly evident that ARVs not only halted death but also the transmission of HIV in adults. In the U.S. AIDS deaths plummeted. The treatment era had begun.

By this time, AIDS policy in South Africa was becoming the province of an increasingly small, insulated, and technocratic group. After the collapse of the Government of National Unity, government health policy became increasingly centralized. Following the Virodene scandal, independent bodies like the MCC and Medical Research Council were restructured under the control of the Department of Health. Minister Dlamini-Zuma had a tense relationship with both civil society groups and with the clinicians who were realizing the epidemic was growing out of control after the early AIDS program missteps.

When the Minister announced in October 1998 that the government would not be making AZT available for PMTCT and that all previously-planned pilot projects would be stopped, many were caught off guard. Her argument that government could not afford the cost of a PMTCT program were especially puzzling in the face of work by prominent South African researchers showing the costs were more than offset by reduced pediatric HIV cases. What many hoped would be a short delay quickly hardened into a government position that using ARVs for PMTCT

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154 ARVs, by suppressing the HIV virus, reduce the likelihood of transmission. This was obvious early in PMTCT programs, but the exact level of effect on transmission in sexual and intravenous transmission was controversial for many years, with competing recommendations about how thoroughly to rely on ARVs (in place of condoms, for example, in discordant couples). It is now evident the prevention benefit is as good as that of condoms—with almost no linked transmissions in a series of large randomized trials. Cohen et al. 2011; Rodger et al. 2016.
was too expensive and, in Dlamini-Zuma’s words, “will have a limited effect on the epidemic.”

Thabo Mbeki became President in 1999 and, when Dlamini-Zuma was redeployed to the foreign ministry, there was some optimism for renewed leadership under Mbeki, who had shown engagement in the AIDS fight. He appointed Manto Tshabalala-Msimang minister, who made an early trip to Uganda to see their PMTCT program and announced she was looking into securing a sustainable supply of AZT.157

“Dr. Tshabalala-Msimang, as a feminist, had been among those fighting for people’s rights to health. And Thabo Mbeki when he was Deputy President seemed focused on the importance of addressing [HIV].” –Former Senior ANC Leader (Interview SA-5)

This optimism was quickly dashed, however, when the President made a speech before the National Council of Provinces in which he suggested AZT was unsafe. Despite the drug being on the World Health Organization’s essential drug list and having passed both the US FDA and South African MCC approval process, Mbeki instead called on leaders to consult the “huge volume of literature on this matter available on the Internet.”158 The President had been introduced to the work of widely-discredited AIDS dissidents by several people in his orbit and had apparently read widely from a network of websites that argued that HIV is a harmless passenger virus and that poverty and ARVs themselves were the real source of AIDS mortality.159 This fit, many have suggested, with Mbeki’s worldview that understood the role of Western science in colonialism and yearned for African solutions over dependence on the global North. In May 2000, while his peers in countries like Thailand and Botswana were preparing new HIV treatment programs, Mbeki instead launched a Presidential Panel to investigate the causes of AIDS, on which he included a group of widely discredited American dissident-scientists who denied the impact of HIV and the efficacy of ARVs. The Minister of Health quickly shifted her stance to opposing the rollout of treatment and over the coming years would espouse a variety of alternatives to using ARVs

157 Ibid., 168.
158 Mbeki 1999.
159 Sparks 2003, 283–95.
including vitamins, olive oil, garlic and African potatoes. While ARVs are powerful drugs with clear side effects—especially early on—their benefit had been clearly established by this time and in both the Global North and South they were used to spectacular effect to halt the wave of unchecked AIDS deaths.

The South African government not only missed its opportunity to be an early leader in HIV treatment but failed to introduce ARVs in the public sector for years after scientific and global political consensus had endorsed their use. Explaining this development includes a variety of factors. Some analysts focus on leadership and the personal role of Mbeki and Tshabalala-Msimang, who expended significant political capital to sustain their opposition to AIDS treatment. Nattrass labels Mbeki’s stance “denialism” and finds policy was driven by his stance that “resonated with him intellectually; and then for reasons relating to his personality, he refused to concede ground.” Parkhurst & Lush suggest that leadership made a critical difference in South African policy, comparing it to the process in Uganda. Lieberman argues against seeing Mbeki as autonomous from his political environment and argues that denialism in the South African administration was the product of the ANC’s need to elevate the social standing of Black South Africans amidst a racially charged epidemic. Others argue the failure was also driven structurally—that South Africa’s public and political institutions were predisposed to support the anti-treatment stance for instrumental reasons. The ideas driving this paradigm were important, but the mechanism was not irrationality of the President; instead, it was the ways that the limited capacity for change and inadequate human resources faced by the post-apartheid government inclined a variety of actors to disperse responsibility for the epidemic across many levels and avoid accountability through obfuscation. While accountability was diffused, power over policy was increasingly centralized within the Presidency under Mbeki, who restructured the executive from a cabinet jointly responsible to parliament to a presidency as the “ultimate adjudicator” with deputy ministers and
directors general responsible to the President and prominent officials in the Presidency playing the key role in coordinating policy across government.¹⁶⁵

AIDS treatment policy thus became the monopoly domain of a small group within the South African government and was largely resistant to change despite fierce challenge using each of the key levers of democracy. The centralization of power in the Presidency (even within the cabinet) and the power struggle between different levels of government exacerbated the influence of this group. Unlike most policy monopolies, this one existed at the apex of South African politics, rather than in the bureaucracy. It was nonetheless rooted in a technocratic politics that mobilized powerful ideas to deflect criticism and contain opposition. It left even those inside government who opposed the policy sidelined and powerless, as suggested by two former senior civil servants:

“Many of us were trapped. There were a number of the reasons that were being advanced that were legitimate concerns in government. … What was very difficult was trying to persuade people that those questions should never be justification not to, in a very managed, well-monitored way, to start doing something. But that was subject to real power and in the end people just used those arguments to argue nothing was to be done... there was no unanimity but we could not break through.” (Interview SA-06)

“I remember our DG coming back from one of the cabinet meetings very frustrated but angry that the statistics were being questioned. It was not informed by any real technical insight, or foresight... it was a political combination of things that could not be questioned.” (Interview SA-07)

There were two powerful main threads to the ideas driving the anti-treatment policy monopoly in South Africa—one political and one far more technocratic, both deployed quite successfully. The first might be labeled the “nationalist” or “anti-colonialist” political thread that weaves together narratives of racism, pharmaceutical-company greed, and a defense of African knowledge to challenge the use of antiretrovirals and instead focus attention on poverty and poor nutrition as the drivers of AIDS.¹⁶⁶ The history of colonial medicine in Africa and the support for Apartheid from the white medical establishment, including a move to self-segregation and the

¹⁶⁵ Giollabhui 2017.
¹⁶⁶ See Robins 2010, Ch 5 for a deeper analysis of this narrative, which he labels nationalist and communitarian, framing AIDS (accurately) as part of the legacies of apartheid and colonialism.
broad lack of responsibility taken for those actions, both undercut the credibility of scientists and encouraged an oppositional relationship with the ANC. The strong anti-colonial mission of the ANC was then relied on by anti-treatment camp to justify itself—casting proponents of ARVs as aligned with a racist conception set on pathologizing and medicalizing Africans. In a speech at Fort Hare in October 2000, Mbeki proclaimed:

“And thus does it happen that others who consider themselves to be our leaders take to the streets carrying their placards, to demand that because we [black people] are germ carriers and human beings of lower order that cannot subject its passions to reason, we must perforce adopt strange options, to save a depraved and disease people from perishing from self-inflicted disease… Convinced that we are but natural-born, promiscuous carriers of germs, unique in the world, they proclaim that our continent is doomed to an inevitable mortal end because of our unconquerable devotion to the sin of lust.”

A text circulated anonymously within the ANC in 2002, but was later credited to Mbeki and allies, called *Castro Hlongwane, Caravans, Cats, Geese, Foot & Mouth and Statistics: HIV/AIDS and the Struggle for the Humanisation of the African* that articulated this view at length. The long, twisting text interspersed quotes from Fanon’s critique of Western medicine with a challenge to the data on antiretroviral medicines, claiming they had killed presidential spokesman Parks Mankahlana who “died, vanquished by the anti-retroviral drugs he was wrongly persuaded to consume.”

Antiretrovirals were being pushed, it was claimed, for the benefit of multinational pharmaceutical companies and supporters had been duped into carrying the water for these outside influences. An ANC National Executive Committee Statement supporting the Presidential Panel claimed demand for ARVs “derives from cheap politicking or from benefits lavished by the lobby of powerful local and international interests.” The brash statement by Mbeki’s spokesman Parks Mankahlana put the motivation more clearly:

“The tragedy is that HIV/AIDS is not going to succumb to the machinations of the profiteering pharmaceutical companies and their propagandists. Like the marauders of the military industrial complex who propagated fear to increase their

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168 Mbeki and Mokaba 2002, 130.
profits, the profit takers who are benefiting from the scourge of HIV/AIDS will disappear to the affluent beaches of the world to enjoy wealth accumulated from a humankind ravaged by a dreaded disease.”

This anti-colonial, anti-pharmaceutical thread spoke powerfully to the ANC leadership at various levels, socialized in a revolutionary political struggle for freedom and cognizant of very real history of white efforts to control black reproduction and sexual health, including Apartheid government research into contraceptive methods to induce sterility in the African population and alleged attempts to spread HIV through a network of infected sex workers. The anti-treatment grouping around Mbeki mobilized race in a powerful way to draw a line between the origins of the epidemic and the scientists, activists, and politicians arrayed in opposition to the government’s stance.

Lieberman argues that the strong racial boundary institutions in South African society made this line of argument particularly resonant in the ANC and throughout society. This explains, in part, why this policy monopoly was so uniquely strong and able to mobilize a surprising degree of negative feedback that contained pro-treatment dissent by marking it as counter to the struggle for African freedom.

The second piece of the narrative was technocratic—what Nicoli Nattrass calls the “discourse of unaffordability” and “rhetoric of expertise.” From the earliest period when activists and medical clinicians began demanding national roll out of AZT to prevent mother to child transmission, government claimed it was unaffordable. “I have to look at the whole picture,” argued Minister Dlamini-Zuma in 1998. “If you have limited resources, you may decide to put your resources into preventing mothers getting infected in the first place. These are difficult issues we have to face.” This came despite evidence that the investment in PMTCT would save money overall. The rhetoric also continued even after the maker of AZT, Glaxo-Wellcome, agreed to

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169 Quoted in Wang 2008, 10.
170 Fassin and Schneider 2003. And see Wang 2008 for a discursive analysis and history on this broader anticolonial thread.
reduce the price by 75%. This discourse of unaffordability was powerful and continued to justify the government’s failure to roll out AIDS treatment for all people living with HIV. AIDS drugs were, of course, quite expensive—topping $10,000 per patient per year in wealthy countries, a price completely out of reach for the South African public sector. Other governments, however, responded quite differently. In Brazil, for example, an Institute of Medicine report notes that “In 1996, the Brazilian public health system began widespread and free provision of ARVs for all citizens… by 2001, public and private laboratories were manufacturing 63 percent of the ARVs available to Brazilians… seven of the 13 ARVs being used to treat Brazilians are domestically produced; others have been procured by the government on the international market through aggressive negotiation of prices.” The South African government did not pursue any of these strategies aggressively but continued to use affordability as a reason for inaction. Instead, it argued for an alternative path that focused on addressing poverty and encouraging nutrition in place of ARVs. Tshabalala-Msimang justified her advocacy for garlic, olive oil and African potatoes saying, “These things are affordable for South Africans, not like things like ARVs, which are not.”

As it became clear that public pressures were undercutting this argument, government shifted instead to focus on the challenges of making any intervention sustainable and on the complexity of crafting an effective HIV treatment program given the limits in technical expertise, human resources, and system capacity. “Managing AIDS is very complex. For instance, of South Africa’s 20,000 doctors, only 2,000 are actually able to manage HIV and AIDS properly in this country,” Tshabalala-Msimang said in defense of her department’s resistance to starting a treatment program.

Both the cost and the system preparedness were highly technical arguments—which were difficult, on their face, to dispute—enabling the deflection of debate and discouraging non-expert ANC leaders from engaging. Technical staff at the ministry was set to work to justify the policy using complex arguments and intentionally obfuscating presentation of data.
“You are trying to think of stuff to say that would convince someone that we as technocrats have got a very thought-through argument based on data from Home Affairs and on that basis, we can justify [the anti-treatment policy] (Interview SA-7)

Insofar as it was a technical debate between economists or health policy experts inside and outside government, the anti-treatment paradigm was highly effective at containing dissent. It was not until 2004, after a series of stinging court losses and eight years after the U.S., Brazil, and Thailand launched treatment programs, that ARVs began rolling out in the public sector. Even then, it was over the active objection of the Minister of Health. In the interim nearly 1,000 people were dying each day from AIDS.

Resisting Democratic Pressures

A basic premise behind the effect of democracy on health is that openness, freedoms, and electoral incentives will change policy either by changing the preferences of leaders or changing the leaders to those with different preferences. On AIDS policy at the end of the 1990s and early 2000s, neither happened despite significant, vocal, and powerful opposition to the anti-treatment stance.

Post-Apartheid democratic freedoms did provide a clear avenue for the free flow of information and evidence. News from the 1996 International AIDS Conference in Vancouver came quickly to South Africa through both media and leading South African Clinicians, who returned from the scientific conference with enthusiasm about what was possible. Registration of the new
“dramatically effective” AIDS drugs in the country generated headlines that year.\textsuperscript{178} As the government stance against treatment in the public sector became clear, expert voices were quickly and quite publicly heard offering a corrective—demonstrating both the science backing ARVs and the evidence of cost-effectiveness (and often cost savings) of implementing a program. “The government’s refusal to give AZT to pregnant women for the prevention of maternal-fetal HIV transmission flies in the face of evidence,” wrote William Malegapuru Makgoba, the first Black president of the Medical Research Council of South Africa. “To conflate causation with cofactors through a mixture of pseudoscientific statements is scientifically and politically dangerous,” he wrote, calling it “merely another entry in a lengthening list of politically driven decisions regarding the South African AIDS crisis.”\textsuperscript{179}

The 2000 International AIDS Conference was held in Durban, South Africa at the height of the controversy. In the lead up the co-chair of that conference, Professor Jerry Coovadia, very publicly laid out the case for ARVs and made a plea for President Mbeki to “leave the science to the scientists.”\textsuperscript{180} In a powerful symbolic move for post-Apartheid South Africa, Archbishop Ndungane, the head of the Anglican church, Bishop Dandala, the head of the Methodist church, High Court Judge Edwin Cameron, and Coovadia wrote together to Mbeki asking him to reconsider his stance. Mbeki was defiant. “I am taken aback by the determination of many people in our country to sacrifice all intellectual integrity to act as salespersons of the product of one pharmaceutical company,” he responded.\textsuperscript{181} The ministers of health, arts & culture, and minister in the president’s office responded together, calling Coovadia and colleagues “journeymen rather than geniuses,” who were simply seeking acceptance by global elites. Since they would not be satisfied with “anything short of provision of antiretrovirals in the public health system,” the ministers claimed they had to “draw a clear line between informed and responsible recommendations on therapeutic interventions by scientists and standing out as the frontline troops of the

\textsuperscript{178} Can we afford new Aids drugs? 1996.
\textsuperscript{179} Pseudoscience Can Damage Your Health 2000.
\textsuperscript{180} Bawa, Herwitz, and Coovadia 2000.
\textsuperscript{181} Mbeki digs in heels over HIV/Aids 2000.
pharmaceutical industry.” The AIDS conference drew 12,000 scientists, clinicians, media and people from NGOs from around the world to South Africa. Mbeki spoke at the conference but, despite hopes, he failed to support HIV treatment or renounce denialist views—focusing his remarks instead on the impact of poverty.

Doctors Without Borders (MSF in South Africa) made a powerful public statement by opening a set of clinics in Khayelitsha, the sprawling 500,000 person formerly-black township outside Cape Town in 2000. In May 2001, with the support of the local Western Cape provincial government then under opposition control, MSF began offering treatment to a handful of people with advanced HIV, publicly demonstrating the efficacy of ARVs—work that the ANC government dismissed. The Western Cape government had already undertaken a small-scale PMTCT program at this point—which the national government called politically motivated “playing games with the lives and hopes of vulnerable people.”

Dissention within the governing coalition was also significant. No less respected voices than Nelson Mandela appealed for a change of policy. Yet when Mandela addressed the National Executive Committee he was met with a “scathing attack” that suggested in the meeting and later in papers that Mandela was selling out to the pharmaceutical companies for money. Archbishop Desmond Tutu, the coordinating bodies of COSATU and the SACP, the premier of Gauteng (a key ANC leader), and the Anglican Church all made statements calling for speedy rollout of an ARV program without changing the government stance. In 2000, a (likely intentionally) leaked draft of an ANC health policy committee report called for an end to the anti-treatment and denialist stances of government, but dissent was quickly squashed. International pressures were also significant. Leaders from Bill Clinton and Bill Gates to Ban Ki Moon sought a change in approach. Over 5,000 people, including Nobel prizewinners and directors of leading research institutions around the world signed the “Durban Declaration” published in Nature.

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185 Mkhize 2016.
186 ANC takes Mbeki to task 2000.
187 The Durban Declaration 2000.
Mbeki’s driving economic vision of African renaissance—the New Partnership for Africa’s Development (NEPAD)—was overshadowed by his AIDS policies, government policy persisted. While Mbeki did personally “withdraw” from the public conversation on AIDS and AIDS treatment after receiving such significant blowback, what Cameron calls the “dead hand of denial” continued to drive government policy until it was eventually confronted by rights mobilization.

The media throughout this period played a strong role in exposing government hypocrisy and the impact of AIDS in South Africa. It also provided a vigorous space for debate and challenge to the anti-treatment stance. Tshabalala-Msimang was even directly challenged on live national radio after she refused to say whether she believed HIV caused AIDS.

At the end of 1998, the Treatment Action Campaign was launched by a group of ANC activists and people living with HIV. As described in greater depth below, the campaign engaged in a long-running activist campaign that included picketing the opening of Parliament in 1999 and 2000, high profile marches with tens of thousands and a series of civil disobedience efforts. The results were mixed, and I argue below these are best understood as part of a broader rights mobilization. But as one interviewee put it, “protests alone drew attention and made our demands clear, but government proved it could was willing to put up with them—it was not enough.”

Electoral incentives were insufficient to break the impasse. There was a significant opposition in South Africa throughout this period, but in the earliest years of AIDS the most important parties opposite the ANC—the Democratic Party and Inkatha Freedom Party—did little to make it a campaign issue. DeWaal and others have argued the 2004 election pushed Mbeki to shift his position. Toward the end of the election the Democratic Alliance and the broader “Coalition for Change” with IFP mounted significant attack on the ANC’s AIDS record—and could stand on their own records, having undertaken limited pro-treatment policies in the Western Cape and Kwa-Zulu Natal where the DA and IFP respectively had ruled for periods since the democratic

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189 Cameron 2003.
189 I will not apologise, vows John Robbie 2000.
191 Interview SA-41.
192 De Waal 2013, 42–45.
transition. The DA’s Tony Leon gave a speech declaring “Across the nation, the ANC has broken its promises on AIDS,” and Patricia de Lille of the Independent Democrats took a public HIV test and demanded Mbeki do the same, claiming “we are 10 years behind from the rest of the world in terms of fighting the AIDS pandemic and are still in denial.”193 These challenges came quite late in the process, however. As described below, after consistent resistance the ANC had already given in to demands and court orders and launched its operational plan to roll out ARVs. At best, electoral concerns may have encouraged the ANC to speed up the implementation; however, the ANC did not take the kinds of actions that would suggest electoral pressures were driving policy. Throughout the campaign, and for several years thereafter, Tshabalala-Msimang remained Minister of Health and continued to speak publicly against ARVs and in favor of nutrition as an alternative despite withering critique and mockery. Rather than rebranding its policy for an election year, government continued to fight ARV rollout up until the last moment to avoid further legal action well into 2004. While mentioned in vague terms, the ANC election manifesto showed little priority for HIV and Mbeki’s closely-watched State of the Nation address shortly before the 2004 election barely mentioned HIV.194

This likely reflected important calculations: first, there was a broad view that “the ANC was entrenched, [AIDS treatment policy] was not a real threat to their continued ruling.”195 Even many leading members of AIDS activist groups like the Treatment Action Campaign were ANC members and the leading opposition, DA, was seen at the time as a largely white party unlikely to capture a significant vote share of the Black population awaiting ARVs. In 2004 the ANC won in a landslide—increasing its parliamentary majority to two-thirds.

While AIDS rose in political importance over the period, it was far from topping the priority list. Table 4.08 shows Afrobarometer polling data conducted just after the International AIDS Conference had raised the profile on the AIDS treatment fight significantly. It shows that, while AIDS makes the list of important issues for the public, it is down in fifth place and pales in

195 195 Ibid.
comparison to other priorities like jobs and crime on the list of what ordinary people think government should address. Surprisingly, both the proportion of people who knew someone who had died of AIDS and the number of cumulative deaths in a country are poor predictors of the proportions of people who cite AIDS as a national political priority.

While South Africans placed AIDS far lower in their political priorities than those in Botswana, it was about the same as in Namibia—illustrating the reality pointed out by Whiteside et. al. that this is a regional phenomenon that, even in the highest-burden region in the world, AIDS does not top the political priority list. “Faced with grinding poverty and widespread unemployment, people may be more concerned with getting a chance to earn an income, feed their families, protect themselves from crime and insecurity, and obtain basic health care, than with being saved from a largely invisible killer.”

Even though polling also showed just 39 percent said that government was handling AIDS “well” or “very well,” the relatively low priority placed on this undercut the incentives for politicians to act.

Finally, South Africa’s electoral system itself undermined the internal democracy of the ANC that might otherwise have helped shake loose policy change. Under the list-based proportional representation system in South Africa, those toward the top of the party list are essentially guaranteed their seats while those at the bottom have their positions in jeopardy. The ordering of the list came from the very same place at the apex of the ANC where the monopoly on HIV policy sat—which increasingly came to mute dissent inside the ANC and substantially disincentivize going outside the party with complaints, which could clearly get you moved to the

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bottom of the list in Mbeki’s ANC.

The Treatment Action Campaign—New Organization Created to Take Advantage of Constitutionalization

On Human Rights Day, December 10th, 1998, the Treatment Action Campaign (TAC) was founded as an offshoot of the National Association of People Living with HIV. It was, from the start, an organization that rose to take advantage of the particular institutional environment created by the 1996 Constitution.

“The constitution was integral to TAC right from the beginning… you could sort of draw a line between South African civil society organizations that believe that the constitution is the key to campaigning for rights and organizations that believe a constitution is a sell-out document… TAC falls very, very much on the side of the constitution.” (Interview SA-41)

Founded by a group that included the former and current directors of the AIDS Law Project, Zackie Achmat and Mark Heywood, TAC’s governing documents set out the group’s commitment to “support the constitutional vision” of South Africa and:

“Challenge by means of litigation, lobbying, advocacy and all forms of legitimate social mobilisation, any barrier or obstacle, including unfair discrimination, that limits access to treatment for HIV/AIDS in the private and public sector.” 197

While there had been movements based on human rights and health in South Africa through the 1980s, these were focused mostly on the right to health as a part of the equality rights violations of Apartheid more than a conception of a positive right to health, per se. 198 By the late 1990s, though, those groups had withered or dissolved under the processes of transformation as leaders focused on building a non-racial health system. The rise of TAC reflected not a continuation of a previous history of health and human rights, but instead is best seen as a part of a set of post-

197 Constitution of the Treatment Action Campaign n.d.
198 Coovadia 1999.
Apartheid “new” social movements that emerged in the late 1990s and 2000s. Following the relative lull directly after transition, when much of the movement structure was absorbed into the state, a set of groups emerged that simultaneously drew on the long repertoire of dissent and activism in the county while linking to emerging networks and waves of internationalized protest.\(^1^9^9\) TAC falls in a unique place within this larger phenomenon insofar as it blends wide grassroots mobilization and organizing with “rights-based opposition [which] attempts to hold the government to constitutionally enshrined rights within the current liberal order.”\(^2^0^0\)

While high profile demonstrations attracted the most attention for TAC, a key part of their strategy was to popularize the very idea of health as a constitutional right. Much of the daily work after the initial launch was building a base of people—mostly Black, living with HIV, many very poor—who were literate in the unique blend of science and constitutional rights that became central to TAC’s work. One TAC leader recalled:

“I remember when I joined...we had to learn and live on Section 27 of the Constitution, to a point where we practically memorized everything and each word and what it means. I think for us it became a living document that way, because we discussed it and we debated: what does it mean to have limited resources? What shows us the state has an obligation to deliver PMTCT? It was a document that we used to refer to that like your living bible. We even said jokingly that it must look dirty and torn to show you’re actually using it.” (Interview SA-43)

By 2003, the group had nearly 10,000 members spread across the country—a relatively small portion of the then-roughly 5 million people living with HIV in the country but, given the depth of engagement, a remarkable grassroots presence for a group that was just 6 years old.\(^2^0^1\) There were 110 TAC branches at the time throughout much of the country, though centered in the major urban provinces of Gauteng, Western Cape, and KwaZulu Natal where the group was regularly able to pull out 10,000-15,000 people for demonstrations.\(^2^0^2\) This grassroots power combined with treatment and constitutional literacy proved critical in exploiting the opportunities

\(^{1^9^9}\) See Brown 2015; Robins 2010; Bond 2010. TAC are best seen alongside others like the Anti-Privatisation Forum, Soweto Electricity Crisis Committee, Landless People’s Movement, and others.

\(^{2^0^0}\) Ballard, Habib, and Valodia 2006, 400.

\(^{2^0^1}\) Achmat 2003.

\(^{2^0^2}\) Friedman and Motiari 2005, 516.
created by the process of litigation where, as described below, a symbiotic relationship between TAC pressure and pro-treatment civil servants was critical to creating policy change from legal developments.

The group’s initial policy campaign in 1998 was crafted around what the founders believed would be a powerful and achievable demand: immediate introduction of a national program to prevent the transmission of HIV from mother to child. TAC called for pregnant women to have a right of access to AZT that could reduce the risk of transmission. Government’s stance at the time was that AZT was too expensive (at the time, Mbeki’s stance was not yet formed or public). So, when TAC started, they began with a savvy multi-target goal in which they made primary demands on the South African government in rights terms, but made AZT’s maker, Glaxo-Wellcome, a secondary target.\textsuperscript{203} The group identified profiteering by the patent holder on an essential medicine as the root cause of a violation of the right to healthcare. By explicitly tying their demand to the Constitution they made it an issue that demanded a legal remedy—flowing from the state’s duty to progressively realize the right to health, they demanded government negotiate aggressively and, if that failed, consider bypassing the patent on AZT.

Much of their initial campaigning was aligned with the governments (initially fair) frame that AIDS drugs were expensive. A meeting on April 30\textsuperscript{th}, 1999 between TAC and Minister Zuma led to a joint statement challenging the price of ARVs and declaring, “government would name an affordable price for the implementation of AZT to pregnant mothers and report within six weeks on the price and other issues pertaining.”\textsuperscript{204} TAC mobilized a South African and global audience to shame Glaxo-Wellcome, demanding a price reduction. "We are not the government’s friend on this issue, but Glaxo-Wellcome could be doing more to make AZT available at cost price,” said one TAC leader during a protest of the Glaxo offices.\textsuperscript{205} In this aspect TAC’s initial work aligned it in some key ways with the government against big pharma, even as it pushed against reluctance by Minister Zuma.

\textsuperscript{203} Interview SA-38.
\textsuperscript{204} Quoted in Heywood 2003, 281.
\textsuperscript{205} Make AZT affordable to all 1999.
Price reductions came quickly. Glaxo quickly announced a drop in price to the lowest in the world—which was costly, but manageable. A new drug for PMTCT, Nevirapine, soon replaced AZT which was not only cheaper but was offered via donation to the government. University of Cape Town economist Nicoli Nattrass showed that even paying state tender prices the government would save about R341,000 (about $43,000) every six months by implementing a PMTCT program.206 Prices fell not just for monotherapy drugs for PMTCT but for first-line combination AIDS therapies generally. Selling for more than $10,000/year from branded companies, by June of 2000 Brazil was producing a full cocktail of ARVs for $2,767 and, by early 2001, the Indian company Cipla was offering a generic version on the international market for just $350/year. Government, however, continued to argue the drugs were too expensive and not effective.

Following the international AIDS conference, which ended with an appeal from Nelson Mandela for a nation-wide PMTCT program, the MinMEC committee (comprised of national Minister of Health and the nine provincial health ministers (MECs)) affirmed the current policy of not using AZT. Unable to resist the pressure, the MinMEC agreed to consider Nevirapine but only after a two-year period in which pilots would be conducted, limited to two sites per province, commencing only once it was approved by the MCC—a strikingly intransigent move in a context where other countries were increasingly implementing not just AZT based mother to child prevention programs, but full-blow ARV treatment programs for HIV-positive adults and children.

As the Mbeki government’s intransigence on PMTCT and ARV treatment more broadly became clearer, TAC increasingly shifted toward confrontation with the state. Between 1999 and 2001, there were meetings with both Minister Dlamini-Zuma and Tshabalala-Msimang, demonstrations throughout the country, multiple memoranda presented to leaders at different levels, and a 50,000-person petition presented to President Mbeki.207 TAC, COSATU and a set of pediatricians who had formed the “Save Our Babies” campaign increasingly built the case for action. Along with MSF, TAC leaders traveled to Brazil and, in defiance of national patent laws,
imported generic AIDS drugs and followed with a press conference challenging government’s narrative of affordability that gained global attention.

In response, leaders in the anti-treatment monopoly mobilized the ideas and allies that had been supporting their position from the start—claiming the TAC did not understand the complex technical issues behind the government’s stance and accused them of being foreign-funded (which they significantly were) tools of the pharmaceutical industry (which they were not). Government worked hard to undermine the group, including providing funding to the National Association of People Living with AIDS (NAPWA), which agreed to support the anti-treatment stance and defended government against the TAC, claiming they were an elite group from the urban areas of Gauteng and the Western Cape that were “disregarding the real issues of people living with HIV/AIDS as experienced by Africans... the fact is, without food the anti-retroviral drugs are more of a poison than anything else.”\textsuperscript{208} Minister Tshabalala-Msimang was even more explicit—claiming a small set of white TAC leaders were manipulating the rest, who “come with busses and go to commissions where they wait for the white man to tell them what to do... Our Africans say: Let us wait for the white man to deploy us; to say to us: toyi-toyi (protest) here.”\textsuperscript{209}

Progressive civil servants inside government encouraged the campaign from the start—some providing information and quiet encouragement while others, caught in the middle, said more with their silence than anything else.\textsuperscript{210} A meeting in June of 2001 stands out, in which TAC and the pediatricians from the campaign for PMTCT met with the Minister, NDOH Director General Ayanda Ntshaluba and Chief Director of HIV/AIDS and STDs Nono Simelela. After the abrupt departure of the Minister, the pediatricians demanded to know what they should tell HIV-positive women who were requesting drugs to stop HIV transition and the civil servants said publicly that they simply had no good answer to the dilemma—which TAC seized upon in a press release.\textsuperscript{211} It was later revealed that Simelela had, in fact, crafted a full proposal for rollout of a
PMTCT program a year prior, which was rejected by the Minister. This vividly illustrated the strength of the policy monopoly: despite all the pressure, fractures within the ANC, support among technical leaders in government, and international encouragement, government persisted in its refusal to roll out ARVs.

**Politics of Litigation**

On July 17th, 2001, lawyers for the Treatment Action Campaign sent a formal “letter of demand” to the Minister of Health and all provincial MECs for health asking that they “provide us with legally valid reasons why you will not make NVP available to patients in the public health sector… or alternatively to undertake forthwith to make NVP available in the public health sector.” TAC had threatened litigation several times, but this letter represented a turning point and a critical moment of frame-shifting as the group firmly placed the question before the elected government in rights terms. The debates about affordability and feasibility would not disappear in the coming litigation, but this re-casting flipped the script, asking the government to justify not making AIDS drugs available rather than on making the case for why government *should* act. The Minister’s response three weeks later repeated the technocratic arguments about concerns about the efficacy and feasibility of the a large-scale PMTCT program and added a new layer: while they understood the ethical challenges for physicians and desires of individual patients, government claimed it had to “balance” their desire for the best treatment with “government’s obligation to root our public policies in the practical realities of the daily life experiences of all our citizens, equally.” In other words, government could not prioritize the “best” treatment for some over public health needs for all—an argument that had carried the day in the recent Soobramoney case dealing with dialysis. In this case, of course, the treatment was neither expensive or complex, but this shift in argument signaled the Minister was preparing for a legal fight.

TAC was able to secure some of the leading constitutional lawyers in the country—Bongani

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212 Heywood 2003, 288.
213 Founding Affidavit, TAC v Minister of Health 2001.
214 Ibid., Annex E.
Majola who had been legal advisor for the South African Constitutional Assembly, Geoff Budlender former director-general of Department of Land Affairs in the Mandela administration and founder of the Legal Resources Centre (LRC), and Gilbert Marcus, a longtime Johannesburg senior counsel. Attracting this level of legal counsel as allies immediately increased the profile of TAC within the legal complex and quickly got the attention of government. “It was immediately impossible to keep arguing that these were a fringe group who could not win, and the ANC noticed,” one former senior official reported.215

After years of lobbying, demonstrating, and making the public case, on August 17, 2001, the TAC executive committee voted to commence litigation against the state, and was joined by 150 pediatricians and the Children’s Rights Center. The founding affidavit submitted by TAC’s Deputy Chairperson, Sipho Mthathi named the national and provincial ministers of health as respondents and laid out the questions:

“The first issue is whether the Respondents are entitled to refuse to make Nevirapine (a registered drug) available to pregnant women who have HIV and who give birth in the public health sector, in order to prevent or reduce the risk of transmission of HIV to their infants, where in the judgment of the attending medical practitioner this is medically indicated.

The second issue is whether the Respondents are obliged, as a matter of law, to implement and set out clear timeframes for a national programme to prevent mother-to-child transmission of HIV, including voluntary counselling and testing, antiretroviral therapy, and the option of using formula milk for feeding.”216

Government opposed the litigation, arguing the proposal was unaffordable, not feasible given the health system’s capacity, and the drugs unproven and possibly harmful.

TAC did not, however, trade social mobilization for the courtroom. Instead, their explicit strategy was to build public attention for the court case to raise the stakes in court and to place pressure on other political targets who they knew would be required to ensure implementation of any decision following a TAC win. On August 24th, a few days after filing the case, TAC picketed the provincial departments of health in Gauteng, KwaZulu-Natal and Western Cape, launching a

215 Interview SA-07.
216 Founding Affidavit, TAC v Minister of Health 2001, Para 20, 21.
campaign aimed at “Convincing the MECs in all nine provinces not to oppose the court case and to start implementing the MTCT programme as widely as possible.” These were places where TAC was strong and had been pressuring for change for several years—in mounting a litigation strategy as well, they hoped to expand their impact but always saw it as synergistic with other types of political work. Leaders were cognizant, for example, that the effects of the landmark Grootboom decision dealing with housing, handed down just two years earlier, was being limited by the lack of political will and TAC was consciously building against that likelihood. The mobilization culminated on November 25th and 26th when rallies and marches took place around South Africa including an all-night vigil with hundreds of TAC members outside the court before the hearing began.

Much has been written about the jurisprudential arguments and course of the case and I need not fully reprise it here. Suffice it to say that TAC won its case in the High Court on December 14th, 2001. In siding with TAC, Judge Chris Botha found that, “prohibiting the use of Nevirapine outside the pilot sites in the public health sector is not reasonable and that it is an unjustifiable barrier to the progressive realization of the right to health care.” “About one thing there must be no misunderstanding,” wrote Judge Botha, “a countrywide MTCT prevention programme is an ineluctable obligation of the State.” He thus ordered government to make Nevirapine available to all pregnant women and craft “an effective comprehensive national programme to prevent or reduce the mother-to-child transmission of HIV, including the provision of voluntary counselling and testing, and where appropriate, Nevirapine or other appropriate medicine, and formula milk for feeding, which programme must provide for its progressive implementation to the whole of the Republic, and to implement it in a reasonable manner.”

The litigation process brought to light significant information that had not previously been exposed, beginning to undermine the anti-treatment monopoly well before the decision was handed down. First, the provinces submitted estimates of the cost of a successful PMTCT program.
which ranged from R21 million in Western Cape to a likely inflated R71 million in the Northern Province.\textsuperscript{221} Together, it was pointed out that this level of funding was far less than the total left unspent in the health budget in 2000/01, exposing the inaccuracies behind government’s arguments on affordability. The Western Cape province, which had defied the national government and allowed a PMTCT program to begin beyond the pilots, ended up providing clear evidence of what was possible when its submission revealed it was drafting plans to reach 90% of HIV-positive women by 2002. Government had also long been claiming that Nevirapine, like AZT, was unsafe and that even the pilots could not begin because it had not been approved by the MCC—even threatening Western Cape officials with legal action for using an unregistered medicine.\textsuperscript{222} Through the court process, however, government documents eventually revealed Nevirapine had been approved in April 2001 and, in fact, registration had been recommended in 2000 but inexplicably delayed by political hurdles.

The litigation process also shifted policy before the decision: The “two pilot sites per province” rule for the Nevirapine had excluded Johannesburg Hospital, an academic teaching hospital with clear capacity to implement. The CEO submitted a letter for inclusion in TAC’s founding affidavit pointing out the irrationality of the policy and, shortly thereafter as government tried to protect its case, the hospital was added to the list of pilot sites. This opened the floodgates; with the two-sites per province rule unenforceable there was an opportunity for pro-treatment health officials in Gauteng to act, and they moved aggressively. “With NDOH trying to salvage its court case and maintain the idea that all the sites with capacity were implementing PMTCT we suddenly had an argument that they couldn’t argue with and we said, ‘now is the time to move’,” recalled one senior provincial official.\textsuperscript{223} By December, when the High Court ruling was handed down, Gauteng province already had 12 “pilot” sites covering most of the major hospitals in one of the most affected urban provinces.\textsuperscript{224}

\textit{After} the high court decision government was faced with a choice—accept legal defeat and

\textsuperscript{221} Ibid.
\textsuperscript{222} Puzzling delay in Nevirapine programme 2001.
\textsuperscript{223} Interview SA-10.
\textsuperscript{224} Heywood 2003, 293.
move forward with a program that had growing political support or continue to oppose the rollout of ARVs in any nationwide form, even to prevent HIV transmission to children. It would not, at this point, have been particularly hard to walk away—Mbeki had already declared his official “withdrawal” from the public debate, even as his views continued to drive policy, and provincial ANC leaders were increasingly agitating for change. A review of the pilot projects by Health Systems Trust was nearly complete, which would show they were succeeding. There were plenty of face-saving avenues that would have had the support of health officials and made for better politics.

Instead, inside government the Minister was forcefully resisting the court ruling and pushing to maintain the policy stance. According to one senior ANC leader:

“At first, in public the decision of the courts was not questioned. But internally the court was challenged with the Minister leading saying ‘We aren’t going to allow the courts to govern, to tell us what to do.’” (Interview SA-5)

Dr. Anyanda Ntsaluba, Director General of the National Department of Health reportedly stormed out of the MinMEC meeting to discuss appealing the case, saying he could no longer “defend the indefensible.”

Just a few weeks before the PMTCT review was completed, the Minister of Health announced she would appeal the decision directly to the Constitutional Court. “Government, not courts must decide on HIV and other social policy,” she wrote in the Sunday Times. That the government went ahead speaks to the strength of the commitment to maintaining the policy.

The litigation combined with social mobilization, however, changed the politics around HIV treatment in South Africa. The presidency and Department of Health had succeeded in cordonning off HIV treatment policy—securing acceptance by other political players that it was a matter appropriately handled by them and successfully fending of challengers. While TAC had persuaded COSATU previously to join the cause, TAC now succeeded in “expanding the scope of

\[\text{\smaller {225 Health Systems Trust 2002.}}\]
\[\text{\smaller {226 Quoted in Heywood 2003, 303.}}\]
\[\text{\smaller {227 Tshabalala-Msimang 2001.}}\]
the conflict” on a major scale. Both the government’s coalition partners—the SACP and COSATU—made it publicly known they had opposed the decision to appeal the case, but had not carried the day.

The political pressure TAC had built also bore fruit in the provinces. Even with the appeal pending, the lower-court ruling provided an opportunity—action on PMTCT had increased legitimacy and many of the national government’s arguments against it had been revealed to be nonsensical. This had the effect of empowering those within government who opposed the ruling policy who became more active.

“It communicated to those in the system, within the institution who may have been feeling frustrated because there was so much negativity going on in the [National Department of Health] to then say ‘the court has ruled, so what I’m doing is right. I’m following what the court has determined. I think it gave strength those of us inside and outside the institution.” (Interview SA-5)

In the provinces where TAC had mounted a serious campaign, pro-treatment officials and political leaders stepped into the fray and began using their power to move policy—able to move out from behind national government’s roadblock and provided with new reasons for action over inaction.

KwaZulu-Natal was and is home to the highest HIV prevalence in the country, as well as both some of the stronger TAC branches and the boldest researchers and doctors in the country.\(^\text{228}\) The MEC for health was Dr. Zweli Mkhize—an ANC leader who maintained support for the anti-treatment policy stance despite his personal misgivings.\(^\text{229}\) As a doctor, Mkhize’s position was particularly vexing for the opponents of the anti-treatment monopoly, but neither meetings nor protests had changed it. The Premier, Lonel Mtshali, was from the Inkatha Freedom Party and disagreed with Mkhize over the issue, though the discord was in private and KZN remained aligned with government in allowing only limited pilots of Nevirapine throughout 2001. After the High Court ruling, however, Mkhize’s leverage was severely undercut. With evidence that the

\(^\text{228}\) It was not happenstance that the 2000 AIDS conference was in Durban, KZN. Jerry Coovadia, chair of the conference was just one of several globally renowned AIDS doctors and academics in the province, many of whom were prominent anti-apartheid leaders, including Salim Karim, Quarraisha Karim, Alan Whiteside, and others.

\(^\text{229}\) Mkhize is today Treasurer General of the ANC and, in 2016, crafted a long detailed letter asking Mbeki to apologize and claiming he was pushing inside against the worst of the anti-treatment policies even as he defended them in public. Mkhize 2016.
governments arguments were deeply flawed now backed by the courts in a constitutional claim and pressure on the Premier mounting, his incentives to act were significantly higher. Where in October he had been deterred by Mkhize’s backing from the national government, after the court ruling Mtshali went public with his support for ARVs, applauding the doctors who were implementing PMTCT in contravention of official policy. In his State of the Province address he announced the province would implement a universal PMTCT program despite the objections of the ANC and MEC. "Children are dying… We shall not wait any longer, neither will we allow any further excuse, delaying tactic or preposterous theory which may get in the way of saving our children," he said. Mtshali followed this by challenging the ANC in court—demanding to replace Mkhize as the voice of KZN in the appeal before the Constitutional Court. He won out over the ANC and promptly switched sides and submitted an affidavit in support of the Treatment Action Campaign.

In Gauteng, a similar story unfolded—this time under an ANC government. With mixed signals coming from the ANC leadership about Nevirapine roll out after the initial court loss, Mbahzima Shilowa, Premier of Gauteng, announced a plan developed by the provincial health department to dramatically expand the PMTCT program to all hospitals and large health centers in the province. In many ways, it was finally a public acknowledgement of what they had been doing quietly for several years alongside a plan to speed up significantly. One former Gauteng official remembers that:

"After the first court ruling the divisions within government were notable, there was no agreement about what to do, though we knew the Minister would do. But we believed there was enough room in what the MinMEC agreed for us to go public and go ahead with the programs our doctors and our communities were asking for." (Interview SA-10)

Tshabalala-Msimang, however, publicly rebuked the Gauteng government and her own department for initial unapproved positive statements about the move—saying the provincial program violated government policy as agreed by the MinMEC. Though at first it seemed the
Minister was acting on her own, it quickly became clear she had backing from the ANC leadership, and government’s official stance remained opposed to ARV rollout in all its forms.\textsuperscript{232} Central control over HIV policy, however, had broken down enough during the year of litigation that, while Shilowa and Tshabalala-Msimang patched over their differences and talk of the program disappeared, it continued on the ground even as government was officially declaring to the Constitutional Court that it could not, such that by the end of the year the province had nearly reached its goal of full coverage across its health facilities.\textsuperscript{233}

The six other provinces took no such steps and instead continued to support and follow the decisions of NDOH and the MinMEC. In Mpumalanga, for example, the ANC-led government instituted government policy as strictly as possible—including closing down NGOs that were providing antiretrovirals to rape survivors. In Mach 2002, the National Executive Committee of the ANC endorsed the decision to appeal the High Court ruling, challenging whether it was really the role of the judiciary to order detailed public policy on a specific medicine. With government refusing to budge, TAC applied for and received a ruling that the High Court’s order needed to be immediately executed, which the state appealed to the Constitutional Court.

More than 5,000 TAC and COSATU activists marched to the Constitutional Court on April 3\textsuperscript{rd} to hear the arguments put forth by government about why it should not be required to implement the lower court’s decision. According to one observer the Court seemed “at a loss” as to what harm was supposed to be done since the government had documented no adverse results from the use of Nevirapine over the 11 months of the pilot sites. The Constitutional Court ruled for TAC and set down the full appeal to be heard the following month. Mbeki, in a surprise move, put out a statement in \textit{ANC Today} decrying that some “seem very determined to impose the view on all of us, that the only health matters that should concern especially the black people are HIV/AIDS, HIV, and complex anti-retroviral drugs, including Nevirapine,” and that government would not be “intimidated, terrorised, bludgeoned, manipulated, stampeded, or in any other way forced to adopt

\textsuperscript{232} ANC Closes Ranks 2002.
\textsuperscript{233} Interview SA-10.
policies and programmes inimical to the health of our people.”

By this point the court of public opinion shifted quite strongly against the ANC’s stance—with Tshabalala-Msimang labeled “Dr. NO” by newspapers and ridiculed in editorial cartoons for resisting the court order. Whatever its benefits, the anti-treatment stance was not good politics or management of the ANC’s image—which took hits not just in South Africa, but around the world. Nonetheless, the national government persisted and no national rollout of Nevirapine was implemented.

Two weeks after the interim court ruling, the Cabinet put out a surprise statement, seemingly bowing to the pressure brought through the rights mobilization and public attention. Ministers had agreed to overrule and out-vote the President and Minister of Health and publicly acknowledge the efficacy of ARVs and promised “a universal roll-out plan to be completed as soon as possible.” That plan was not soon in coming, having been laid on the Minister of Health to draft, but the statement signaled the beginning of the slow destruction of the anti-treatment monopoly.

By the time the Constitutional Court formally sided with TAC, the decision was an expected but welcome relief to those seeking the rollout of PMTCT programs. The landmark ruling set a critical precedent that the right to health in the South African Constitution had meaning—that it was judiciable and that it was the role of the courts to weigh into complex matters of public policy to identify whether government had plans that were “reasonable” and moving “progressively within available resources” to achieve full realization of health rights. Distinguishing from Soobramoney, the Court found the government’s policy failed this test—“it was not reasonable to

234 Mbeki 2002.
235 Now I must poison my people, says Dr No 2002.
restrict the use of Nevirapine” and “they failed to implement a comprehensive programme for the prevention of mother-to-child transmission of HIV.”

**Impact of Rights Mobilization**

“Without that case and everything around it, probably something gets done on ARVs. But maybe not until Mbeki and Manto get sacked. They were still incredibly powerful. Or maybe cabinet eventually steps up but I don’t see anything, as I think back, that would have done that for at least another few years. I think it helped concentrate minds a bit.” – Former Senior Health Official (Interview SA-06)

“Do you know about the adult ARVs case? Where government was taken to court for the right to provide antivirals to all South Africans? You can’t because there wasn’t a case. That’s the point.” – Former Senior Health Official (Interview SA-54)

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236 Constitutional Court of South Africa 2002, para 44, 95.
Most policy change in a democracy comes from changing the preferences of policymakers or replacing the policymakers themselves. In the traditional sense, neither of these happened: Mbeki and Tshabalala-Msimang continued in their posts until Mbeki was ousted by Jacob Zuma in 2008, six years after the Constitutional Court judgement. They also persisted in their opposition to the rollout of ARVs. As Bilchitz noted at the time in critiquing the Court’s ruling, “this seems like a strikingly bad moment to express good faith in the government’s ability to deliver Nevirapine expeditiously.” Looking only at the court order and government’s willingness to implement at that moment, it was hard to see how the case would really have significant impact at the kind of population level explored here. Yet beyond the specifics of the court order, what we see is that rights mobilization successfully interrupted the anti-treatment policy monopoly. It did so by expanding the conflict to include the legal complex, the ANC’s governing coalition partners, and non-health cabinet ministers, creating space for health policy change.

Following the Constitutional Court ruling, government immediately ceased opposition to the provision of Nevirapine and many provinces began implementing robust PMTCT programs. However, despite the 2002 Cabinet Statement it took another year before the comprehensive plan was actually put in place as the Minister continued to put up one roadblock after another. With continued national intransigence, TAC returned to court against the Mpumalanga province for failing to rollout Nevirapine. The group also engaged in a high-profile civil disobedience campaign to push government to fully implement the Court’s orders. Finally, in August 2003, in a “cabinet revolt” Senior Ministers, including Minister of Education Kader Asmal and Minister of Public Enterprises Jeff Radebe, overruled the Minister of Health, endorsed the long-delayed report of the task team charged with examining the treatment options and ordered the Department of Health bureaucrats to develop a detailed operational plan and commence ARV rollout. “I am not the one making the decisions; the Cabinet decides collectively,” the Minister complained amidst reports she was “despondent” over the cabinet decision. This was a unique set of developments, to put it...

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237 Bilchitz 2003b, 23.
mildly, in which the courts and non-health ministers set out national health policy and issued orders to the public health system despite the persistent opposition of the sitting President and Minister of Health. Still the Minister dragged her feet; indeed, the actual procurement of ARVs was nearly derailed again in 2004 until TAC threatened litigation, forcing the Minister’s hand.

The point in the quote above regarding the lack of a case concerning adult ARVs is an important one. It is worth remembering that the landmark TAC case was focused on PMTCT, the most palatable of ARV interventions meant to stop the spread of HIV to babies. The Constitutional Court ruling completely avoided the broader question of whether ARVs would be made available to children and adults for lifelong treatment. Yet that case and the surrounding mobilization shifted the power distribution on the issue. Immediately after the case, this was the subject of broader negotiation within the ANC and between TAC and civil society groups and government. Relying on the Constitutional Court case, the non-health cabinet ministers felt empowered to order a sweeping policy shift that went well beyond both what the court had ordered and what the minister could support to start a full-fledged triple combination ARV treatment program, of which PMTCT was just a small part. The Treatment Action Campaign, for their part, claimed the legitimacy of the Constitution and Constitutional Court and, in making what was (at the time) shocking use of anti-Apartheid tactics of civil disobedience against the ANC, were protected against attacks from the anti-treatment cabal by their ability to cloak themselves in the language of law and rights.

Finally, on April 1st, 2004, ARV initiation began in the public health sector and, as shown in Figure 4.9, AIDS deaths quickly fell dramatically. By March 2005, the target of the comprehensive plan—to have at least one service point for AIDS-related care and treatment in each of the country’s 53 districts—had been met. HIV prevalence, which had been steadily climbing, finally leveled off as people living with HIV stopped dying and ARV treatment also began to cut new infections.

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239 Simelela and Venter 2014.
Neither Mbeki nor Tshabalala-Msimang backed down. The Minister complained publicly that she was being forced to “poison my people” by the courts. She went on to block attempts by the provinces to apply to the Global Fund for financing for the ARV program, interrupt procurement tenders for ARVs, and to sow confusion among the public by promoting “alternatives” to ARVs. Mbeki, for his part, defended his stance as recently as 2016, saying, “it was absolutely necessary for ‘the AIDS industry’ that South Africa was whipped into line so that it sets an example by being an enthusiastic purchaser of ARVs!” Constitutionalization, however, created opportunities to bypass these powerful actors, undermine their legitimacy, and redistribute resources on the basis of an alternative ideational framework.

Figure 4.10 shows both the rapid expansion of the ARV treatment program and the significant shift in funding for HIV treatment and prevention in South Africa. These calculations are based on the Treasury expenditure analyses updated by audited-year for the time period. It cannot capture all AIDS spending, since data are limited about how provinces spend their unconditional transfers, some of which has gone to fight AIDS. The national funding levels, however, are comparable across years and show that from 1997 to 2001 HIV funding barely registered in the health budgets, even as similar countries like Brazil and Thailand were shifting

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240 Now I must poison my people, says Dr No 2002.
significant resources into the AIDS response.\textsuperscript{241} Funding even dropped in 1999 following the discovery of effective combination treatment (note that there is a year lag-time between decision and funding). That began to change around the time TAC launched its legal battle and by the year following the Constitutional Court decision the country was on an entirely new spending trajectory. It is worth noting that the medium-term expenditure framework (MTEF) which laid out planned spending included R372 million for AIDS in 2002-2003 period—at a point when the size of the epidemic was clear—but the budget was repeatedly revised upward under pressure and, in the end, expenditure totaled R1,131 million across the two years. A new program of conditional transfers to the provinces was also introduced at the end of 2001 and rapidly expanded after 2003.

The forced investment in building a treatment program paid off and as HIV prevalence, which had been growing each year, finally leveled off and the AIDS deaths plummeted after 2005 as the ARV program gained steam. The impact of rights mobilization on the health of South Africans in this context is hard to deny.

\textsuperscript{241} Nunn et al. 2012; Ainsworth, Beyrer, and Soucat 2003.
Conclusion

Had South African leaders, like their peers in Brazil and Thailand, acted and rapidly implemented an HIV treatment program, they might have been able to control the epidemic. Had they started alongside other African countries a few years later, millions fewer would have died. This failure looms large. But had South Africa waited for a change in leadership or a change of heart, it would have been at least several more years still before ARV treatment began, at a cost of hundreds of thousands of lives and new infections.

It was not until September 2008 that Thabo Mbeki was “recalled” as state President by the ANC after losing the election for Presidency of the party to Jacob Zuma at the party’s Polokwane conference. Among interim-President Kgalema Motlanthe’s first acts was to move Tshabalala-Msimang to another post, replacing her with longtime ANC stalwart Barbara Hogan who, in turn, welcomed TAC leaders to her home in celebration just hours after her appointment. It was finally the end of the anti-treatment era for the ANC. From there, Hogan set out righting South Africa’s AIDS policy, re-focusing the department on creating a strong AIDS response, and rebuilding the Department’s standing among physicians, scientists, activists, and international leaders. It took several more years for her successor, Dr. Aaron Motsoaledi, to finally reach the level of rapid expansion needed to get ahead of the now-crushing AIDS epidemic.

All of this could have come far earlier with better leadership, but would be far further off course without an institutional environment of constitutionalization that opened opportunities to challenge that leadership. Several modeling studies have, in fact, shown that the move in 2004 to start ARV treatment made it possible to get back on track toward halting the AIDS crisis in the country. Today South Africa has the largest ARV treatment program in the world. The Gauteng health department is piloting a program to provide ARVs through ATM-like dispensing machines in the provinces shopping malls. Life expectancy has reversed its decline and has nearly returned to where it was in the 1990s.

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The effect of constitutionalization, in this context, illustrates both a positive effect and the interplay of courts, democracy, and social movements. The legal complex in this case played a critical role, but it was not so much the court order that mattered as the way the turn to the courts as an additional venue for health policymaking changed the politics around HIV treatment. That AIDS activists could mobilize prominent lawyers and draw on the legitimacy of the courts mattered more, I would argue, than the order itself—implementation of which was resisted fiercely by the Minister of Health. Indeed, the order to implement a PMTCT program was far narrower than the eventual impact it had, helping spark a full-blown AIDS program over the objection of the President. It only had that effect, however, because it built the power of actors like the AIDS Law Project and the Treatment Action Campaign—unique organizations that emerged explicitly to take advantage of the constitutionalized environment around health in post-Apartheid South Africa and, in that context, were able to break the anti-treatment monopoly on policymaking and take on the powerfully dominant African National Congress party. This resulted in significant redistribution of resources—pushing billions of Rand into AIDS treatment in the public sector, the recipients of whom are mostly poor, black, and a significant majority of whom are women. These resources have also, in turn, helped build civil society organizations and legal service organizations involved in both the previous example from the Eastern Cape as well as the issues dealt with in the coming section—building the support structure needed to translate the constitutional promise into meaningful policy change.
CHAPTER 4.5: TUBERCULOSIS IN PRISONS

“They are the power inside and they use safety and control as the reason to oppose anything they don’t want to change. More outside time, different cell configurations, whatever. They say they’re studying it. There is a culture of impunity and rights matter very little across the board. It’s not just health.” – Attorney (Interview SA-39)

“No one truly knows a nation until one has been inside its jails,” wrote Nelson Mandela in *Long Walk to Freedom*.243 And among the knowledge Mandela acquired while incarcerated was that the nation’s prisons provide a perfect environment for the spread of TB—which he acquired in 1988 while at the Pollsmoor Prison. Twenty-four years later, the Constitutional Court issued a ruling for another Pollsmoor prisoner who had also contracted TB at the prison—a sweeping judgment that advanced the right to health jurisprudence in South Africa and drew praise from public health leaders around the world.

Unfortunately, tracing the policy process on TB in prisons to the present illustrates the limits of the impact of constitutionalization. Evidence suggests rights mobilization has had significant impacts on the policy space, following the mechanisms I describe, that may yet bear fruit—but overall the policy monopoly in corrections in South Africa has been largely able to contain and diffuse policy change. The result is that, according to the most recent data from the South African National Health Laboratory Service, TB rates are as high now as they were five years ago.

South Africa has among the highest rates of tuberculosis in the world. It is the leading cause of natural death among South Africans in 2015 if you include deaths among those with underlying HIV infection.244 Transmitted through the air in conditions of poor ventilation, TB has been a

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244 Stats SA 2016. Note: this is based on a calculation of cause of death which attributes many deaths that might otherwise be attributed to HIV (e.g. in the causes of death chapter 4.1) to TB, the opportunistic infection that lead proximally to death.
longstanding problem associated with both the mining sector and substandard housing in the
country; exploding into a major epidemic as HIV disrupted the immune systems of millions of
South Africans.245

South Africa also has one of the largest prison populations in the world.246 When the ANC
government took office, South African prisons had an official capacity of just over 96,000 and an
actual prison population of nearly 117,000—overcrowding at 121% capacity.247 In 2016 the
imprisoned population had grown to 161,984 and the capacity deteriorated to 133%. Prisons
worldwide are places of disproportionate risk for TB (as well as HIV) with rates of infection an
order of magnitude higher due to poor ventilation and nutrition, limited health services, and
populations with higher risk of TB exposure before prison—risks significantly exacerbated by
overcrowding.248 South African prisons in particular provide extremely conducive conditions for
the spread of TB with overcrowding, substandard living conditions, and poorly functioning health
services resulting in higher rates of TB than both the general public and the mines.249 South African
prisons may, in fact, be among the most dangerous places in the world when it comes to TB—with
incidence 5-8 times higher than reported in other studies.250 Little has changed since Mandela
identified Pollsmoor as a place with a “modern face but a primitive heart with clean staff spaces but
housing for prisoners that is archaic and dirty.”251

The result is TB infection cycles driven by incarceration that spread throughout the
community—with people leaving prisons (either staff or inmates) infected with TB regularly. 79%
of prisoners are imprisoned for less than twelve months and the number of people passing through
the system annually exceeding 368,000.252 Stuckler and colleagues have shown clearly how mass
incarceration is directly tied to increased rates of TB and South Africa is a prime example.253

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245 Lawn et al. 2006.
247 Steinberg 2005.
248 Baussano et al. 2010.
249 Johnstone-Robertson et al. 2011; Telisinghe et al. 2014.
251 Mandela 1994.
252 Johnstone-Robertson et al. 2011, 809.
This has been a longstanding issue, but public health officials and advocates have struggled to address the problem. As with other issues in this study, significant democratic pressure has been applied, but has failed to address the problems.

The issue has been repeatedly documented by the Judicial Inspectorate and reported to the national department and the Presidency. In 2003, for example, the year that Dudley Lee—whose case is described below—contracted TB, the Inspectorate documented over 19,000 complaints about medical care and noted that there had been a 584% increase in natural deaths in the prisons, far faster than the rise in prison population—but had no information about the causes, and little was done. In 2001, Dr. Steven Craven, one of the doctors at Pollsmoor, sounded the alarm about TB—writing to various bodies including the South African Medical Association and eventually speaking before the parliamentary portfolio committee on corrections in testimony that appeared prominently in the *Cape Times*. The provincial health MEC visited and called it a “scandal.” The South African Medical Journal ran a feature article examining the issue in-depth. The Department of Health set up a special task team to deal with TB in prisons, but its recommendations were followed only temporarily. In 2007, the cycle repeated again when Parliament’s portfolio committee and the inspecting judge of prisons described conditions as a “health time bomb.” The doctor who exposed the health crisis and spoke to the inspecting team was quickly fired by the department, and few changes were made.

Three major barriers have long existed: First, prisoners have among the least political power in most societies and South Africa is no different. One might imagine that the recent history of unjust imprisonment of so many ANC leaders would result in significant public and political commitment to improve prison conditions, but the high crime rate in the country means there is little sympathy for prisoners. As a result, the small group of public health and NGO leaders that

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256 I Got TB in Prison, Former Inmate Tells Court 2012.
257 Pollsmoor whistle-blower gets his job back 2007.
258 The U.N. General Assembly even named new international standards for prisoners after Nelson Mandela, *UNGA 2015*. 
tried to push for improved conditions and a plan to address TB among prisoners found it very hard to garner much support.

“The reality is that for years we have tried to get people to pay attention to the health needs there but people just say ‘ah, well, prisons are not nice places, they are punishment for doing wrong. What can you do?’”—NGO leader (Interview SA-64)

The second major issue was that information was nearly impossible to come by. While many people in South Africa recognized there was a problem, the Department of Correctional Services largely did not test prisoners for TB, and what testing they did was not made public. It was, therefore, nearly impossible to assess the size of the problem or understand the degree to which incarceration was driving South Africa’s increasingly large TB epidemic.

“There were previous attempts to address the issue, and even to do so through the courts, but there was simply no data. We would ask if they were testing and they would say only rarely. We would ask to see the results and they would say no. We would ask to come in to provide TB testing and they would say no. There was a blockade at the prison gate.”—Physician/Researcher (Interview SA-66)

A quick review of media, as shown in Figure 4.11 below, illustrates the reality intersection of lack of information and lack of political priority. While there were occasional articles dealing with the TB in prisons—rising a bit as global attention to TB increased in the late 2000s—the most significant media before 2012 came from Nelson Mandela acquiring TB in 1988.
Third, and perhaps most importantly, the kinds of changes needed to address TB are significant (e.g. changing the conditions and physical construction of prisons) while the governance of those prisons in South Africa, as in most places, is a tightly controlled, militaristic enterprise. The need for control and power by jailers is considered paramount, power in the system is hierarchical, and information is centralized. There is, in theory, statutory power vested differently between the political leadership of the system—the Minister of Correctional Services (now the Deputy Minister in a consolidated Justice and Corrections Department)—and the civil service leadership, vested in the National Commissioner of corrections. The latter has a statutory duty to issue standing orders with the force of law behind them, to give effect to existing legislation under the Correctional Services Act, including health regulations.

“The reality we learned was that the Commissioner had issued all sorts of orders but they simply ignored them. This is binding law and I have spoken to the leading officials in DCS about it but they look at you like it’s another language. They were a fig leaf and they would point to them and say ‘yes, yes.’ It took us quite a while to figure out how to get past that. Politicians we asked would inquire and be told, yes we have all that…” –Attorney (Interview SA-39)

In 2012, some of these conditions started to shift when public health leaders and attorneys decided to mobilize around a court case filed by Dudley Lee, who had been imprisoned in

Figure 4.11: Media Articles on TB in Prisons in South Africa
Pollsmoor Prison where Nelson Mandela contracted TB decades earlier. Lee was arrested with four others for fraud, counterfeiting and money laundering and sent to Pollsmoor in November 1999 to await trial. After over 70 court appearances Lee was eventually acquitted in 2004. Three-and-a-half years into his imprisonment awaiting trial, however, Mr. Lee was diagnosed with TB. Pollsmoor was beyond 200% of its designated occupancy and Lee was often held for twenty-three hours per day in his crowded, damp cell. The Court noted that this represented fairly standard conditions for detainees, perhaps better than average since he spent much of his time in a cell designed for a single inmate (which he shared with two other prisoners): 259

“The responsible authorities were ‘pertinently aware of the risk’ of inmates contracting TB… Pollsmoor is notoriously congested and inmates are confined to close contact for as much as 23 hours every day – this providing ideal conditions for transmission; on occasion, the lock-up total was as much as 3052 inmates and single cells regularly housed three inmates; communal cells were filled with double and sometimes triple bunks; the responsible authorities relied on a system of inmates self reporting their symptoms upon admission to the prison and during incarceration… In Mr Lee’s case, his vulnerability as a prisoner, which meant he was unable to put himself out of harm’s way, together with the lack of proper care on the part of the prison authorities, makes a similarly powerful case. 260

Upon his diagnosis, Lee was actually sent back to his poorly-ventilated cell with others despite having active, infectious TB. The statement of agreed findings submitted to the Court noted that Lee then “begged, bullied and bribed” in order to get access to TB drugs and was eventually cured, though he suffered ongoing lung damage. Upon his release a year later, he sued the department of corrections, and the Western Cape High Court found in his favor—finding the failure to institute an effective TB control program in the prison constituted a negligent breach of constitutional and statutory duty on the part of the department. 261 The court noted in particular that the authorities failed to respect their own Standing Correctional Orders on TB and infectious diseases. The government appealed and the Supreme Court of Appeal (SCA) found that they were indeed negligent and that rights violations had occurred—calling the state’s case “defending the

260 Ibid., vol. 2013 2 BCLR 129 (CC), para 8, 101. Note quotes from both main and concurring opinion.
However, the SCA nonetheless overturned the lower court decision on narrow grounds of factual causation since the case was a question of negligence for previous acts—finding that Lee failed to show that “but for” the (in)actions of prison authorities he would not have contracted TB, a standard many have argued was impossible to meet in a case such as this.°

Lee’s attorneys at the time originally planned not to appeal.° The SCA’s application of the standard would, in many legal contexts, be considered a limited but reasonable interpretation of a widely-accepted test of causation. Activists and health rights attorneys, however, took note of the case and pushed Lee to challenge this finding at the Constitutional Court based on the constitutional right to health, which they believed required greater flexibility in the service of justice. The Treatment Action Campaign, the Wits Justice Project (a journalism effort at the University of the Witwatersrand), and the Centre for Applied Legal Studies joined the case, represented by the NGO SECTION 27. Successfully applying to join as amici, the groups made the argument that this case had critical constitutional and public health implications. The TAC did more than just engage legally, however—identifying the issue of TB as critical to their work, the group held pickets at both the Constitutional Court and at Pollsmoor Prison ahead of the case being heard and worked to make the case a political issue. The legal mobilization generated major media attention—as seen in Figure 4.11 above, the spike in articles in 2012 was significant—many of which came well before the case was announced in December—with continuing growth in 2013.

As in other examples, the process of engaging the legal complex opened space for information flows. Here, medical and public health actors who had been trying to address TB in prisons were able to finally connect the dots. Where previously a physician whistleblower was largely sidelined upon speaking out, the legal proceedings in this case opened the door for prison doctors to share what they knew and for public health experts to gain access to the facility and the data to assess the problem. On appeal, a team of infectious disease experts from the University of Cape Town were able to gain access to the prison.

° Meerkotter 2015.
° Interview SA-38.
“Next to HIV, the strongest risk factor we saw in our clinics in the community was previous incarceration. But we couldn’t make the link for sure. With this case, they finally had to let us in. We were able to look at the size of the rooms and the ventilation. They finally gave us the data. And it was shocking.”—Physician (Interview SA-51)

In a submission to the Supreme Court of Appeal that was later published in a medical journal, the researchers concluded the annual risk of transmission of the TB bacterium was probably 90% per year incarcerated—combined with poor nutrition and health services, the risk of developing active TB was quite high.265 An effective program, however, was possible and the researchers showed that “active case finding” (meaning seeking out those likely to have TB for screening) together with implementation of minimum national and international standards of incarceration could reduce transmission by up to 94%.

The Constitutional Court agreed with the amici and found for Dudley Lee. “Denying recompense, and insulating the prison authorities from responsibility, merely because Mr Lee was unable to pinpoint the source of his infection, may have trenched upon his constitutional rights,” wrote Justice Cameron.266 The Court split on the question of whether the existing common-law standard of causation must be applied more flexibly in cases involving constitutionally protected rights (as the majority found) or if a more radical step was needed to further develop the common law and develop a new standard. But the Court agreed that the government’s widespread failures and practice of “self reporting” were not reasonable policy stances and that, under the SCA’s standard, “it is unlikely that any inmate will ever be able to overcome the hurdle of causation and further, no effective alternative remedy will be available” to protect the health rights of prisoners.267 Mr. Lee won damages and the government was handed a high profile loss that was hailed in public health and legal circles around the world as a critical advancement in jurisprudence.268

Did this matter?

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265 Johnstone-Robertson et al. 2011.
267 Ibid., vol. 2013 2 BCLR 129 (CC), para 65.
268 Bateman 2014; ConCourt makes landmark TB ruling 2012; South Africa’s notorious Pollsmoor prison joins the global battle against TB 2015; Torriente, Tadion, and Hsu 2016.
It did set an important legal precedent—the idea that a long-standing rule in common law at the heart of negligence lawsuits the world over had new meaning in a constitutionalized health policy context actually opened the courts to the many more people and issues. Dozens of lawsuits were filed by others who had contracted TB, which the department claimed was helping it see the error in its ways. The decision also shifted the policy space significantly—new guidelines were adopted immediately thereafter directing comprehensive and coordinated TB management in prisons. These guidelines were issued by the National Department of Health—crossing ministerial lines and giving public health actors greater legitimacy to act in a sphere dominated by corrections. A new grant from the Global Fund explicitly cited the research done as a result of this case in order to make the case for funding a large new investment in TB control in prisons. An NGO called TB/HIV care was contracted to assist department of corrections in running the TB program in Pollsmoor and ninety-five other corrections facilities. A new body called the “National Task Team for the implementation of HIV and TB services” was created and NGO leaders now sit on it.

What we would hope and expect to see from this shift in attention is, first and foremost, a decrease in TB in South African prisons. Figure 4.12 shows data from the South African National Health Laboratory Service on the percent positive among TB tests done in inmates in four cellblocks in Pollsmoor prison. A successful TB program should see decreasing outbreaks or spikes in the data over time. This data is not publicly available and I have access to only a limited period of time. Yet what we see from this data is not promising—outbreaks continue and they seem to move from one cell block to the other, with several cell blocks reaching higher levels in 2016 than two years prior.

The reason, several different interviewees agreed, is that corrections authorities have not made, and have little interest in making, the changes needed to address the problem. In this context, medical care is insufficient by itself to address the problem. Instead what is really needed are changes in how the prison is built and run—which take both money and shifts in practice by corrections officers. To halt TB, for example, critical shifts would include not keeping inmates in cells twenty-three hours per day and giving them more access to fresh air through more open cells.
and fans. Improved nutrition would also help prevent those who have become infected from progressing to active disease.

Three years after the Lee case, Justice Edwin Cameron of the Constitutional Court visited Pollsmoor and wrote a scathing report, suggesting little has changed:

“Regretfully, my law clerks and I found conditions very far from the standard the Constitution and the statute require. The extent of overcrowding, unsanitary conditions, sickness, emaciated physical appearance of the detainees, and overall deplorable living conditions were profoundly disturbing... inmates are locked in their cells 24 hours a day. They cannot leave their cells to exercise, to eat, to use the restroom, to shower, or to go to the library... Detainees complain of hunger in the evening because they are not given an evening meal. The thickness of the air and lack of ventilation was palpable... The air seemed so thick, one felt one could cut it with a knife. There seemed to be no air flow... It raises the obvious question whether the Department is adhering to its own norms and standards.”

269 Cameron 2015.
On the one hand, addressing these issues involves money—and prisoners continue to have low priority. Prison health spending did increase significantly—from R664 million to R846 million.\textsuperscript{270} Overall, however, spending grew far slower and both staffing and construction were significantly constrained in most of the corrections system. There is no sign of significant spending to address ventilation or overcrowding. The questions raised in Dudley Lee appear to have been cordoned off to an increase in spending on medical care, most especially on TB screening, while the wider structures remain untouched.

Perhaps far more importantly than money, addressing TB in this way would be a major change to the idea guiding the actual practice of jailers—ideas based around maximizing the control exercised over prisoners. A variety of feasible changes to the practice of managing prisoners would make a big difference for TB. But it would also require corrections officers to do their jobs differently in an environment where consistency and predictability is valued and security of the prison trumps all.

“There is a conflict between health and security in their minds, and security wins. If you look at the legislation the importance of security is not higher than health. But in their minds, it’s so obvious it’s not even a starter for a conversation.” – Attorney (Interview SA-39)

Health rights, in this setting, have struggled to counter or complement this idea. The monopoly over how prisons are run is incredibly strong by its nature—no person can even observe the functioning of the prison without the knowledge and approval of corrections officers. Both the practice and the structural ideas that support these practices have not shifted and power remains unchanged. The policy monopoly has not been disrupted. Prisoners are still unpopular and wield little political power to challenge their conditions. Those from the outside who had put significantly energy into change are now part of various committees and advisory boards, but so far these have had little power to affect the core conditions of confinement.

While forced to open their doors and their policies to examination during the Dudley Lee case, the authorities largely seem to have been able to dampen attention and limit the impact of the

\textsuperscript{270} Authors calculations based on the Treasury Department’s 2016 Estimates of National Expenditure.
case. Information is a good measure here; during the trial, there was significantly more transparency at Pollsmoor, but today data collection and release on prisoner wellbeing, for example, has only improved incrementally. The Minister, in his recent budget speech, noted that the auditor general “still has serious concerns about the credibility of our records,” in which the data on health and care programs did not match actual evidence.  

The changes in policy and attention may still bear fruit—Justice Cameron’s very presence at the Pollsmoor facility and attention to health issues is an important signal that the judiciary is investing in addressing prison conditions. The court order is powerful and precedent-setting. For the moment, however, tracing the policy to the present shows evidence of some surface policy change without much disruption to the policy monopoly writ large. Impact on population health seems unlikely. This is not particularly surprising however—the argument in this project is not that constitutionalization is a fix-all. As an incredibly strong policy monopoly, it should be clear that even as the mechanisms largely followed the theory outlined in the previous chapter, extremely powerful counter-ideas like control of prisoners and strongly structural policy monopolies like those in prisons are still capable of defending policy stasis.

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271 Masutha 2016.
CHAPTER 4.5: THE SPECTRUM OF HEALTH POLICY & RIGHTS IMPACT

“The Constitution gives us leverage at every level, sometimes it’s enough, sometimes not. At the end of the day sometimes as a healthcare provider I can say ‘stuff you, the constitution says so…” –Physician/Administrator (Interview SA-50)

“The fact is, the constitution became like a mist that permeated everything we were doing; it helps give you the moral strength, it gives you the justification to act now instead of waiting, it gives you a beacon. That beacon meant we, in the health department, had to be differently responsive, we had to talk to a different set of people that we might otherwise, and gave us power within government to break out of certain patterns—not just from Apartheid but from a very complex, fragmented system with lots of interested parties. It’s not like a stitch that you can just point to that stopped the bleeding. It’s not a single effect on its own, but there is no doubt that it shifted the space we had to make change and address health equity.” –Former Senior Health Official (Interview SA-54)

The constitutionalization of health in South Africa has changed political power balances, shifted resources, and provided the openings to advance health policy change across a wide swath of policy issues. The majority of the impact has not come through judicial orders and apex court cases. It has also not been uniform—in some cases the institution shifts under the new constitution mattered quite a bit, while in others the impact was not significant. In this chapter I briefly trace the other health policy issues—building on the examples in EMS services in the Eastern Cape, HIV treatment, and TB in prisons—where the right to health has been mobilized in South Africa. Further examining the spectrum of impact through these issues can tell us more about how constitutionalization works, which is particularly interesting for those interested in deepening this impact. Together with the previous chapters, the additional examples in this chapter illustrate relatively well the different ways in which the right to health is instantiated in South Africa. We have seen policy entrepreneurs making use of the environment created by constitutionalization to counter a classic policy monopoly in the Eastern Cape EMS case, to overcome a monopoly at the very apex of politics on HIV treatment, and to directly confront prison authorities through the courts with far less success. In this chapter, we see greater engagement of the right to health with
private actors including multinational pharmaceutical companies and South African mining conglomerates, as well as examples where rights are used to help drive policy change from within the state through a resistant bureaucracy and a skeptical international policy environment in the user fees case. Together, they suggest a spectrum of impact tied to factors including the strength of the policy monopoly, the support structure available to advance rights mobilization, the relative power of those seeking to disrupt policy status quo, and the character of the idea that supports policy status—some of which are more easily unsettled by the “reasons for action” forwarded by a rights framework than others.

Table 4.09: Health Policy Issues Subject to Rights Mobilization by Nominal Level of Impact

<table>
<thead>
<tr>
<th>Impact</th>
<th>South Africa</th>
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| High   | HIV Treatment 
        | Eliminate User Fees 
        | Drug pricing 
        | Eastern Cape Emergency Services 
        | National Health Insurance 
        | Private Sector Health Inquiry 
        | Silicosis & TB in Mines 
        | Migrants access to health |
| Low    | TB in Prisons |

Source: Author estimations. Impact level is roughly nominal based on author estimation but is not systematically measured.

Each of these cases broadly supports the idea that constitutionalization matters—that it creates a new politics of health policy that benefits pro-health policy change—but noting the differences also illustrates the interplay between constitutionalization and other political institutions from electoral rules to the political construction of citizenship.

**Eliminating User Fees in Healthcare—Rights and Bureaucratic Initiative**

The Apartheid government embraced a set of neoliberal policy prescriptions in the health sector including, in particular, significant point-of-service user fees and promotion of private healthcare. By the time of transition, these user fees represented a significant barrier to accessing
healthcare—with 20% of Black South Africans in one survey reporting they had not undertaken needed medical treatment because they could not afford to pay for it.\footnote{Hirschowitz et al. 1995.} These fees accounted for about 9% of health facilities budget at the time, though at the individual facility level fees sometimes made up more than half of financing.\footnote{McCoy and Khosa 1996, 157; Health Systems Trust 1996.} Inspired by the global Alma Ata Declaration, the ANC’s health plan focused on building primary care and eliminating barriers to access.\footnote{African National Congress 1994.}

On May 24, 1994, Mandela announced in his State of the Nation Address the new government’s policy of free health services for children under the age of 6 years, pregnant and nursing women and all women for a period of six weeks after the end of a pregnancy. Free healthcare commenced the following week. It was followed by a large and immediate increase in healthcare utilization. Patient loads increased by as much as 300% at some primary health facilities, with average increases about 60%.\footnote{Khosa and Thomas 1995.} Figure 4.13 illustrates the typical jump in pediatric and antenatal visits in two example cities starting as soon as the user fees were eliminated. There was also increased referral to higher level health services including pediatric admissions. In 1996, free primary healthcare was extended to all. A clinic infrastructure program was also launched in which nearly 1,500 new clinics were built or upgraded to support the new focus on primary care. The sharp increase in antenatal visits was almost certainly associated with better health outcomes, though the exact effect on wellbeing is obscured by the growing HIV crisis of the time. A survey at the time, however, found that “three quarters of the public health sector workers believe that the policy was successful in preventing serious illness or death amongst women and children under 6 years of age.”\footnote{Quoted in Gilson et al. 1999, 77.}
The new program was incredibly popular—with nearly all Black South Africans showing awareness and support for the new policy, though less so among whites. However, despite its popularity there was significant resistance. The first came from free-market-oriented sources that claimed free healthcare would undermine financing of the health system and allocative efficiency within the relatively weak system. Government had “not yet faced up to those difficulties concerning financing and bureaucracy,” one editorial complained. “The answer lies in setting of priorities otherwise [free healthcare] could become a monster.” The World Bank at the time in particular advocated user fees targeting curative care and drugs, for which people were most likely to be willing to pay, to generate revenue and eliminate excessive usage. This analysis was questioned even at the time and has since been abandoned by most health and development agencies. At the time, however, it was very influential and even the new ANC government received pushback from free-market thinkers, orthodox economists and international

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277 Kaiser Family Foundation 1999.
278 Deteriorating Health Services 1994.
279 Shaw and Ainsworth 1995; Akin, Birdsall, and De Ferranti 1987.
280 Gilson 1997; McIntyre 1994; Wilkinson, Sach, and Karim 1997. Former WHO DG Margaret Chan, for example, recently said, “User fees punish the poor. User fees discourage people from seeking care until a condition is severe and far more difficult and costly to manage. Diabetes is a prime example. User fees waste resources as well as human lives.” Chan 2016.
organizations that was hard to ignore for a new government seeking the approval of international financiers.

More problematic was the surprisingly strong opposition from health workers to the policy. Much of the leadership in the public health sector remained staffed by administrators from the Apartheid era—both white and Black—who were protected by the negotiated settlement that kept the civil servants in their jobs and protected by “sunset” clauses at least through the second election in 1999. The abrupt change, especially associated with rapid increases in patient load, were resisted by much of the bureaucracy that was simply resistant to change.

Physicians had successfully opposed elimination of fees at various points in South African history since the 1940s when the Gluckman Report had proposed the creation of free and affordable primary care centers—a proposal foreclosed by the election of the National Party in 1948.²⁸¹ Efforts at the provincial level to eliminate or reduce user fees had been thwarted because of this opposition and the new initiative aroused similar opposition.

Far more important in 1994, though, was opposition from the nation’s nurses. At the time, there were about 165,000 registered and enrolled nurses—about 1/3 of whom were white and the rest largely Black, with 95% of them women.²⁸² In large parts of the country they were the only providers and recent legal changes had increased both their scope of practice and their centrality to frontline health services provision in the public sector. For many nurses, the new policy was experienced largely as a major shift in both burden and status. Government was committed to expanding access to healthcare, but simultaneously influenced by its own Department of Finance and external agencies, including the World Bank that maintaining fiscal discipline was critical—meaning additional resources, especially additions to the wage bill, were more limited. The influx of new patients therefore meant far greater patient loads for nurses without significantly more human resources. One study found that 85% of nurses experienced an immediate increase in workload and about 56% of survey respondents disagreed and strongly disagreed with the

²⁸¹ Marks 1997; Digby 2008.
²⁸² Marks 2005.
statement that ‘implementing free care has been rewarding’ for them personally.\textsuperscript{283} Wages, meanwhile, were starkly disparate at the time of transition between different parts of the fragmented health sector. White workers, dominant in certain sectors, started at higher salaries but demanded increased pay after a period of starved budgets.\textsuperscript{284} Addressing this disparity was a priority, but limited funds meant it was impossible to increase salaries equitably to avoid racial tensions while also expanding infrastructure and commodities to address the influx of patients.\textsuperscript{285}

Nurses, meanwhile, perceived the new policy as increasing their workload and undermining their working conditions while patients were abusing and overusing the health services and that those who were not entitled (e.g. foreigners) were accessing services.\textsuperscript{286} User fees were also sources of funds that provided greater autonomy to clinic administrators (often nurses) allowing greater power to set spending priorities.

The new government was therefore faced with a choice—expand access by building clinics and eliminating user fees or increase the wages and workforce. Complaining about the limited options available, Mandela worried that in the previous government’s budgets “ninety-one per cent of this was for salaries and administration and only nine percent for the needs of the people.”\textsuperscript{287} One can certainly debate which was the more important priority, but health officials focused on access as both a symbolic and substantive step that they saw as critical to jumpstarting transformation of the post-apartheid health system.

The push-back, however, was strong. Leaders in some hospitals announced they would not implement the policy or only do so selectively.\textsuperscript{288} The public health sector was thrown into turmoil from periodic nursing strikes throughout the country. In September 1995, 2,000 nurses went on strike at Baragwanath Hospital, the country’s largest, and several thousand additional nurses struck in Soweto’s clinics paralyzing the city’s health sector. Lawsuits were threatened by disaffected health workers. Walker and Gilsen note that, as “street level bureaucrats,” nurses had both significant

\begin{footnotes}
\item[283] Walker and Gilson 2004, 1254.
\item[284] Public services still on the boil 1995.
\item[285] Bachmann and Makan 1997.
\item[286] Health Systems Trust 1996; Schneider and Gilson 1999.
\item[288] Shortage of Funds Threatens Province’s Health Projects 1994.
\end{footnotes}
interest in having a say over policy and capacity to undermine implementation in policies set from above. Since fees were collected at various points throughout the system in ways that differed between provinces and that, in some cases, were idiosyncratic at the facility level and the definition of “primary care” was hotly debated, there were plenty of opportunities for resistance at the facility-level to actually abolishing fees.

Political leaders in certain provinces also fought the policy, which was a significant barrier given the power granted to provinces over healthcare delivery. The Western Cape and Gauteng provinces, for example, resisted the policy for quite a while, dragging their feet on full implementation.

“When it came time for implementation suddenly some of the provinces said, ‘No, we can’t remove the fees. It’s only where the need arises. We are going to be doing a means test.’ They said, ‘Look you know, we don’t have the money’ and others were saying ‘well, the unions might not agree.’ Typical of South Africa where people argue forever and nothing can move.” –Former Senior Health Official (Interview SA-57)

Early in this process of implementation, the new constitution was publicly announced and provided a new tool to health officials seeking to advance full implementation of the new health policy and to expand it to provide free primary care to all, as announced in 1996. The constitution did not dictate the free health policy, which had been a long time ANC promise, but several officials from the Mandela administration credit it with helping them push the expansion through a skeptical government and helping cut through recalcitrance of civil servants and overcome the pressure from both health workers and the neoliberal thinking of the time.

When it came to implementation—pushing administrators and frontline health workers to respect and follow the new policy in both letter and in spirit, Section 27 of the constitution in this context became an ideological reason for action in clear ways:

“Guys like me had to go out and defend this decision. I had to go out into the clinics

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290 The new constitution was published in 1995 at the height of the debate about free healthcare—how fully to implement the first phase for pregnant women and children and whether to expand free primary care to all. The final text was approved a year later, but was in wide circulation throughout the debate.
and hospitals against staff who were not policy people, but were people who saw the queues that they had to treat and still get home. I had to market the case and the base on which I did that was the Constitution. Here you had a constitutional right that you could argue that people were being deprived of under Apartheid.”

–Former Senior Health Official (Interview SA-54)

Rollout thus came to include a strong component of meetings and directives between central government and frontline health administrators that built from the Constitution as a starting point.

Countering a strong push from labor unions, the constitution provided a critical idea that put government on the side of the realization of people’s rights rather than against the interests of labor—which was a critical difference in a governing alliance in which COSATU was a powerful member. Indeed, this was part of the justification that kept COSATU-member unions largely on the sidelines, even as thousands of local nurses’ unions struck in wildcat actions.291

The constitution also shifted the power of health actors inside the state vis-à-vis their counterparts in more powerful ministries like the Treasury Department. The initial policy of free healthcare for pregnant women and children under six as enacted quickly—a direct promise in the ANC platform, it was announced with very little prior debate and relied on Mandela’s political capital. When it came time to consider whether to expand the policy, however, the complicated and diverse ideology within the Government of National Unity made it a harder. Under pressure from international financial institutions, Mandela first kept in place the National Party Finance Minister, overseeing the Treasury Department, and then appointed banking CEO Chris Liebenberg to succeed him—creating a powerful faction in government dedicated to a more neoliberal policy bent focused on maintaining fiscal discipline to drive economic growth.292 In this context, expanding free primary healthcare faced a more complicated policy setting. The government had also wrapped itself tightly in the new constitutional order, which created a very real ideological commitment and political basis for action.

291 Public services still on the boil 1995. Also Interview SA-45, senior health official, who was part of the negotiations of the time.

292 Bond 2014.
One former health official put it succinctly, remembering back to the debates and the ways in which the constitution represented a background political commitment that could be drawn up on in policy debates:

“The thing I can remember being like a truly positive move in line with the aspirations and those rights was the early years of Nkosazana Zuma when she said, ‘We’re making healthcare free at the primary care level. Screw it. We’re doing it.’ We fought for a constitution that includes health and we are not going back on that now was really how we thought about it.” –Former Senior Health Official (Interview SA-62)

As a policy anchor, the constitutional right to health in this context created a powerful framing process that helped health actors legitimize the push for free healthcare.

“I was sitting on the committee for that and I included treasury in those discussions. They kept saying things like, ‘This is fiscal nonsense.’ I remember their words, ‘Fiscal nonsense.’ We kept saying to them that the Constitution says this and we have to find a way to ensure universal access to primary healthcare, to the healthcare system overall. They were not happy.” –Former Senior Health Official (Interview SA-57)

Constitutionalization thus provided an important ideational tool for bureaucratic initiative. While the policy goal was driven by apex politics, those charged with implementing the program and negotiating the details with the rest of government drew on the institutional legitimacy offered by the right to health to advance policy change. By 1998, 86% of those who sought care in the public sector reported paying no fees—a portion that may not seems surprising for a presidential priority, but which shows far faster and more thorough uptake in two years than many of the Mandela governments’ policy changes amidst an embedded and resistant bureaucracy.

Drug Pricing

The issue of drug pricing also started early in the new republic. In 1994, South Africa faced a constrained health budget, significant unmet need for medicines, and drug prices that were far higher than similar countries. The post-Apartheid government set out a vision in the National Drug

293 Kaiser Family Foundation 1999.
Policy of 1996 that included a commitment to lowering drug expenditure through widespread use of generic rather than branded drugs. The Medicines and Related Substances Control Amendment was passed to give effect to the new policy in 1997, which included provisions amending the patent act to allow production and importation of generic medicines. Before it could go into force, the Pharmaceutical Manufacturing Association (PMA) sued to block its enactment. The Treatment Action Campaign was born later that year and immediately took up the issue—attacking the PMA’s case and noting that “making healthcare more accessible to South Africa’s poor is now a constitutional duty facing the government” (original emphasis). TAC joined the case on the side of government and mobilized global protests. When it came to the High Court in March 2001, public outrage in South Africa and abroad was clear, and so too was the legal standing of the companies—which stood little chance of blocking a law that met WTO TRIPS standards and was framed in the service of constitutional obligation. Within six weeks, the case was dropped.

Following this victory, and along with public campaigns to push companies to lower ARV prices, the AIDS Law Project and others again shifted venues—this time to the Competition Commission. In other countries and contexts, the Competition Commission has little to do with health policy and advancing health equity, but in a constitutionalized environment, advocates successfully used it as a venue to break new ground. Government at this point was still dragging its feet on implementing an ARV program, leaving activists and NGOs to take the issue of continued high prices up themselves. Alleging that GlaxoSmithKline and Boehringer Ingelheim were violating the Competition Act by charging excessive prices Hazel Tau, supported by the ALP, submitted a complaint to the Competition Commission. The submission claimed the Competition Act had to be understood in context of Section 27 of the constitution and demanded companies be ordered to license their drugs for generic production. The commission agreed and, in a striking press release, found that in South Africa competition law had to be interpreted toward “advancing social and economic welfare and correcting structural imbalances.” A settlement quickly followed in which

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294 South Africa 1996.
295 Treatment Action Campaign n.d.
296 For a full discussion of the PMA case see Cameron and Berger 2005.
297 Competition Commission 2003.
the companies agree to grant licenses to make or import generic versions of their AIDS drugs—a practice that has become standard practice in the country for all drug companies making HIV medicines. With little further support structure, however, the same standard has not extended outside of HIV—to additional high priced drugs for heart disease, cancer, etc. where government has also shown little appetite to challenge international drug companies and make use of the space afforded by the legal context.

**Silicosis & TB in Mines**

The history of South Africa’s economic development is inextricably tied to mining—in particular gold mining, on which the city of Johannesburg and much of the South African economy was built. It was not just the South African economy built on the gold mines—in the 1930s the country produced over 60% of the gold upon which the Western financial system rested. By the 1980s South African gold mines generated half of the country’s exports and employed over 750,000 people—a small group of unionized white miners and massive numbers of Black migrant workers from across the region and the rural parts of South Africa.

Health in South Africa is also deeply tied to mining. Triple epidemics of silicosis and tuberculosis, alongside the more recent addition of HIV have been driven by the mines and shape the disease profile of South Africans today. Silicosis is the “paradigmatic occupational disease of industrialism”—caused by inhaling silica dust from mechanized drilling, it scars the lungs and is not only fatal in itself, but it also greatly increases the chances of acquiring tuberculosis. TB, for its part, is spread incredibly effectively in the confined and poorly ventilated environments in mining and, in South Africa, reaches disastrous levels through the crowded communal housing where dozens of men share small sleeping spaces with poor nutrition and little opportunity for

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298 Interview SA-13.
299 McCulloch 2012, 8.
301 McCulloch 2012, 5.
hygiene. Sex work is common around the all-male hostels, increasing the risk of HIV transmission, which in turn increases the risk of active TB.\textsuperscript{302}

South Africa was, for decades, seen as a leader in addressing the health of miners. Between 1912 and 1918 the state enacted the world’s first compensation programs for silicosis and TB, a system of regular medial inspections, sanatoriums for white miners, and a system of paid annual leave—all for white miners.\textsuperscript{303} However, Black workers—from Malawi, Lesotho, Mozambique, and Botswana as well as South Africa’s Eastern Cape and other rural areas—were labeled temporary laborers, not miners, as the companies and the state worked together to craft a labor system designed to bring an adequate supply of young men to work. They were covered under a different, inferior system that paid lump sums instead of pensions and, instead of sanatoriums, Black men were repatriated, absolving mining companies of long term care obligations.\textsuperscript{304} South African scientists nonetheless played a leading role in studies of silicosis and, according to the mine’s self-reports through the 1980s, achieved lower levels of dust than most of the world.

At the time of transition to majority rule, it became clear that industry narratives of progress were fiction. The Leon Commission of Inquiry into mine health in 1994 found that death rates had not changed substantially between 1940 and 1980 and that “dust levels have remained roughly the same over a period of about 50 years. This constitutes a priori evidence that the absence of a downward trend in the official figures for certification is correctly interpreted as a failure to control dust related disease.”\textsuperscript{305}

The compensation system has been the key public health policy in question. This critical check on the industry is supposed to pay workers both to address their health issues and to incentivize companies toward creating a healthy workplace. It has achieved neither. Repeatedly, studies have shown compensation has not been paid to the majority of workers.\textsuperscript{306} Hundreds of

\textsuperscript{302} An in depth study in one town showed that more than two thirds of the sex workers were HIV-positive, Auvert et al. 2001.

\textsuperscript{303} Marks 2006, 577.

\textsuperscript{304} Ibid., 581.

\textsuperscript{305} Leon Commission 1995, 54.

\textsuperscript{306} Trapido et al. 1998; Roberts 2009; Maiphetlho and Ehrlich 2010.
thousands of mine workers and former workers currently suffer from lung disease that remains uncompensated in South Africa alone, not even considering nearby countries.307

Meanwhile, there is no evidence that interventions have reduced the risk of TB or silicosis to acceptable levels.308 While there are many fewer miners than at its heyday, over half a million active miners continue to work in the country, representing one of the largest pools of employed men in the region.309 Those miners have a greater incidence of TB than do any other working population in the world.310 Stuckler and colleagues have studied the region and shown that each 10% increase in mining activity was associated with a 0.9% higher rate of TB incidence—meaning a standard deviation change in mining was linked to 33% more TB.311 With a migratory population, even miners who start TB treatment at the mines are unlikely to be able to complete it, which generates a disproportionate number of secondary infections, spreading TB (and HIV) throughout the region in a manner similar to that of the gulag prisons in the former Soviet Union. Research has also shown prevalence of silicosis in miners to be far higher than let on by the companies—between 22% and 36%, with up to 60% of miners eventually developing silicosis.312

The compensation system through the end of Apartheid was both segregated and ineffective, designed to overlook the majority of workers and ensure a profitable industry rather than protect public health. As Brian Williams and colleagues have shown, companies “conveniently externalized the long-term costs of caring for these often-sick former workers” to ex-miners’ households and governmental health services in their regions of origin after they contracted TB and silicosis in the mines.313 Through the twentieth century, the impacts were largely felt in rural communities, with the migratory nature of mine work making much of the impact invisible.

With majority rule came a new ANC government that included the COSATU union and hope for significant reform. Cyril Ramaphosa, founder and head of the National Union of

307 Boyko et al. 2014.
308 Murray, Davies, and Rees 2011; Knight et al. 2015; Ndlovu et al. 2016.
310 Stuckler et al. 2011.
311 Ibid.
312 Trapido et al. 1998; Nelson et al. 2010.
313 Lurie and Williams 2014, 36; Campbell and Williams 1999.
Mineworkers, became general secretary of the ANC (and is today Deputy President of the country). The mining companies, however, proved nimble players—exercising power well beyond their share of the South African economy. The industry has always been concentrated—in the 1980s nearly 40% of shares on the Johannesburg Stock Exchange were accounted for by just one mining company, Anglo American. As McCullough notes, “Anglo American has almost limitless resources with which to defend itself, and much of the evidence about dust levels and disease rates lies in corporate hands.” The concentration of the industry and tight price control has enabled it to act as a single, decisive political force. It quickly incorporated Black leadership, including Cyril Ramaphosa who soon owned part of several of the companies and, by 2009, was under consideration to be chairman of the board of Anglo.

“There were senior members of the current government leadership who were negotiating on [the miners’] behalf. Unfortunately, they were not negotiating with good faith. They were actually negotiating their way to being shareholders, and ultimately, they are stinking rich. The health of the miners, of communities, it’s not what they really want. So, what do we do? Vote DA? I don’t think so.” – NGO leader (Interview SA-64)

This helps explain why, when the compensation law was amended—the Occupational Diseases in Mines and Works Act (ODMWA)—the core of the failing system remained intact despite the removal of racial clauses. Black Miners’ working conditions have changed little. There is wide consensus among organized labor, industry, the state, and most recently the judiciary, that the century-old system is not working, yet reform has been stopped a sprawling bureaucracy that cannot agree to a consensus to fix it and by politicians cautious of upsetting a powerful industry. In place of reform, the industry has built up an impressive set of tertiary medical institutions, which they say shows the industry is an actor for good—even critics note that mining employees have access to far better medical care than the communities surrounding them. In practice, however, only a minority of miners have access to these facilities since they live far from the mines and many

314 Lipton 1986.
315 McCulloch 2012, 158.
316 The new Randlord 1997; Anglo chairperson list includes Ramaphosa 2009.
318 Ehrlich and Rees 2016; Boyko et al. 2014.
are short term contractors. Tertiary care also does little to prevent the underlying conditions of TB and silicosis.

There have been repeated efforts and ideas to reform the compensation system or merge it with the more robust general COIDA worker compensation system—with each push focusing on the need to align the incentives behind the system with prevention of TB and silicosis. A decision was made in 1996 to merge different compensation systems with this in mind, but it has not yet been implemented—blocked at each turn by a narrative that doing so would be too complex, too costly, and could undermine a key area of the South African economy.319

With health policy intractable in this area, miners have more recently turned to the courts. In 2006, human rights lawyer Richard Spoor filed a case on behalf of Thembekile Mankayi, who had contracted TB while working for Anglo Gold for nearly 20 years. The High Court and Supreme Court of Appeals both rejected his claim on the basis that it was foreclosed by compensation laws, but in 2011 the Constitutional Court ruled for Mr. Mankayi, finding that “The golden thread that runs throughout ODIMWA and its antecedent legislation is that they address and limit the impact and spread of infectious diseases contracted in mines… [these diseases] exacted their toll on not only the health of mineworkers and their families, but have posed and continue to pose a danger to the health and welfare of the public.”320 Unfortunately, this ruling came too late for Mr. Mankayi, who died the week before the ruling. His case opened the door, however, to a broad class action lawsuit involving tens of thousands of former miners that is now making its ways through the courts—with certification of one of South Africa’s first ever class actions approved in May 2016.

While this is a private-law case claiming compensation for a “delict” (aka civil wrong or tort) by the mines, the constitutionalization of health has played an important role in broadening out the scope and bringing in public health concerns. The health and anti-violence group Sonke Gender Justice, along with the Treatment Action Campaign, successfully petitioned the court to join the case as *amici curiae*, represented by the legal services organization SECTION 27. Together,

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they highlighted a number of issues of constitutional law, pointing to the ways in which the actions of the mining companies had been not just negligent but also violated core rights protected by the Constitution including the interrelated rights to health (§27), life (§11), bodily integrity (§12), and environment necessary for health (§24). They also, importantly, addressed the “right of access to any information that is held by another person and that is required for the exercise or protection of any rights.”

The groups raised the public-law policy issues that lay behind the case, including the gendered impact of the actions of the mining companies—noting that women in these rural areas became the unpaid caregivers for sick miners; lost income when they fell ill, which affected the health of the whole family; and themselves were subjected to TB ad HIV due to the conditions of the miner’s work. They submitted affidavits from the economist Francis Wilson that outlined the implications for broader health policy of not allowing the class action to proceed given the policy stalemate and from former UN Special Rapporteur on the Right to Health, Anand Grover, outlining the international health rights framework that includes obligations of corporate actors. They also argued that the common law rules about damages needed to be developed in the context of South Africa’s constitutionalization of health to further allow transmissibility of damages to the families of those miners who died.

“We have got to strike earlier in the process. Not just at the end of the story where people are ill, and now you are trying to get medicine into people’s mouths. You want to create a healthy society. To do that you have to strike at the root of the system. You have to say that companies conduct themselves in a manner which spreads illness. We’ve got to deal with that. We’ve got to deal with TB as an underlying issue and use rights and the law to force changes in how people are forced to live that results in poor health.”
—Attorney (Interview SA-01)

The Court agreed with them in significant part, certifying the class based on both the public and private law arguments and agreeing with the amici’s argument to develop the common law and allow transmissible damages in the service of public health and justice.

322 Nkala and others v. Harmony Gold Mining Company Limited and others 2016, 204–215. Note that not all of the affidavits were officially admitted as evidence by the court, but the arguments are visible in the decision nonetheless.
323 Ibid., para 204, 214.
The rights groups also helped bring the issues out of the courtroom—holding widely-covered demonstrations outside the High Court and at the offices of the Teba agency, which is responsible for much of the recruitment of miners in the Eastern Cape, focused explicitly on the argument that private actors have constitutional obligations on health as well.

These groups are engaging in such a manner because of the constitutionalization of health—mobilizing around a court case and intervening both inside the courtroom and out because they see it as a way to change their legitimacy and address power relationships.

“We got involved because we know that on the ground, ordinary women are getting the brunt of burden of TB that emanates from the mine houses. Young girls have got to vacate and leave schools ungodly early without even thinking about that, because there’s no one to sustain them at school level not at university level. That’s the reality. But these are not the ones politicians care about. Many of them are even outside the country, though we feel the effects right here… So, we are actually trying to entrench ourselves in the constitution of the country, to say this actually protects us even if government will not. We will see…” – NGO leader (Interview SA-64)

Whether this intervention will bear fruit is not yet clear. As the court case proceeds public health officials expect to once-and-for-all be able to establish the actual size of the problem—information currently in the sole possession of the mining companies. Government *has* taken notice and, in January 2016 while the parties awaited the High Court judgement, the Deputy Minister of Mineral Resources convened a 2-day meeting with the mining houses and unions aimed at reforming the compensation system. “We are trying to solve a big problem. The ball was dropped before and a process led by labour minister Membathisi Mdladlana stopped,” he was quoted as saying.\(^{324}\) So far, however, the new ball seems no less dropped. It thus may be that the best chance of reform lies in a coming settlement of the class action—and whether a large payout prompts a change in practice, or perhaps whether the settlement itself might mandate reforms as some have advocated.

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\(^{324}\) Mining sector to reform worker compensation system 2016.
Migrants’ Access to Health

The economic hub of the region, South Africa is the destination for migrants from throughout Southern Africa and it is generally acknowledged that migrant groups experience major challenges accessing public healthcare. Migrants access to health has been another area of mixed impact for the constitutional right to health. Various statutes and policies govern different categories of migrants in the country—asylum seekers, refugees, economic migrants, and others all have varying status in the country. Different categories of cross-border migrants are granted different access to the public health system. By law, refugees and asylum seekers should be treated as South African citizens in terms of access to free public healthcare. Others are to be charged a foreign fee for certain health services, though the National Health Act (2003) assures everyone in the country access to emergency and life-saving care no matter the immigration status. Attorneys and activists together won access to ARVs without identity documents—an important policy not just for migrants but for public health overall on medicines that help stop the spread of disease.

In practice, however, ambiguity prevails. One of the major challenges has been that some public health facilities have been found to generate their own guidelines and policies that counter national legislation and continue to demand South African identity documents and deny access to international migrants no matter their status.

“It's not pro-migrant in its day-to-day implementation. What they'll say is that, yes of course, migrants have the same access to emergency healthcare that everybody else does, or we have a very good ARV regulation out there that says that you do not need an ID book to access ARVs under Department of Health Policy. But when you get to the clinic they don't implement it. They still deny access without the ID books.” – Attorney (Interview SA-65)

Lawyers for Human Rights and the Legal Resource Centre have both been active in supporting migrants’ claims for access to care. There has not been a major apex court case ruling on the rights of migrants to access health and, in general, there have been relatively few cases that make it into court. But on a range of specific issues—from access for children to ARVs—important

325 Amon and Todrys 2008; Vearey 2014.
326 Vearey and Nunez 2010.
policies have been set through litigation. On a day-to-day basis, meanwhile, the xenophobia of South African Society is often on display in clinics and the major impact of the constitution is that national government and public health administrators know they are likely to lose if the request is reasonable and they largely settle and grant access to healthcare when challenged. Access therefore is possible, but depends directly on the legal support structure.

National Health Insurance and the Private Sector

Finally, perhaps paradoxically, I turn now to the policy issue that could well have the biggest impact on wellbeing over the long term—the question of public sector and private sector health coverage. This is particularly interesting given how much of the international conversation on the right to health focuses on the idea of universal health coverage. As noted in chapter 4.1, one of the biggest issues facing South Africa is the two-tiered health system that remains significantly skewed in funding, human resources, and priority toward the 16% of the population with private health insurance. With high overall costs, poor clinical outcomes, and massive inequities in access, there is broad agreement that something must be done to reform South Africa’s health financing and access structures. South Africa has long had a significant tax-funded welfare state for white people, with its origins in the 1920s based in the left-right Pact Government of the time and rooted in a general strategy of racial segregation in response to the swartgevaar (‘black danger’). As the U.K. was launching its National Health service, the Gluckman Commission in 1945 recommended the same for South Africa—built upon establishing primary healthcare centers throughout the country. This idea enjoyed only a brief heyday before the National Party election in 1948 and the rise of the Apartheid state which labeled the idea “socialist.” At the behest of private doctors who viewed it as competition, government proceeded to dismantle the nascent primary health infrastructure—instead building the fragmented, racially hierarchical system inherited by the new government in 1994.

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327 Sridhar et al. 2015; Ooms et al. 2013.
328 Seekings 2007.
329 Pick, Rispel, and Naidoo 2008.
At the ANC’s 2007 Polokwane national conference, where Mbeki was ousted, a resolution was also pushed by KwaZulu-Natal premier Zweli Mkize and others to advance the creation of a National Health Insurance (NHI). Rollout has been slow, but in 2017 the final White Paper was released—setting policy for a fairly radical reorganization of healthcare through a system designed to pool funds for the purchase and provision of healthcare services into a single-payer system covering all South Africans. The new policy envisions an increase in public health expenditure from roughly 4% of GDP to 6.2% by 2025 through mandatory tax-based payments and the phase out of subsidies and tax breaks to private health insurance companies. The effort is currently in its pilot phase, envisioned to begin in earnest in 2022, and its future is both controversial and uncertain. Nonetheless it may augur major changes addressing the heart of some of South Africa’s biggest health issues.

So, what has been the role of the constitutionalization of health in the NHI? First, it is worth noting that the heart of the NHI push is directly related to party politics. The ANC has long promised an NHI of some sort and the decision in Polokwane to move the policy ahead was clearly based on electoral pressures and political dynamics within the governing coalition toward more progressive policies and provision of greater public goods. The exact shape of the NHI, however, has been hotly contested and subject to significant political pressure. That a single-payer system with a commitment to cost containment has been agreed was far from a foregone conclusion; private health providers and companies in South Africa are powerful. Private insurance “schemes” control 49.9% of health spending in the country and, while they are required to be non-profit, the administrators of those programs are largely for-profit entities with strong stakes in the status quo. Another 12% of health spending is out of pocket, most of it spent in private providers. Private providers from physicians to hospital groups are profit-making and they currently have access to roughly $16 billion per year in private provision income. Three large hospital groups own in excess of 80% of all private hospital beds in the country. Previous regulations including the

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330 South Africa 2017, para 203, 305-309.
331 Ataguba and McIntyre 2017.
332 South Africa 2017, para 66.
Medical Schemes Act of 1998 that required insurance schemes to cover at cost 270 prescribed minimum benefits have led to remarkable growth and profit in this sector that far outstrips inflation. Government employees including ministers and their staff are covered by these private insurance schemes and the plan to eliminate government payments for private insurance has worried quite a few.

This is an array of powerful interests in the status quo—a grouping and history of path-dependent processes that have killed health reform in other countries, including the U.S. In this context health actors have explicitly relied on the legitimacy of the constitution and the ideational framework of health as a right and a state obligation to justify the move toward a progressive single-payer health system and against the lobbying of medical schemes and the private health sector. The White Paper States that:

“NHI derives its mandate from Section 27 of the Bill of Rights of the Constitution of the Republic of South Africa in which a commitment is made for the State to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to health care.”

This reliance has been particularly important in a context in which the Treasury Department has actively opposed the move toward a single-payer system in overt and subtle ways. The Constitution has been a key part of these debates between Health and Treasury Departments.

“… very contentious, and the root of the fights between treasury and health is this issue of multi-payer and single-payer. Because multi-payer protects the interest of the few but it is also less costly and far more favored by the financiers… even though it doesn’t say in the Constitution that it should be a single-payer, but if you want to have everyone to have access to the same services, the same envelope, you got to have one single-payer, that would ensure that the standards and everything are the same flow-out. So, we made sure that was clear.” –Former Senior Health Official (Interview SA-57)

The second place where Constitutionalization has played a role has been opening space for and structuring a “market inquiry in the private healthcare sector” by the competition

333 Competition Commission of South Africa 2016.
335 South Africa 2017, para 8.
A variety of health actors quietly pushed the competition commission to launch the inquiry alongside the push toward the NHI because a great deal of information needed to actually launch the NHI and effectively restructure the health financing sector are simply not available—a particular challenge for a system meant to use a single public payer but include private service provision. Nothing in current legislation compels private medical insurance schemes to share the level of information about how their financing systems work and the actual costs, patterns of use, and trends over time with Department of Health or the public. However, under constitutionalization, the commission was able to combine an inquiry into whether the current structures “prevent, distort or restrict competition” with an inquiry into the health utility for patients.

“The Panel appreciates that access to healthcare services is a constitutional right and that this right also informs the competition assessment that it must undertake… Private healthcare provision takes place within the context of a constitutional commitment to the provision of healthcare services to everyone.”

Activists pushed the commission to both conduct the inquiry and frame it in this way so that critical new information about the current functioning of the health system could be placed in the public domain. In the end the inquiry was launched under the leadership of former Constitutional Court Chief Justice Sandile Ngcobo and has brought in patients to understand their experience with private health insurance and made a wide set of data and information available that leaders within government say has informed the planning for the NHI. “Because this is about access, as a constitutional issue, alongside competition between firms they have asked for and received data that they did not think they could get and that we have sought for years in the push for a real NHI,” reported one NGO attorney.

336 Full details on the market inquiry can be found at http://www.compcom.co.za/healthcare-inquiry/
337 Competition Commission of South Africa 2014, para 15, 19.
338 Interview SA-57, SA-62, SA-68.
339 Interview SA-42.
CHAPTER 4.5: CONCLUSION: South Africa’s Deep Institutionalization

“I think the Right to Health is the indispensable start, it gets things moving that otherwise might not. I’m not sure how it matters after that but it does open things up to where we can take a look and see…” — Justice, Constitutional Court of South Africa (Interview SA-03)

“If we hadn’t had that embedded into the Constitution we would have had just a straight political battle, but embedding that into the constitutional gave the court the possibility to step in and that truly changed the question.” — Senior ANC Official (Interview SA-50)

South Africa provides an example of deep institutionalization of the right to health. A great deal has been written about South African constitutional jurisprudence on health and the transformative role of the Constitutional Court. The contribution this chapter makes is to go beyond jurisprudence to the broader policy process and beyond the courtroom to the political realm. This exploration touches too on cases of rights mobilization that not received scholarly attention like EMS in the Eastern Cape and policy processes like the NHI and user fee elimination that have not been analyzed from a constitutional perspective. Taken together, the issues explored here show the diversity of contexts in which constitutionalization shifts politics and policy on health.

The country has faced a fairly clear set of health challenges over the decades since the fall of Apartheid—a massive HIV burden that is only now approaching the possibility of epidemic control, high mortality rates from causes highly amendable to basic medical intervention like deaths in childbirth, a two-tiered health system with a massive misalignment between resources and the burden of poor health. The case for policy change on a variety of fronts is clear and, while deeply complex, many of the core policy prescriptions have wide agreement among public health actors. Not surprisingly, the problems have been political. Post-Apartheid South Africa is characterized by
a wide variety of powerful competing interests, many of which have pushed hard against changes to the status quo—the whiter, wealthier communities resistant to redistributing health resources; a President resistant to introducing medicines to treat an epidemic he believed was overblow; self-interested private actors or corrupt officials looking to sustain their economic interests; and bureaucrats throughout the country resistant to policy changes that upset the usual order and threatened their position and authority.

Constitutionalization has hardly been a silver bullet, but it has been a positive force. Much in the way any shift in the institutions of governance might be, the effect has been slow and piecemeal, but taken together it does add up to changes in policy that can be traced back to improvements in wellbeing—change that would not have happened or not happened as fast without constitutionalization.

The right to health has been mobilized by a wide variety of actors—from civil society groups like the Treatment Action Campaign that rose specifically in a constitutionalized space to take advantage of the context to cause lawyers, judges, bureaucrats, and politicians. By providing opportunities to disrupt policy monopolies, the constitutionalized space has helped broaden the actors engaged in health policy to break policy stasis. Where Mbeki and Tshabalala-Msimang had closed off AIDS treatment policy, local bureaucrats had closed ranks against change in EMS policy, and multinational pharmaceutical companies sought to foreclose changes in drug pricing rules, constitutionalization gave policy entrepreneurs an opportunity to venue shift. Some examples included a shift to the Constitutional Court, but a diverse set of venues have proved responsive to rights mobilization on health policy with surprising efficacy, including both the Human Rights and Competition Commissions. Repeatedly, we have seen it is the threat of a turn to the courts that matters as has often been the case in migrant health.

These venue shifts have not always resulted in health benefits—as in the case of TB in prisons where, despite a Constitutional Court order, evidence suggests the key matters have not significantly changed. This is hardly surprising, however—literature in public policy has long shown that some policy monopolies are more resistant than others, and so it is in public health
issues. Where constitutionalization was able to break through even the opposition of the State President, correctional administrators who exercise great command and control over practices in the physical space of the prisons have proved a far harder monopoly to overcome. This point drives home a broader reality shown through this case—that apex court orders in themselves have been far less important in the scheme of things than the broader bargaining over policy that starts well before and continues long after any court order. Constitutionalization improves the bargaining endowments of key health actors—as it did even in the case of TB in prisons, where previously-ignored health actors have been able to access facilities, start new TB programs, and secure greater and greater resources to address the disease. That the shift in bargaining endowments has not yet been sufficient to also change how prison officials control and house inmates reflects only that the relative power of corrections officials remains significantly greater.

Constitutionalization has repeatedly helped liberate critical information even as democratic mechanisms from media coverage to electoral competition have not. There is an ambulance in Xhora Mouth today because of the intervention of the Human Rights Commission, which notably lacks enforcement power but brought to light data about underspending and planning to fail. Even more importantly, officials were personally compelled to reveal this information, explain their actions, and sit and listen to the testimony of communities. With this context of force transparency and a different kind of accountability, constitutionalization helped win change for some of the poorest and least powerful members of South African society.

Ideas and information have been key to the changes brought under constitutionalization. The South African experience includes several examples where the most important use to which the constitution has been put has been as an idea—a “reason for action” that has helped drive policy change. At a moment when international consensus supported expansion, not elimination of user fees, health leaders in the early ANC government mobilized health as a constitutional right to drive elimination through a resistant bureaucracy. In struggles over the NHI, the constitution has had powerful legitimating force for health actors to secure a policy commitment to a single payer over objections from Treasury. The ideational force of the constitution and the claiming of individual
and collective rights has been a powerful ideational counter the dominant ideas that have legitimated health policy monopolies—from the nationalist rhetoric of Mbeki to the idea of slow “transformation” of health services in the Eastern Cape.

The constitutional right to health matters in South Africa—and has its effect because it is not just the province of the courts, but has become embedded in the legislative directives at national and provincial levels, in the bureaucratic expectations in the health system, in the narratives and tactics of civil society, and in the repertoires of pro-health actors within the state. This deep institutionalization bodes well for continued impact and, as we will see in the next chapter, explains the gamut of impact of constitutionalization can be observed to have in other national contexts.
Chapter 5: India—Judicially-Led Constitutionalization

“The orders that are taken seriously are those where somebody reasonably senior in the department is facing the threat of contempt and whose presence is being demanded, I can vouch for this. Somebody comes running to me saying that, ‘Sir, we have to do something. Otherwise on the 13th of next month you have to appear before this judge.’ Then all the stops will be pulled out and something would be done and we would take a look [at] an issue that maybe was not a priority before so we could say to the courts ‘Please don’t call the secretary.’” – Former Senior Government Official (Interview IN-42)

Supreme court is powerful and the judges can shape policy and they have. It has actually opened a lot of doors. But then there are limits where they cannot interpret, they can fill some of the most critical gaps but in the end Supreme Court cannot legislate. And there is a, within our Indian constitution, there is a limit. – Physician/Public Health leader (Interview IN-14)

India, as its leaders like to say, is the world’s largest democracy—a vast, diverse subcontinent where policymakers face some of the most complex health and governance challenges on the planet. In 1995, in Consumer Education & Research Center v. Union of India, the Supreme Court of India established that health and access to public medical care, is a constitutional right.
The judiciary has since followed up with a spate of cases at various levels that has firmly enshrined that principle in jurisprudence. The effects of this move have cascaded through government and civil society. There remains, however, actively conflicting views about whether it is an established fact of law and governance, a promising idea requiring further government action to achieve real instantiation, or a bad idea advanced by an unaccountable judiciary. My goal here is not to settle this debate but instead to identify the impact that this move toward constitutionalization has had on health policy.

India can thus be identified as an example of partial constitutionalization; there are apex court cases and government policies responsive to health as a right and rights mobilization is both active and widely recognized by actors throughout the health sector. It is a particular type of institutionalization—one led by the judiciary. As such, it can be contrasted to the example in South Africa, where constitutionalization occurred in the same period but instead took form in the negotiated settlement that established the republic, and was included in far more explicit language in the constitutional text. I should note at the outset of this chapter that India is in some ways unique—there are few, if any, other examples where the national apex court has newly read a right to health in existing text and thus established a constitutionalization process so clearly. 1 This, however, is what makes India a particularly useful example for to explore qualitatively. It represents a textbook example of what critics of the right to health worry about—as Tushnet describes: “how could a court describe a better program? And even if we can somehow imagine what a court might say… In the end, we would have the courts running everything—raising taxes and deciding how the money should be spent.” 2 While India’s judicially-led constitutionalization is distinctive, many other countries have seen a highly judicially-focused implementation of the right to health. 3

Meanwhile, understanding India as an example of constitutionalization that differs not just in style, but in degree, provides a view into the mechanisms through which health rights act. In South Africa, stronger institutionalization has led to wider impacts, and rights mobilization on

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1 I should note that I include 1995 as the date India moved to a constitutional right in the large N dataset in chapter 2, but a robustness check dropping the case as an outlier confirms that the Indian case is not distorting the results.
2 Tushnet 2000, 169.
3 Flood and Gross 2014; Rodriguez Garavito 2013.
some of the same issues has yielded deeper impact. Nonetheless, as I describe in this chapter, constitutionalization in India has had a significant positive impact in several health policy issues acting through the same “policy anchor” mechanisms as in South Africa—creating space for policy change through disrupting policy monopolies and shifting the ideational frameworks governing health.

**Health & Health Policy in India**

Like South Africa, India represents a complex health environment where health leaders have struggled to address the large burden of disease amidst weak institutions. This is unlike Thailand, for example, where constitutionalization came in a context of strong political leadership, innovative approaches to addressing limited resources, and an effective medical and public health system. In India, health has been a low priority and poorly-governed, with few interruptions, since the colonial era—the effects of which are clear in mortality and morbidity rates in the world’s second most populous nation. Constitutionalization has mattered in India insofar as it has addressed this political context, aiding the formulation and implementation of better health policy.

Under the British, health in India had a low priority, even by the standards of colonial rule, and focused largely on protecting the British civilians and military. While 4.1% of revenues were spent on education in the late 19th century, just 0.15% was spent on health.\(^4\) Institutions like the

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\(^4\) Harrison 1994, 196.
respected Indian Medical Service and Calcutta School of Tropical Medicine were created as well as Sanitary Departments at national and provincial levels. However, without sufficient resources they did little for the health of most Indians. At independence in 1947, the new state inherited a significant health burden and little capacity. Life expectancy was estimated at just 26 years, 20 out every 1,000 births ended in maternal mortality, and millions of deaths resulted from epidemic diseases. There was only one nurse for every 43,000 people (goal was 1:500) and there were only about 5,000 trained midwives in the country. The Bhore Committee set up in 1943 put forward a vision of a national health system built on an ambitious architecture of primary healthcare centers, with one doctor for every 4,600 people. The post-independence government accepted the report but there were significant divisions among provincial leaders about whether and how to implement the recommendations and, with just four percent of public expenditures going to health at the time, dependence on the Center for financing hobbled the effort from the start. The tone was thus set early for the decades to come: under-investment in health, weak public policy and institutions, a problematic prioritization of impressive tertiary facilities, and disjuncture between states with fiscal dependence on the center continue to undermine the health system.

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5 Mushtaq 2009.
6 Bhore 1946, 7–19.
7 Bhore 1946.
8 Rao 2017, 10.
In the 50 years between independence and the Supreme Court’s move to identify health as a constitutional right, life expectancy in India more than doubled to 60 years. A series of disease-specific campaigns successfully improved health—bringing malaria deaths down from over 100 million cases to 2 million and eradicating smallpox in 1975. Economic growth was a major factor—figure 5.1 shows that there has been sustained improvements over the last forty years—as we might expect under economic conditions that saw sustained growth of just over six percent per year.

In the past two decades, India’s economy was one of the fastest growing throughout Asia—an emerging economic powerhouse, it has exercised increasing political power as well. Yet it is an oft-repeated reality that its health indicators fall below those of its neighbors like Bangladesh and Nepal. Despite being home to just 17% of the global population, India accounted for 20% of the global burden of disease (though this was a slight improvement since 2005). This has been a consistent trend for decades—Indians face more life years lost due to premature death and greater illness and injury than similar countries. As seen in Table 5.1, many of the major killers are preventable, treatable, or both, through public health interventions and access to basic healthcare. Deaths linked to birth and childhood infections still represent a large portion of deaths in India, resulting in high infant, child, and maternal mortality. Major epidemics hit the country hard: India has more new tuberculosis cases each year than any country in the world—at 2.8 million it is three times the number than that in more populous China, with a growing problem of drug-resistant strains. It is also home to the third-highest number of people living with HIV at two million, largely by dint of large population size. It is also the only country in Asia in the top-10 list of new malaria cases, though high treatment coverage has significantly reduced malaria’s ranking on Table

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10 Sharma 1996; Bhattacharya 2004. Note malaria cases would later rebound and today India faces a major malaria epidemic.
13 World Health Organization (WHO) 2016.
14 UNAIDS 2016.
5.1. Meanwhile, a growing portion of deaths and ill health are caused by non-communicable diseases linked to smoking and living conditions.

Health inequality is unmistakable; most major health indicators are worse in girls, in rural populations, in scheduled tribes and castes, and among the (related) poor, with wide variation across states.\(^{15}\) Measles provides a good example of how health system limitations and inequalities play out: In 2010 India accounted for nearly half of the 139,300 measles-related deaths that occurred globally.\(^{16}\) Researchers found that although vaccine cards showed relatively high vaccination rates, tens of thousands of deaths still occurred because the health system could not deliver an effective cold-storage chain and so vaccines lost potency, the most vulnerable populations had little access to healthcare and low vaccination rates, many children were vaccinated at the wrong age or with the wrong vaccine, and inadequate medical care for those with signs of measles meant fewer infected children survived.\(^{17}\)

<table>
<thead>
<tr>
<th>Country Name</th>
<th>Total health expenditure (% GDP)</th>
<th>Government health expenditure (% GDP)</th>
<th>Out-of-pocket expenditure (% of total health expenditure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>4.7</td>
<td>1.4</td>
<td>62.4</td>
</tr>
<tr>
<td>China</td>
<td>5.5</td>
<td>3.1</td>
<td>32.0</td>
</tr>
<tr>
<td>Brazil</td>
<td>8.3</td>
<td>3.8</td>
<td>25.5</td>
</tr>
<tr>
<td>South Africa</td>
<td>8.8</td>
<td>4.2</td>
<td>6.5</td>
</tr>
<tr>
<td>Mexico</td>
<td>6.3</td>
<td>3.3</td>
<td>44.0</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>9.1</td>
<td>7.6</td>
<td>9.7</td>
</tr>
<tr>
<td>United States</td>
<td>17.1</td>
<td>8.3</td>
<td>11.0</td>
</tr>
</tbody>
</table>

These kinds of health failures are the result of a set of particular factors in the political economy of health in India.

\(^{15}\) Patel et al. 2015.
\(^{16}\) Simons et al. 2012.
\(^{17}\) Awofeso, Rammohan, and Iqbal 2013.
The trend of low political priority and low public spending begun under the British has continued uninterrupted. As shown in table 5.2, India spends less of its GDP on health than other similar countries, and government spending makes up a particularly small portion. This small portion of the public budget going to health drives one of the world’s highest rates of out-of-pocket spending. A report by the Reserve Bank of India showed that this low spending for public health services is a driver of household debt and poverty—with the interest alone on emergency credit to cover medical expenses driving average Indians significantly down the wealth distribution.\(^{18}\) While low, public spending as a portion of GDP did increase from 0.98% in 1975 to 1.36% in 1986, only to fall back to 1.28% in 1991 and still further to 0.9% in 2000—among the lowest in the world.\(^{19}\)

As seen in figure 5.2, in recent years health spending has climbed back up, finally matching its previous levels in 2014.\(^{20}\) There are a multitude of factors driving this increase in spending, but it is notable that this corresponds to the period of constitutionalization which has arguably (as I do below) contributed toward programs like the National Rural health mission.

Under-resourcing, along with poor management, has left the primary health sector chronically weak. One recent study showed that “most facilities fall far short of minimum

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\(^{18}\) Reserve Bank of India 2017.
\(^{19}\) Rao 2017, 17.
\(^{20}\) Reliable and comparable spending and GDP data are not available from international sources before 1995. Graph relies on Rao 2017; Reddy and Selvaraju 1994 which report only certain years reflected here.
standards, with a long tail of facilities which are barely functioning.” The authors showed a striking variation in the quality of care across states, with districts in the South performing fairly well, while care was worse in West Bengal, Uttar Pradesh, and Manipur. Low-quality care was correlated to the highest levels of avoidable mortality. The National Rural Health Mission and more recent Urban counterpart have sought to reverse address this trend, with some success—adding thousands of new clinics and hospital beds in the public sector and investing in quality improvement, but much work remains.

The combination of steady economic growth, the rapid advances in allopathic medicine, and the stagnant public health sector has led to a dramatic expansion of under-regulated private sector clinics, pharmacies and hospitals. “In this din of swanky hospitals, modern technology, shifting aspirations backed by the willingness to pay, the concept of a family doctor and the neighborhood clinic that Bhore had envisioned was lost,” writes Sujatha Rao, former Union secretary for health. Liberalization in the 1990s sped up this trend as government cut public expenditure while subsidizing and facilitating the private sector.

“Not a single nurse, doctor was added on in some of the weakest districts between 1993 and 2005. Nobody. Not even to replace those who retired or died in the interim.” –former Senior Health Official (Interview IN-36)

At independence, the private sector provided just 5-10% of healthcare, but by the early 2000s it accounted for 82% of outpatient visits, 58% of inpatient expenditure, and 40% of births in institutions. Nearly all of this private spending has been out of pocket—leading the poor to use hospitals far less-often and, when they do, to suffer catastrophic financial burden. One World Bank study showed hospitalized Indians spent 58% of their total annual expenditures on health care, and more than 40% had to borrow money or sell assets—including farmland—driving them

21 Powell-Jackson, Acharya, and Mills 2013, 58.
23 Sengupta and Nundy 2005. Note this has since reduced to roughly 70% of outpatient care (Patel et al. 2015, 2428).
24 Reserve Bank of India 2017.
into poverty.\textsuperscript{25} This private sector has remained remarkably unregulated, undermining any sense of an effective health “system.” In major urban centers, facilities are increasingly run by large corporations that have absorbed smaller providers and become powerful local political and economic players. Meanwhile, in slums and rural areas, a large number of underqualified and low-skilled health providers contribute to such problems as improper immunization.\textsuperscript{26} The private sector context has driven high expenditure on drugs and a major problem with “irrational” use of the wrong drugs to treat the wrong symptoms, both of which government refused to tackle until recently. All of this has also created a vicious cycle resulting in abandonment of the public health sector by anyone who can afford private care, creating a powerful interest group able to resist regulation and public-sector encroachment.

Governance of the health sector represents a major challenge running throughout all of these issues. According to the Constitution, health is a state subject, yet almost two-thirds of health funding comes from the center and much of health policy is driven (or not) by central initiatives and legislation. Many of the laws and policies that have passed, however, have not been implemented—from the 2010 Clinical Establishments Act to the 2006 Medical Devices Regulation Bill, health legislation and policies languish. Given India’s size and diversity, there are significant limits to what central authority can accomplish and, in 2003, constitutional status was granted to local government, providing a key opportunity to improve accountability through decentralization, though the effectiveness of these reforms remains in question.\textsuperscript{27}

It is into this context—a long history of compounding challenges, huge burden of ill health, and weak public institutions—that constitutionalization has been introduced. The question before us then is whether this move has mattered and, if so, how?
Constitutionalization

Constitutionalization of health in India needs to be seen in the light of the specific institutions of the Indian judiciary, and the Supreme Court in particular, as an actor in the messy political democracy of the country. Pratap Mehta calls the judiciary’s role in India “promiscuous”—not only interpreting laws and ruling on the constitutionality of legislation but also formulating policy, supervising investigations, and ordering new institutions to be set up.\(^{28}\) The Court itself is a sprawling institution with 31 judges who sit in benches of multiple sizes—more of a multi-level judicial system in itself, dealing with tens of thousands of cases every year, than an apex court of final arbitration.\(^{29}\) The Supreme Court in 1993 even took the remarkable step of interpreting the Constitution to mean that Justices of the Supreme Court could only be appointed upon recommendation of the other Justices.\(^{30}\) Early in the Court’s history, it was focused largely on procedural issues and then on protecting property and first-generation rights. Often more conservative than the executive branch and seen as an impediment to social transformation of post-colonial India, nearly half of the first amendments to the Constitution were aimed at curtailing the power of the judiciary.\(^{31}\)

Following its failure to defend the Constitution during the Emergency period, the Supreme Court worked to regain its legitimacy by expanding access to the courts and championing human rights and good governance.\(^{32}\) Relaxing rules on standing gave far wider access to the Supreme Court, which began to expand its remit to a far wider range of policy issues, giving rise to a new class of public interest litigation (PIL) cases. The judiciary has thus become far more “inventive and activist” and a substantial political force as developments like the PIL transformed both the form

\(^{28}\) Mehta 2015, 233.
\(^{29}\) Robinson 2013 shows that the total number of cases has risen in recent year but constitutional benches have become increasingly rare.
\(^{31}\) Mehta 2005, 168.
\(^{32}\) See Baxi 1985; Desai and Muralidhar 2004. During “The Emergency” 1975-77, the government declared a state of emergency in what is regarded as a dark period in Indian democracy, and the Supreme Court ruled the government could suspend even fundamental rights. In the period that followed, the Court needed to fix its tarnished image and turned toward more populist measures.
and substance of the courts.\textsuperscript{33} The Supreme Court has established court-appointed commissions and crafted a practice of “continuing mandamus” in order to monitor implementation of judicial orders as it has in cases on food, the environment, education, and more.\textsuperscript{34} These moves have been highly debated. Some hail the PIL as a critical accountability mechanism to issues no other part of government will tackle, while others have argued that, while addressing critical shortfalls, “the growth of PIL has also taken its toll on the apex court, which spends increasingly less time deciding important questions of a constitutional nature and more on populist posturing.”\textsuperscript{35} Still others suggest the PIL is funneling policy issues into a binary between state and marketplace that fails to reflect the true needs of the poor.\textsuperscript{36} It is clear to all, however, that the Court exercises significant power that comes, in significant part, from the vacuum created by the weakening of India’s legislative and executive institutions.\textsuperscript{37}

Analysts have thus described the Court as a “good governance court”\textsuperscript{38} and “accountability court” an “embedded negotiator” court among many other adjectives—in other words a a far more complex institution than typically imagined in a “court”\textsuperscript{39}

Constitutionalizing Health—Courts and State Action

The Indian Constitution directs that “the State shall regard the… improvement of public health as among its primary duties.”\textsuperscript{40} This is a directive principle of state policy (DPSP), however, distinguished from Part III of the Constitution which enshrines a series of civil and political rights as “fundamental rights.” The former is not enforceable by courts, and in the early years this

\textsuperscript{33} Galanter and Krishnan 2003; Suresh and Narrain 2014.
\textsuperscript{34} See e.g. \textit{PUCL vs Union of India & Others} 2001, the “right to food” case in which the Court ordered the creation of an office of Supreme Court Commissioners to “track side-by-side hunger and the implementation of interim orders relevant to the Right to Food Case across the country.” (www.sccommissioners.org)
\textsuperscript{35} Kapur, Mehta, and Vaishnav 2017, 9. But see Gauri 2014, 102 arguing PILs take up only a small part of the Supreme Court's overall caseload, identified by Robinson (2013, 572) as about 1% of the overall workload.
\textsuperscript{36} Rajagopal 2007.
\textsuperscript{37} Khosla and Padmanabhan 2017.
\textsuperscript{38} Robinson 2009; Mehta 2015; Shankar 2013.
\textsuperscript{39} Robinson 2009.
\textsuperscript{40} Article 47.
prohibition on judiciability was strictly enforced by the courts.\textsuperscript{41} With the post-Emergency expansion into social issues, however, the Court began to unite the two sections of the Constitution. In \textit{Francis Coralie Mullin v. Delhi}, the Court formally set aside the barrier between civil and political rights and socioeconomics rights, using the idea of dignity as a prism through which to interpret the right to life, originally construed as a classic negative right against unfair state action, as a positive right conferring duties on the state.\textsuperscript{42}

In 1995, the Supreme Court ruled in \textit{Consumer Education \& Research Center v. Union of India} that health was a judiciable right under Article 21 of the Constitution—the right to life. In a PIL seeking the protection of workers against the health hazards associated with asbestos exposure, the petitioners sought to fill gaps in the compensation systems and medical services available to workers suffering from asbestosis. “The expression ‘life’ assured in Art. 21 of the Constitution does not connote mere animal existence or continued drudgery through life…” the Court ruled. “Therefore, it must be held that the right to health and medical care is a fundamental right under Article 21…”\textsuperscript{43} In its 1996 decision of a case involving a man who had been turned away from six different government hospitals after falling from a train, the Supreme Court of India articulated its understanding of the right to health as one that includes a state duty to provide medical care. “Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21.”\textsuperscript{44} Reading access to healthcare into the right to life also addressed the Court’s desire to give meaning to Article 38 of the Constitution, which designates the Indian Union as a welfare state. The following year, the Supreme Court affirmed, “It is now settled law that right to health is integral to right to life. Government has constitutional obligation to provide the health facilities.”\textsuperscript{45} While doing so just a decade before would have been a relatively innovative act in global perspective, by

\begin{footnotesize}
\begin{itemize}
\item 41 Article 37.
\item 42 \textit{Francis Coralie Mullin v. The Administration, Union Territory of Delhi} 1981.
\item 43 \textit{Consumer Education \& Research Center v. Union of India} 1995, para 24, 26.
\item 44 \textit{Paschim Banga Khet Mazdoorsamity v. State of West Bengal and Anr.}, 1996 SCC (4) 37.
\end{itemize}
\end{footnotesize}
the mid-1990s it was becoming commonplace for constitutions to include an explicit right to health, and it continued the Court’s moves to read the DPSPs into the Constitution’s fundamental rights.

India’s constitutionalization thus came not from a negotiated political settlement, but from a set of court cases. Various governments since have accepted this move and incorporated recognition thereof in pieces of policy (e.g. draft National Health Policy, 2015). There is no clearer evidence that institutionalization of health as a right is only partial, however, than the continuing conversations over whether the government should legislate a right to health. There was much talk in the first UPA government (led by the Congress party) about a right to health bill—a version of which was finally introduced near the end of the first UPA government in 2009 on the way into elections. The bill recognized the Supreme Court’s jurisprudence in its preamble and moved on to structure a judicially enforceable right to health and outline the core responsibilities of the state around public health and medical care.46 The bill, however, never passed.

“Mostly we just ran out of time. UPA-I we had a lot on our plate and during UPA-II there was far less left support. The energy went into the Food Security Act and there was a sense that UPA-III would have done the Right to Health Act but there was no UPA-III.” –Senior Congress Party Leader (Interview IN-39)

The NDA government’s first pass at a draft Health Policy directly engaged with the rights discussion—acknowledging the Court’s finding, yet noting there remained debate about the best way to give shape and form to the constitutional obligation. “To break the deadlock and this vacillation and move forwards with determination- the draft national health policy proposes the following formulation- the Center shall enact, after due discussion and on the request of three or more States a National Health Rights Act, which will ensure health as a fundamental right, whose denial will be justiciable.” After significant internal debate, however, the final Health Policy dropped the idea of health rights.

“To be honest I was surprised to see that in there the first time. Health Assurance is this government’s framework and that is certainly not rights. In fact, no one is quite sure what it will mean. It is not hard to see that the Supreme Court will have its say though, we will see.” –Public Health Leader (Interview IN-44)

46 The National Health Bill, 2009 (GoI Working Draft) 2009.
On the side of the judiciary, though, development of a robust jurisprudence on health as a right has continued apace. Between 1996 and 2016, the Supreme Court and the next level High Courts addressed Article 21 alongside health in 2,771 cases.47 This includes cases that did not turn on the right to health, but it indicates that health quickly became recognized as part of the fundamental rights in Indian Constitutional jurisprudence. Figure 5.3 shows the growth in these cases which happened quickly after 1995. As seen here, a more recent increase in these cases since 2010 might be attributable to the dramatic spike in cases overall in the High and Supreme Courts, but throughout the 1990s and 2000s the number of these cases rose even as overall cases did not.

Charles Epp documented the weakness of the early Indian “rights revolution” through the early 1990s, and the limited utility of the judge-created PIL opportunities due to the limited support structure in India.48 In more recent years, however, there are signs of a strengthening infrastructure and use of the courts—the right to health is one of these areas. While hardly a panacea, several

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47 Based on a boolean search using the Indian Kanoon database for “Article 21” and health” in Supreme Court and High Court. Note article 21 is the right to life, discussed infra, which the Indian Supreme court identified as the source of the right to health and around which the jurisprudence was built.

important right to health cases have come to the courts through PIL, as described below. Shankar and Metha note that still few poor people approach the court, but the not-insignificant number of cases that have come illustrate an eagerness of the courts to act.⁴⁹

Subjects of Litigation

The key questions for this project is whether constitutionalization of health is good, bad or indifferent—which in India hinges significantly on how the right to health is mobilized around the courts. As the case studies later in this chapter illustrate, even in India’s judicially-driven context, the most important aspects of the right to health come in the bargaining over policy outside the courtroom, not from court orders. Nonetheless, the question of whether litigation is touching on important public health issues or instead driving a distorted policy likely to undermine effective public health is a key starting point. One of the worries is that with the Supreme Court offering low barriers to access and a robust—but not always coherent—legal analysis, that it will be captured by individualist or middle-class interests. In Latin America, this apprehension has been most clearly focused around medicines as large numbers of cases for access to specific medicines for individuals has been a driver of much of the court attention.

In the case of India, there is at least some evidence that courts are navigating a path to avoid this pitfall and have focused on what many experts agree are the main challenges in the Indian system—low investment and poor implementation. In 224 cases, the highest courts in the country drew upon the right to health explicitly—from which I was able to draw a sample of at least 121 cases that I could clearly identify as rulings in which the right to health was central to the decision.⁵⁰ These ranged from ordering the state to provide antiretroviral AIDS drugs and health facilities to religious pilgrims, to considering health impact as a factor in denying patents on life-saving drugs,

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⁴⁹ Shankar and Mehta 2008.
⁵⁰ I drew the sample by drawing on the cases included in the Global Health & Human Rights Database, Georgetown University O’Neill Institute and Lawyers Collective n.d. alongside a subset of cases mentioned specifically in one of several sources including Shankar and Mehta 2008; Parmar and Wahi 2011; Muralidhar 2008.
to ensure affordable generic versions were available. They collectively show a very active court addressing far-reaching policies, despite expectations to the contrary. As previous research has shown, plaintiffs in right to health cases are highly successful—nearly 70% win.51 Figure 5.4 shows the categories into which the 121 cases in our sample of significant Supreme Court and High Court rulings fall.

A number of the cases fall into the category of individual remedies for government workers. These cases are the most traditional adjudication cases in the model of the courts as neutral third-party conflict resolvers.52 The court has ruled that government must fulfill its healthcare obligations to current and former state workers,53 cannot arbitrarily change the rules, and must reimburse employees that seek urgent care.54 The litigants are often relatively privileged government employees seeking higher reimbursements and so could be seen as the type of adjudication critics

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51 Shankar and Mehta 2008.
52 Shapiro 1986.
have worried about. Importantly, though, these cases can largely be understood as the Court enforcing and interpreting obligations already taken on by the state—not creating new and costly obligations on behalf of an advantaged group. Indeed, when recently asked to do just this by ex-servicemen, the Court declined to do so.55

Meanwhile, much of the Court’s work has been in tackling core problems of health system performance and public health—the work that Nick Robinson has labeled part of a “good governance court.”56 The Court has built out the idea of a minimum core of health services to which people are entitled, including emergency medical care, without creating a specific court-mandated set of requirements, largely leaving this to government.57 The Court’s work has included using the right to health to hold state officials responsible for denying poor people access to services to which they were entitled,58 prevent unregistered and unqualified individuals from practicing medicine,59 enforce agreements by hospitals to provide free treatment in exchange for land,60 require regulation of blood banks,61 enforce minimum health obligations of companies involved in dangerous businesses,62 and many other issues. Recently the court, on its own motion, took note of deaths of Amarnath pilgrims and ordered authorities to create proper medical and other facilities for the pilgrims.63

As the bulk of the courts work, these kinds of cases have shown a thoughtful and restrained engagement in which the courts respond to failures in the system. Rather than order individual remedies, court engagement has focused on “catalyzing changes in law and policy” (Muralidhar 2008, 117). While the court has refused to accept financial constraints as an absolute response, it has also not ordered costly individual remedies in large numbers, instead primarily identifying state and private obligations to be addressed more broadly. It has focused largely on raising unaddressed

55 Confederation of Exe Servicemen Associations v. Union of India, 2006 (4) SCR 872; (8) SCC 399.
56 Robinson 2009.
58 Laxmi Mandal v. Deen Dayal Harinaragar Hospital and Ors., 2010 HC-Delhi 2983.
60 Social Jurist v. Government of NCT of Delhi and Ors. 140 2007 HC-Delhi DLT 698
61 M. Vijaya v. Chairman and Managing Director, Singareni Colleries Co. Ltd., Hyd. And Ors., AIR 2001 AP 502;
63 Court On Its Own Motion vs Union Of India & Ors. Suo Motu Writ Petition (Civil) No 284 of 2012.
issues and setting benchmarks for progress toward improved health service delivery. Worries that the courts will end up running everything have not shown themselves in Indian RTh cases.

Concerns that the courts will simply go from case to case without ever affecting real change are also being addressed, if imperfectly. As former Chief Justice Bhagwati noted,

“The orders made by the Court are obviously not self-executing. They have to be enforced through State agencies and if the State agencies are not enthusiastic in enforcing the court orders, the object and purpose of [Social Action Litigation] would remain largely unfulfilled. The consequence of the failure of State machinery to secure the enforcement of court orders in SAL cases would not only result in the denial of effective justice to the disadvantaged groups but would also have a demoralizing effect on further attempts at litigation.”

The courts have responded to this concern with a series of innovations that go beyond the broadened standing requirements in the PIL, to using a range of innovative structures in an attempt to both help it understand the full scope of the health system issues and enable better enforcement. Parmar and Wahi document the use(s) of many of these elements in right to health cases. To increase its understanding, the court has established expert committees and external investigative commissions — efforts designed to specifically address the limitations of the courts. In order to try to deal with the enforcement issues inherent in such cases, the court has exercised continuing mandamus in which the courts have issued interim decisions but retained supervisory jurisdiction over a number of cases in order to continue to monitor them. In addition to mandatory orders, the courts have set up oversight committees appointed for a range of purposes—to fill vacancies of health professionals, to report back to the court on the conditions of mental hospitals, and even to identify which pharmaceutical drugs should be banned. Whether these bodies are helpful innovation or harmful parallel systems, however, has to be judged in the context of the policy cycle as a whole.

These actions do not well-conform to the concerns about courts in the literature. Courts are still, without question, imperfect vehicles by which to set health policy—but the Indian courts seem to be navigating a different role and instead creating an accountability function on the right

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to health where failure of other public and private actors is clear and significant. Its focus seems
designed, in part, to have the improved service delivery that the large-N regression in chapter 2
suggests.

As I have repeatedly argued here, though, to understand the impact of constitutionalization
we must look well-beyond court orders in isolation and trace policy issues from before rights
mobilization to well-afterward to see how power, ideas, and actors shift. Therefore, I turn now to a
set of such policy issues. I begin by going into depth on three policy issues—HIV treatment, where
the mechanisms of action of constitutionalization are perhaps most clear; clinical trials, where court
intervention has been highly contentious in public health circles and I suggest is misunderstood in
snapshot depictions in the West; and the implementation of the National Rural Health Mission
where we begin to see the outlines of constitutionalization beyond the court. I then turn to briefer
examination of issues dealing with the safety and affordability of medicines, maternal healthcare,
LGBT rights, and the unsuccessful effort to legislate a right to health. In each of these issues we see
the mechanisms outlined in chapter 3 at play—the shifts in institutional environment under
constitutionalization, in actors, venues and ideas, has a significant effect on policy. However we
also see the limits of judicially driven constitutionalization.

**HIV Treatment**

“The Constitution is a tool we have learned how to use to push through issues that
politicians ignore and bureaucrats want to just take their time on and then say they
are still considering it while people drop dead around them. The Constitution says
no, do it now.” –PLHIV leader (Interview IN-08)

The story of the refusal to roll out HIV treatment in South Africa described in chapter 4.3
generated significant global attention—but in India the timelines were nearly identical, with
government standing in the way until years after other countries had rolled out treatment.
Mobilizing a different set of ideas centering affordability, the Indian policy monopoly was at least
as strong as that in South Africa

HIV was first detected in India in 1986 among female sex workers in Tamil Nadu, and was
further revealed throughout significant swaths of the country. By the early 2000s it had been
detected in 29 of India’s (at the time) 32 states and union territories. The exact size and trajectory of the epidemic in India has been hotly debated for years. In the early 2000s, opinions verged from a “disaster in the making” or, from the U.S. CIA, dire warnings of potentially tens of millions living with HIV, to the more sober estimates that nonetheless recognized that millions in India were living with HIV by the turn of the century.\textsuperscript{65} More recent estimates show over 2 million people living with HIV in India in 2015—making it the third-largest epidemic in the world behind South Africa and Nigeria.

Taking India as a whole, 2 million is not a large number—translating to just 0.3% prevalence in 2015, down from closer to 0.5% around 2000. Compared to Southern Africa, these are low rates. However, comparing India as a whole gives a distorted epidemiologic picture since the HIV epidemic has been concentrated in a subset of states, and many states in India have populations far larger than many countries.\textsuperscript{66} Maharashtra, Karnataka, Andhra Pradesh, and Tamil Nadu have all had “generalized” epidemics (i.e. more than 1% of women attending antenatal clinics were HIV-positive) largely driven by heterosexual transmission. Together these states have a population roughly the same as the United States and larger by a third than Brazil, but have two-to-four times the HIV prevalence respectively.\textsuperscript{67} At the height of the U.S. epidemic 41,000 people were dying of AIDS per year,

Figure 5.5 India HIV Prevalence

Source: 2012 data, Antenatal prevalence NACO 2015, John et. al. 2011

\textsuperscript{65} Kadiyala and Barnett 2004; National Intelligence Council 2002; NACO 2003b.
\textsuperscript{66} NACO 2003a; NACO 2006a; NACO 2017.
\textsuperscript{67} UNAIDS n.d.
while more than twice that number died in these four Indian states. Meanwhile on the Myanmar border in Manipur, Nagaland, and Mizoram, most districts report well over 1% antenatal prevalence and HIV infection largely linked to intravenous drug use—rates higher than Myanmar or Thailand. Suffice it to say the AIDS problem in India has been significant. Meanwhile sub-populations have been particularly hard hit—including sex workers, intravenous drug users, men who have sex with men, and truck drivers. In some areas, these populations have had between 30% and 55% prevalence.\(^68\)

Indian and international public health experts raised the alarm early in the epidemic. The few who were getting tested for HIV including sex workers in Mumbai and injecting drug users in Manipur had well over 5% prevalence. The WHO warned India had just a few years to get its HIV epidemic under control or it could risk dramatically rising prevalence.\(^69\)

In the early response to HIV, as in many parts of the world, blame of marginalized groups and foreigners for spreading the disease undermined an effective early response.\(^70\) Instead the programmatic effort was punitive and coercive, which was not particular effective. The National AIDS Prevention Bill of 1989 would have mandated medical providers to identify “high risk” people and bring in authorities to institute compulsory HIV testing and isolation for those found HIV-positive.\(^71\) State bills passed in Goa in 1987 required quarantine, and in Maharashtra allowed arrest and segregation camps.\(^72\) While media reports about chained and jailed addicts in Manipur created outrage, the coercive instincts of the state were only contained after sustained pressure from human rights and public health experts who decried such steps as ineffective.\(^73\) The first AIDS bill was eventually withdrawn, but the government’s instinct toward basing its HIV strategy on identifying and changing the behavior of a small subset of the population perceived as driving the epidemic

\(^{68}\) Brahme et al. 2006; Boily et al. 2013; Chandrasekaran et al. 2006; NACO 2006b.
\(^{69}\) Mangla 1992.

\(^{70}\) Blaming foreigners has been “among the earliest and the most enduring responses to the HIV/AIDS epidemic.” Amon and Todrys 2008. In India some observers “blamed it on Sri Lankan militants, promiscuous African students, and the West for selling condoms.” (Kadiyala and Barnett 2004). This is hardly unique. In the U.S. see Farmer 2001 on the blame of Haitians and far more recently see the comments of Nigel Farage in “Nigel Farage’s HIV claim criticised by leaders’ debate rivals” 2015.


\(^{72}\) Padmanvati 1991.

\(^{73}\) Aids Is A Blessing, Says Keeper Of The Chained Addicts 1991.
(through varying degrees of incentive and coercion) has persisted.\textsuperscript{74} The identification of “high risk” groups in the Indian strategy has not only focused far more exclusively on groups like sex workers and men who have sex with men than is warranted by the epidemiology, but it has carried shades of ethnic and caste mapping.\textsuperscript{75}

The government did take early steps to build an AIDS response. It started a National AIDS Control Program in 1987, but lacking both resources and leadership, it did little to stop disease progression and did a lot to expand quackery by deputizing poorly trained health workers across the country to fight AIDS. As one doctor distributing homeopathic pills she hoped would cure AIDS put it, “I admit we are working in crude ways. But we have almost no money budgeted for this programme. The government is too busy in meetings to realise what is going on. So I’m taking the initiative. I believe in miracles.”\textsuperscript{76}

By 1992, the government began a program in earnest—taking out an $84 million loan from the World Bank to create the National AIDS Control Organization and launch an effort that actually made the AIDS program the second-largest in the center’s health budget behind malaria.\textsuperscript{77} But that too faced significant challenges in the absence of political leadership—left largely to a technocratic group within the Ministry of Health and Family Welfare, the new central program seeking to address issues largely left to state-level government faced an uphill battle.\textsuperscript{78} “Stimulating states’ commitment to HIV-related work generally failed, resulting in an uneven response, particularly among those with high incidence and weak health systems.”\textsuperscript{79} Head of UNAIDS, Peter Piot, reported attending meetings in India where he “heard great speeches, but as for action, zero.”\textsuperscript{80}

These dynamics—lack of political attention, technocratic governance, complex federalism, and a disease enmeshed with caste politics—are not unique to HIV, even as some particularly

\textsuperscript{74} Chatterjee 2006; Chandrasekaran et al. 2006.
\textsuperscript{75} Lieberman 2009, 204.
\textsuperscript{76} Losing the battle with AIDS. 1990.
\textsuperscript{77} Mangla 1992.
\textsuperscript{78} By the end of the loan there remained significant unspent funds, which had to be spent down quickly in an extension period—largely programmed through NGOs for large “communication” campaigns that were never evaluated for efficacy (Chhabra 2007).
\textsuperscript{79} Rao 2017, 203.
\textsuperscript{80} Worldwide war on AIDS/HIV still coming up way short 2003.
exceptional conditions distinguish the epidemic. A similar deep malaise can be seen across various parts of the under-funded, under-capacitated Indian health system. See, for example, the TB program has been struggling for fifty years between optimism and failure.\textsuperscript{81} The argument here is not that these factors are distinctive, but instead too-common and that rights mobilization had to address these factors to be effective. In particular these factors explain, in part, one of the major failings of the AIDS response through the early 2000s: a lack of any public antiretroviral treatment program.

\textit{Failing to Roll out ARV Treatment}

The year after HIV was revealed in India, the Food and Drug administration approved the drug AZT as the first treatment for AIDS, though it was only partially effective.\textsuperscript{82} By 1991, the Indian generic drug company Cipla had produced a version of the drug, which was soon selling for one quarter of the price offered by multinational drug companies.\textsuperscript{83} By 1996, the breakthrough of combination antiretroviral (ARV) therapy was proven effective and, from the U.S. and Europe to Brazil and Thailand, hospitalization and deaths plummeted where ARVs were rolled out.\textsuperscript{84} As seen in Figure 5.7, however, no such roll out happened in India.

Instead, the Indian HIV program remained exclusively focused on \textit{prevention} strategies, with a sharp focus on the “high risk groups.” The 1998 National AIDS Policy set forth a program with the chief aim to prevent the further spread of HIV “by making the people at large and specially the high-risk groups, aware of its implications and provide them with the necessary tools for protecting themselves from getting infected.”\textsuperscript{85} The main strategy was to use nongovernmental organizations (NGOs) to deliver HIV prevention interventions—with over 660 NGOs engaged

\begin{footnotesize}
\begin{itemize}
\item\textsuperscript{81} Sharma 2017; John 2014.
\item\textsuperscript{82} FDA 2014.
\item\textsuperscript{83} Flynn 2014, vol. 11, 119; Hakansta 1998.
\item\textsuperscript{84} Zuniga et al. 2008; Palella et al. 1998.
\item\textsuperscript{85} National AIDS Policy 1998.
\end{itemize}
\end{footnotesize}
across different states. Treatment was identified as too expensive and “still in the initial trial stage.” By 2002 National Health Policy had little more to say—with only passing mention of HIV except for a pledge to “bring about a behavioural change to prevent HIV/AIDS and other life-style diseases.”

Not starting an HIV treatment program had three broad and negative effects in India: First, of course, people living with HIV had no access to medicines to sustain their health. Figure 5.6 shows that, until 1995, Brazil had more AIDS deaths than India, but after the advent of effective ARVs Brazil implemented a national program that quickly reversed the trend of AIDS deaths. India, on the other hand, did not act for another eight years and deaths continued to climb. There is significant debate about the exact mortality numbers from this period, given poor data on mortality overall in the country and HIV prevalence in particular, as well as the challenge of separating AIDS deaths from other causes. This debate is illustrated in Figure 5.7 by the large uncertainty bounds around the AIDS mortality figures. Overall, likely somewhere between 150,000 to 270,000 people were dying each year at the height of the epidemic. Second, the lack of rollout significantly

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86 Over et al. 2004, 18.
exacerbated stigma and undermined prevention activities. With no treatment available, HIV was a near certain death sentence, which undercut Indians’ motivation to get tested and engage with HIV programs overall. Finally, HIV treatment to suppress the virus is among the best HIV prevention strategies—as or more effective than condoms in practice—and the lack of a treatment program ensured many thousands of additional HIV infections that could have been averted.

There was also a vicious political cycle associated with the lack of a treatment program. HIV stigma intersected with stigma toward marginalized people (e.g. sex workers, transgender people) which is deeply intertwined with caste, region, and ethnolinguistic identities. The lack of a public treatment program transformed this complex politics of social exclusion and hierarchy into a politics of “blame” with the most visible AIDS deaths among those without the money or social standing to hide their illness—which then further undercut the political will to act.88

88 Lieberman 2009 makes this point in chapter 5, but does not connect it with the stigma dynamics of an untreatable disease vs. one that can be managed—see, for example, Biehl 2007; Comaroff 2010 on the critical role that treatment availability plays in the shaping political power and interpretive frameworks for HIV.
Government justified its opposition to creating a public treatment program largely based on the idea that it was too expensive. Early on this argument had a clear foundation—while AZT had been made somewhat less expensive, the full combination “cocktail” cost more than $10,000 per patient per year from the multinational pharmaceutical companies. In the private sector, ARVs became available but were far too expensive for most Indians—leaving just a handful of wealthy Indians with access to drugs. The Brazilian government’s response to this was to focus on negotiating far lower prices and building the capacity for generic production within Brazil that made treatment cost effective. The Indian government, after a decade of liberalization and with a very limited public health strategic capacity, instead left it to the private sector to solve the problem.

In September 2000, that happened. Drugs suddenly became far more affordable when Indian company Cipla offered a full course of ARVs to the world for just $800 per patient per year. Cipla’s colorful CEO Yusuf Hamied made headlines around the world just five months later when he announced an even bolder gesture—a price cut to less than $1 per day and an offer of the company’s ARV drug production technology totally free to any developing country government which wanted to produce its own drug against AIDS. This was good news, but for the average Indian this still left treatment out of reach. In the private sector that meant about Rs 15,050 for the ARV drugs, plus Rs. 5,585 for initial tests, and Rs 5,155 every six months for monitoring tests—totaling just about $2 per day before transportation or provider fees. According to UNDP, 86% of Indians lived on less than $2/day in 2000.

However, it did make treatment cost effective for a public-sector program. Nonetheless, the 2002 National AIDS Prevention Policy, adopted after a great deal of public consultation and what NACO identified as deep engagement with people living with HIV, again did not include HIV treatment and instead doubled down on a prevention-only approach. The policy repeated, almost exactly, the stance from four years before:

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89 MSF Access Campaign 2012.
90 Hamied 2006.
91 Over et al. 2004, 30.
92 UNDP 2002.
“The treatment options are still in the initial trial stage and are prohibitively expensive. While there is no vaccine in sight, multi-drug antiretroviral therapy, popularly known as ‘cocktail therapy’, is not a cure to the disease and may help only in prolonging the life of the patient. Standardisation of treatment regimens for these drugs is still evolving and there are fears of patients developing drug resistance and side effects if the therapy is not administered under proper medical supervision.”

At this point, there were parts of this policy that were demonstrably false. ARVs were no longer in a “trial stage”—in 2002 well over a million people worldwide were on HIV treatment—many tens of thousands throughout Asia, and even 50,000 in Sub-Saharan Africa, which lagged furthest behind. Treatment regiments were well-established after six years of use across the world, and had been quickly incorporated into HIV treatment programs in both the rich and poorer countries. And while the costs were not insignificant, the new Global Fund had launched that January to support ARV treatment costs and the country already had a major concessional loan from the World Bank that it was spending on HIV—just not on treatment.

“Government, everyone knew that after 2000 the piece about how expensive it was, that was just an excuse. They just did not want to get stuck with the bill and they did not want to be forced to put more in the health budget. So they said we are still thinking about it but someday it will be affordable. How do you argue with that?”

–Community based organization leader (Interview IN-13)

By 2001, roughly R10 billion ($225 million) per year was being spent on the AIDS response by government, international aid, and philanthropic sources—but almost none of it was going to treatment programs.

The decision was taken inside a classic policy monopoly made up of technocrats inside NACO, from other parts of the Ministry, and from the international financial institutions. These bureaucratic policy structures focused not only on the idea of cost effectiveness, but also on a narrative of “indigenization” of HIV medicine. The National AIDS Policy said it would “pursue all available means to encourage indigenous drug manufacturers to take up manufacture of antiretroviral drugs within the country”—ironic, since at the time those drugs were not only already

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93 UNAIDS n.d.
94 In this they had an ally in World Bank staff, who issued reports backing the idea that treatment was not cost effective (Over et al. 2004). That work was later discredited as both inflating the costs and underestimating the impacts, but helped maintain policy status by advising government to “proceed cautiously.”
available from Indian companies, but being shipped across the world to treat people living with HIV programs in countries with public-sector AIDS programs. The policy also included an extensive section on the use of alternative remedies that, when read in the context of the South Africa case study, are notable for their similarities to the arguments from the Minister of Health there at the same time—seeking “cost-effective alternatives to antiretroviral drugs.” Perhaps because it was wrapped in technocratic language and delivered by far more sober bureaucrats than Manto Tshabalala-Msimang, this push never received the attention that focused on the similar South African move, but stalled ARV roll out just as effectively.

_Breaking Policy Stasis—Rights & Democracy_

There were numerous efforts to break the stalemate on HIV treatment. There was significant public attention to the issue in the media—reports of people turned away from hospitals because they were HIV-positive, of the mounting death toll including young children who lacked access to treatment, and some on the disconnect between a robust generic industry offering ARVs to the world while Indians could not access them. Throughout all of this attention, however, the narrative of unaffordability went largely unchallenged. The generic company Cipla helped underwrite a public information campaign aimed at pushing for a government supported ARV program called “You don’t have to die of HIV/AIDS,” which included well-produced ads that aired in major TV markets. The effort generated significant attention, but not action, as NACO responded that the cost of drugs was not the only factor in a treatment program and citing diagnostics, human resources, and other barriers.

The issue was not one of party ideology since between 1996 and 2006 India had five changes of government with all of the ideological perspectives represented in the central government at

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96 You Don’t Have to Die of HIV/AIDS 2001. Of course the ad campaign was also aimed at the small private market for ARVs and so served the economic interests of Cipla in multiple ways. See example add at https://www.youtube.com/watch?v=CfKcCu0L9Xo
some point. In addition, since health is a state subject any state could have taken the lead and proceeded with the aggressive HIV treatment program health leaders were urging.

A set of politicians did push for a bill in the parliament that could have replaced the more conservative AIDS policy with a broader long-term vision and framework. Introduction was repeatedly delayed however as jockeying between politicians derailed each effort. Drafting of a bill started in August 2002, inspired by an international policy conference held in Delhi and led by Kapil Sibal, Rajya Sabha MP. Civil society groups including the Lawyers Collective—a prominent legal and advocacy NGO—and networks of people living with HIV, mobilized input and support. It struggled to get attention and support, however—undermined by the negative stigma associated with HIV and burdened by various problematic proposals from politicians against which public health leaders had to push back. The question of ART was central in debates but NACO and others continued to suggest it was unaffordable which further hamstrung the process. People living with HIV and their allies largely lacked sufficient political power to ensure treatment was guaranteed, or that the bill was prioritized. Two years later, announcing that the bill was finally to be tabled, Sibal acknowledged the delay. “Undue delay in responding to the wakeup call will result in adverse consequences of unmanageable proportions,” he said. 97 It never came. In fact, it waited 15 years until April 2017 before any HIV bill was actually passed.

“Indian politicians, they are supposed to represent the people but the day they are elected is the last day they see us. It is impossible to meet them. Too much bureaucracy. We don’t have a large enough portion of the population in any one place to threaten their vote, so we are marginalized.” –PLHIV leader (Interview IN-08)

Indian people living with HIV (PLHIV) increasingly organized in this period—forming groups in Manipur, Delhi, and eventually throughout most of the country under the banner of the Indian Network of People Living with HIV (INP+) in the late 1990s. 98 In 2001, these groups came together with other civil society organizations to launch a public campaign titled the “Affordable

98 Bhardwaj 2009.
Medicines and Treatment Campaign” (AMTC). The founding statement read “the right to life and health is a fundamental right, guaranteed to every person living in India and is non-negotiable.”

This framework helped mobilize not just HIV-oriented groups but also legal aid organizations like the Lawyers Collective and the Alternative Law Forum to support. The effort pushed for both a publicly-funded HIV treatment program and for the protection of space within the Indian intellectual property regime for generic AIDS drug production—which was threatened as India joined the WTO TRIPS agreement. Campaigners went on to hold public meetings in a half-dozen cities, put up information stalls in the main Mumbai railway station, held marches in Mumbai, Delhi, and Banaglore, a candle light vigil in Delhi with signs reading “Sirf rok tham adhuri hai, Chikitsa Bhi zaroori hai” (Only prevention is incomplete, treatment is also necessary), and a nationwide signature campaign. A similar campaign was launched in Tamil Nadu the following year led by advocates for orphans and children living with AIDS.

These pressures began to weigh on government, including the availability of external resources which they began to consider more seriously—but leaders remained concerned that any life-long AIDS treatment program would eventually fall on Government, which the Finance Ministry was reluctant to take on. In the 2002 budget statement the best the Minister of Finance would commit to was to exempt HIV drugs from the excise duty.

Things began to change more quickly when the Courts began to engage. A set of PILs was filed by two organizations working with intravenous drug users—Sahara House in Delhi and Sankalp Trust in Mumbai—and wound their way slowly through the courts. Filed with support of the Lawyers Collective in 1998 and 1999, the cases were not originally about ART but instead sought to address the common denial of access to basic medical care due to their HIV status, arguing government needed to have a comprehensive policy on HIV.

“People were just dying, we could see our clients just die. But government was delaying and delaying on really addressing anything besides prevention…. I think it was just apathy. And bureaucracy.”  –Attorney (Interview IN-27)

100 Budget Speech 2002-2003 of Shri Yashwant Sinha, Minister of Finance 2002, para 123.
For years the case languished in procedural motions as the court was reluctant to set policy, and government issued a series of promises that it was working on a new policy. As the need for ARV treatment became increasingly within reach, however, the Supreme Court took note of the news and treatment campaigning. When the 2002 policy failed to address treatment, the Court began to push government—bringing members of NACO before the court and demanding affidavits about exactly what their plan was. A third PIL was filed by the Human Rights Law Network on behalf of the Voluntary Health Association in October 2003, which was joined to the initial petitions and added to pressure on government. One exchange from this time was particularly memorable:

“"There was a particular interaction with the Chief Justice, and it was a particularly rough exchange. But, we told the Chief Justice that this case is pending for quite a long time and the policy of the central government is to allow people to die. Then, we gave some rough figures. Then he turned to the other, to the attorney general, and he said, ‘put an affidavit in now from [Health Minister] Swaraj.’ They are making a very serious allegation, that you people have a policy of letting people die.”—Attorney (Interview IN-28)

Within a few months of this exchange Union Minister for Health & Family Welfare in the BJP led NDA government, Sushma Swaraj, announced a new policy aimed at providing free antiretroviral treatment to 100,000 people living with HIV in six high-burden states. The Indian government planned to provide treatment for 100,000 people in the first year, at a cost of 2 billion rupees (US$40 million). There are differing opinions about just how important the court intervention was in this decision—several of those interviewed for this project note that initial preparations were underway for some time. Political pressures from campaigners and a few high-profile stories seem to have moved Minister Swaraj to act, surprising many. What all agree on,
however, is that judicial engagement played a critical role in transforming this initial announcement into a true national program. The ART program did not reach 100,000 people—instead a year and a half later the program was running in only a handful of hospitals and only 10,000 patients were enrolled. The new Minister for Health & Family Welfare (now in the Congress-led UPA coalition) inexplicably reported to parliament that Government’s goal had never been to treat 100,000 by 2005.106

The Supreme Court had not closed its case—instead it had continued it and re-listed the case every few months. When it became clear that government was still failing to fully implement its original plan, the Court stepped up the pressure.

“I remember after the judges had all been quite happy about the initial plan, when we came in with our documented evidence to show them what was wrong with the program, and the denial of treatment in practice, they called in the head of NACO who was subjected to a bit of scathing criticism and a threat that the Minister would next have to answer.” –Attorney (Interview IN-25)

From there, the Court kept the case open and it became essentially a bargaining platform. At regular intervals government and the plaintiffs would come to court and make public arguments about how the ART program was functioning. By November 2005, the head of NACO was replaced by Sujata Rao who was widely seen as far more effective and who built the capacity and professionalism of the organization. She and her team increasingly used the Court as an opportunity for dialogue.

“She’s literally sat on our side and said, ‘Let’s take this from the top and say what are the things we need to do and what can we do before the next time in court…’ We were on opposite sides but Sujata Rao had this beautiful way of saying it so the government spoke to us and a lot of it was done without any animosity.”-NGO leader (Interview IN-13)

At this point the treatment program finally got underway in earnest—with a big jump in treatment numbers in 2006 that finally reversed the trajectory of AIDS deaths as seen in Figure 5.7 above.

106 Jain and Stephens 2008, 3.
Constitutionalization also facilitated intra-bureaucratic bargaining. NACO strategically used the Court’s intervention as justification to advance the ART program faster than political leaders might have planned or than the ministry of Finance preferred. The Court provided not just a reason but a venue, since it continued to monitor and issue periodic order, to continue to advance the policy over time. Federalism was a particular challenge as it is with many health issues in India since, while drugs were procured centrally, the program required staffing and other supports that were state responsibilities and not all wanted to make the investment.

“We used it. Completely. We kept fighting with different parts that did not want [the ART program]—with Finance, with the states, who would be saying ‘no, no, no’ and I would say ‘lets use the case. We are doing this.’

In fact, we encouraged the whole dialogue with Supreme Court so that if any state does not give ... since it was not an adversarial, it was political. We needed to get state governments on board. We insisted that the Secretary of Health must constitute a committee at the state level where he periodically once a month or once in three months to review what the Court had ordered.” –Former Senior Health Official (Interview IN-01)

This is not to say, however, that NACO and activists were in agreement or that NACO became immune to the bureaucratic inefficiency and conservativism that mark other parts of the state. Over the course of the years that followed, a series of issues came up including the expansion in the number of treatment centers, use of newer drugs, introduction of earlier treatment, and programming to address the living conditions of people living with HIV. Some NACO agreed with and Court orders proved helpful in overcoming resistance in other parts of the state. In other cases, NACO officials resisted change and build strong narratives that justified their stance. Second line treatment—providing an additional set of drugs for those who, in the normal course of disease, developed resistance to their first drug regimen—was the most prominent example that became central in the cases as activists pushed for what was widely recognized as standard practice but NACO leaders felt was beyond the system’s capacity. In the end a negotiated solution was reached at the behest of the Supreme Court to this and other issues and the plans were entered as orders.

“You could really see that every time the Court heard the matter and submissions were made, someone in the government obviously in the AIDS program was
reading them, and said, 'Okay, now we have to adapt the guidelines because when we go to court we have to say that we could respond to the problem by this and yes we have a real plan. You want the court case to go away, so just move faster... we kept moving the goal posts and we finally had the power...”—NGO Leader (Interview IN-43)

Indeed, the official National AIDS Policy was, for the first decade of the ARV program, never as science-based or comprehensive as the set of agreements reached in these negotiations and enshrined in court orders from the Supreme Court.

The unregulated private sector came into the picture too. Both NACO and the PLHIV groups agreed the private sector was presenting a problem—offering poor-quality services, prescribing ARVs in combinations that were more profitable but that did not work and produced drug resistance, and allowing quack remedies. Despite a push by NACO, there was huge resistance to formal regulation and the Ministry could not be moved to act against the powerful private physicians sector opposed to regulation in all forms.

“Then standard protocols and all were developed, but we haven’t built a system where you can legally enforce them. It is still very much professional organization, self-regulation, that kind of a thing, but there is no legally enforceable regulation where we can penalize you for not doing it. We were hamstrung, but we had this opportunity at the Supreme Court.” –Former Senior Health Official (Interview IN-01)

The Supreme Court ordered the Medical Council of India to immediately disseminate and enforce NACO protocols for treatment programs in the private sector—directing the Council and, if not, then directing the Consumer Courts to “take a strict view of private practitioners who take advantage of the illiteracy and poverty to prescribe wrong or unnecessary medicines or charge exorbitant amounts.” According to a senior official, “The private sector complied immediately. We found a lot of patients shifting from the private sector into the public and, if they did treatment, private sector treated them ethically or they were actually threatened and punished.” (Interview IN-01).

\[107\] Ibid., 58.
Finally, the Court also waded into federalism to address the huge challenges there. PLHIV had low political power and were rarely able to move politicians—which meant that at state level, where implementation happened, they were low-priority and NACO officials were not able to call on strong political backing to push recalcitrant states to act. For example, PLHIV in several states regularly reported that they were denied treatment on the grounds that equipment was not functional while in other states healthcare workers refused to give injections to PLHIV because “post exposure prophylaxis” or PEP was not available for cases of needle sticks. The Supreme Court issued orders addressing these pieces and ordered states and NACO to separately report back on progress on each—which gave NACO and PLHIV networks far more leverage and sped policy change at that level.

By 2008, 172 HIV treatment centers were functional and new second-line drugs were being brought into the program. Funding to the HIV program had grown both from the government of India and from international sources such that treatment programs were no longer restricted. The Court did eventually close the case and issue final orders and, in so doing, the effect of having the Court as a venue for health policymaking has actually become quite obvious to some HIV advocates.

“For example, I know the drug Dolutegravir to be so much better than Efavirenz. And I’m like, my god, this is so much better than having to put people on treatment that you know will fail in 5 years, and so on. We want to move that goal posts, but we can’t. We don’t have the court case to move the goal posts with and we have to present our arguments to bureaucrats who can act as slow as they want. Of course, they’re still a little worried we will go back to court, so they still take us seriously. We’ll see, maybe we go back to court or maybe we just threaten…” —NGO Leader (Interview IN-43)

Courts, Activists, and AIDS Treatment

The interplay between political freedoms and constitutionalization of health is on clear display in case of HIV treatment in India. The legislature, for all intents and purposes, never acted on HIV treatment. Meanwhile civil servant policy entrepreneurs in favor of treatment inside government had a hard time breaking through the powerful technocratic arguments about cost.
Constitutionalization created an environment that brought together networks of people living with HIV with rights groups to frame demands for treatment as a constitutional right in both public campaigns and in court filings. The Supreme Court in this case perhaps most clearly embodies the idea of a venue for policymaking. It is not that the Court is “making” policy per-se, but instead it is providing a platform for discussion while putting its legitimacy behind action over inaction. This empowered activists who had been stymied by limited political power as well as a set of health actors within government vis-à-vis their more reluctant counterparts, who together took apart the existing policy monopoly and, in the course of a few years, transformed the HIV policy landscape in India.

Khosla makes a key observation about the way in which the Supreme Court’s socioeconomic rights jurisprudence takes, as its departure point, the policy and programs government actually puts forward—arguing the Court makes social rights like health “conditional upon the nature of state action undertaken.” We can see important echoes of that here—the Court did not act for several years, while government prevaricated about HIV treatment with no policy. In the framing and the asking, however, I would argue it was less that the right was conditional than that the court itself was more venue than adjudicator. Rather than ordering particular policy, the Court forced government to justify its choices, demanded information, and provided an opportunity for a group with limited political power and clout to demand action. Constitutionalization engaged rights actors and provided a framework in which a decision to “allow people to die” was not legitimate. Of course, in reality all health policy includes weighing competing priorities and some people will die. But as an idea, the rights framework in this case forced Government to defend its choices and, in that way, moved an issue that had been bureaucratized into one of public politics. Bargaining over policy, of course, continues. In 2017 the NDA government passed the long-lingering HIV bill that includes a robust treatment commitment, including a policy change allowing immediate treatment for all PLHIV (rather than restricting it to only the sick)—placing India as a leader in HIV treatment policy. While it is not possible to identify

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108 Khosla 2010.
the exact contribution of constitutionalization to these decisions, some of the same players who scoffed at an ARV program in the early 2000s today frame access to ARVs as a core right.

Clinical Trials

Another recent area where constitutional rights have been central in the policy debates is the issue of clinical trials. There, however, the picture has been far less clear—exposing the limitations of judicial constitutionalization.

Starting in the 1990s, pharmaceutical companies began to “outsource” clinical trials from the U.S. and Europe to the rest of the world, both because of an increasing need for research subjects and the increasing cost and regulatory environments.\textsuperscript{109} India has been a significant destination for this “globalization” of clinical trials by multinational companies (MNCs). It is particularly attractive given the large, genetically diverse population who have not been exposed to many medications and the large burden of diseases from infectious to chronic. Meanwhile, a large pool of English-speaking physicians, many of whom trained in the US or UK, is available and the costs are a fraction of what they would be in the U.S. or Europe—less than one tenth.\textsuperscript{110} Multinationals came to see India as an appealing location, particularly after India joined the WTO and began protecting product patents in 2005. The Indian government saw potential to both position the country as leader in drug discovery and to help drive economic growth through what the Planning Commission in 2006 identified as a $60 billion industry, of which India had just $100 million but could grow at the rate of 80% per year.\textsuperscript{111} Government thus introduced a series of legal measures to facilitate access to MNCs, including cancelling the 12% service tax on clinical trials and amending Schedule Y of the Drugs and Cosmetics Act of 1945 to make trials easier to conduct.\textsuperscript{112}

Public health leaders, however, expressed concern as large clinical trials—sponsored by both multinationals and local Indian companies—rapidly expanded without what they saw as

\begin{footnotesize}
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\item\textsuperscript{109} Petryna 2009.
\item\textsuperscript{110} Kamat 2014; Glickman et al. 2009.
\item\textsuperscript{111} Planning Commission of India 2006, para 1.11.
\item\textsuperscript{112} Imran et al. 2013.
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sufficient safeguards. Press reports regularly came to support this view. In 2008 alone, the deaths of 49 children were linked to a nutritional supplement study in Delhi;\textsuperscript{114} the drug company Wyeth was revealed to be violating study protocols by recruiting children with serious illnesses for a pneumonia vaccine study when one died in Bangalore;\textsuperscript{115} and a young man making his living off clinical trials in Hyderabad died from effects of a blood pressure medicine under study.\textsuperscript{116} It was argued by advocates that these represented just the “tip of the iceberg” (Interview IN-02). Given limitations in records it is nearly impossible to tell with certainty what portion of these or any other deaths while in a clinical trail were caused by the trial itself. As noted, Indians face high mortality risks overall and those engaged in many trials are explicitly seeking treatment for illness and thus are at higher risk. That said, there was plenty of evidence that at least some trial participants were being given drugs and other treatments of suspect quality, were not properly screened and monitored, or were subjecting themselves to harm in the service of quack medicine. The point is that, in the largely unregulated environment of the time, it was essentially impossible to know what portion of trials were well-run and which represented reckless experimentation on human beings that not only harm participants but provide questionable evidence for the treatments they are supposed to evaluate.

Clinical trials, by their nature, include a trade-off between elevated risks for participants and the potential for benefit to both the participant and the wider community if the treatments are successful. Protection from harm is never absolute but is supposed to come through three channels: government regulation, within-study ethics review, and a system of compensation that incentivizes trial sponsors to protect the safety of participants.\textsuperscript{117} In the context of the time, however, none of these functioned properly. Prior to 2005, the main regulatory hurdle was the requirement for a “phase lag” in trials of drugs and other interventions developed outside India, which ensured they showed some level of efficacy and safety before they were brought to India. Phase 1 trials were only

\textsuperscript{113} Nundy and Gulhati 2005; Sengupta 2009; Sunder Rajan 2007.
\textsuperscript{114} 49 babies die during clinical trials at AIIMS 2008.
\textsuperscript{115} Wyeth drug tests fall foul of watchdog 2008.
\textsuperscript{116} Clinical Drug-Test Claims Volunteer’s Life in Hyderabad 2008.
\textsuperscript{117} Porter 2017.
allowed for drugs developed fully in India. In India’s weak regulatory environment and limited capacity to monitor, this acted as a check that in part outsourced the regulation to foreign environments. When this requirement was lifted in 2005, little regulatory infrastructure was in available to replace it. While the Indian Council of Medical Research had put out guidelines, there was no legal requirement to follow them, to sufficiently train researchers in good clinical practice (GCP), or to fully register trials and ethics reviews. The Drugs Controller General of India (DCGI), responsible for monitoring trials and reviewing complex protocols had just five qualified staff as of October 2008.\(^{118}\) While state governments had responsibility for the public health system where much of the research was happening, they had no authority to regulate research trials. The Indian Council of Medical Research (ICMR) set up a Clinical Trials Registry but there was no legal requirement to register trials. In the broader context of poor quality, under-resourced public health system and patients desperate for better-quality affordable care, there was particular concern as private contract research organizations (CROs) set up shop in the public sector offering free medicines and potential cures.\(^{119}\) The requirement for internal ethics review was similarly weak. In theory all trials needed to be subjected to evaluation by a local ethics review committee (ERC) at each site that met international standards. In practice, however, there was no central register of these ERCs—many were never set up properly, members were not sufficiently trained, and little support was provided to conduct thorough reviews. An ICMR survey found that only 40 of 179 institutional ethical committees follow the legal provisions to avoid conflict of interest and properly use ethical guidelines.\(^{120}\) There was also no mechanism to prevent a protocol rejected by a an ERC from simply being submitted to a different, more friendly ERC. Finally, the last check in the system to incentivize good practice is a compensation system, yet the self-regulating system was largely non-existent—of several thousand deaths between 2007 and 2010 just 22 were compensated and those only after MP Maneka Gandhi probed the matter.\(^{121}\) Essentially no real regulatory or legal action was taken against any company, committee, or sponsoring organization before 2012.

\(^{118}\) Srinivasan 2009, 30.  
\(^{119}\) Srinivasan 2009.  
\(^{120}\) Mudur 2005.  
\(^{121}\) Puliyel 2012.
Activists documented widespread violation of ethical standards, lack of informed consent, conflict of interests among physicians who recruited their patients into trials, and too many incentives for low-quality trials and low-quality medicines to be tested. Participants who had been harmed or misled in clinical trials submitted hundreds of complaints through various government agencies with no follow up.\textsuperscript{122}

Despite significant media attention, the issue was very low on the priority list of the government of the time, which was focused on incentivizing trials. Activists and public health leaders began raising concerns in the late 2000s as the explosion in the number of clinical trials and reports of ethical violations increased, but struggled to get attention.\textsuperscript{123} Basic information about how many people were dying in trials was unavailable and responsible parliamentarians were largely unconcerned. This changed in 2010, when deaths of seven girls in a massive Gates Foundation-funded trial of HPV vaccination by the NGO PATH sparked a media frenzy and allegations that the group had not followed proper ethics and consent procedures. The case was hugely controversial with both sides claiming the moral and public health high ground—activists and parliamentarians citing ethical lapses that treated the rights and health of poor, rural girls as unimportant, and questioning the motive of pharmaceutical MNC co-sponsors, while PATH and Gates accused their critics of ignoring the huge potential value of the HPV vaccine.\textsuperscript{124} What is quite clear is that Parliament’s response was ineffective—a series of reports and hearings featured a questionable understanding of science but also effective fact-finding and dramatic rhetoric.\textsuperscript{125} A scathing report of the Standing Committee On Health and Family Welfare provided evidence of illegal collusion between drug companies, CROs, and physicians to skirt safety rules in clinical trials and drug approval processes—but resulted in little action.\textsuperscript{126} Government seemed to be living up to its image as a “flailing state.”\textsuperscript{127}

\textsuperscript{122} Clinical Trials: Regulating Chaos 2012.
\textsuperscript{123} Sunder Rajan 2007; Bhart 2004.
\textsuperscript{124} Shetty 2011; Bagla 2013.
\textsuperscript{125} It’s a PATH of violations, all the way to vaccine trials: House panel 2013.
\textsuperscript{126} Department-Related Parliamentary Standing Committee On Health And Family Welfare 2012.
\textsuperscript{127} Pritchett n.d.
A number of civil society groups responded by filing a set of PILs on the basis of the constitutional right to health. The most significant of these was filed by Indore-based NGO Swasthya Adhikar Manch (SAM) in 2012 with support of legal aid organizations.\textsuperscript{128}

“After all the campaigns and media, the Parliament took it up, but it was just talk, there was no substance. For that, to really get their attention, that took the court.”

–NGO leader (Interview IN-02)

The court demanded information from government and, in an affidavit submitted by the Ministry of Health and Family Welfare, they revealed that they had only analyzed the data upon the court’s request. It showed at least 2,868 people died in clinical trials between 2005 and 2012—of which 89 were definitively linked to the trial, but with limited information to ensure whether most of the others were related or not. This finding was widely covered in the media, sparking further outrage. Through a series of hearings, the Court pushed government for action rather than further committees, delays in regulation, and promises to respond to the court after further consideration. “You can get back to the court but what about those people who are losing their lives in such clinical trials. People who lost their lives can’t get their lives back,” the Bench observed in one interaction.\textsuperscript{129}

There were seven different hearings over the year, with the Court expressing increasing frustration over the failure to regulate. “You have to protect health of citizens of the country. It is your obligation,” the court pleaded.\textsuperscript{130} After several months of back and forth, the Supreme Court finally made good on a threat it had issued and banned all new clinical trials in the country in January 2013. It issued a series orders that put all drug trials under the direct supervision of the Union Secretary for Health and ordered that a new regulatory framework be developed before any further trials be approved. It later put 162 existing trials on hold, exempting those explicitly approved by the Ministry. The Court also directed the Ministry of Health and Family Welfare to

\textsuperscript{128} Swasthya Adhikar Manch, Indore & Anr. vs. Ministry of Health and Family Welfare & Ors. 2012.
\textsuperscript{129} Clinical trials of untested drugs creating ‘havoc’: Supreme Court 2013.
\textsuperscript{130} Ibid.
organize a meeting of all state-level Secretaries to discuss the legal framework for strengthening the regulation of clinical trials.

This sent a shockwave through the research community and was covered in media around the world. Building on the perception from the HPV trial that India was not a welcoming place for biomedical research, a ban was a very blunt instrument that was easily attacked by industry as out-of-touch on the value of medical research. However, it did get ministry’s attention and they finally responded—issuing new policies within two months and then passing a series of new regulations in 2014 for patient consent (including audiovisual recording of consent), patient reimbursement, and adverse events, and issued a directive that clinical trials could only be carried out at accredited centers. In March 2013, the DCGI set up an expert committee to examine reports of deaths in clinical trials, and further rules have been put in place requiring stronger independent ethics committees. The government also began regulating compensation to those who experience adverse effects rather than leaving it up to the companies.

For public health, this has been largely positive. It is difficult to know exactly how the new regulations have affected the safety of clinical trials because there is not reliable data before 2013 on which deaths during clinical trials were actually linked to the trial rather than due to unrelated causes. Based on data released through a right-to-information request, year-on-year the number of total deaths among those in clinical trials does seem to have fallen from 670 in 2010 to 443 deaths in 2014, and 302 deaths in 2015. Of course, these numbers provide only very weak evidence given we lack causal connections. Deaths in clinical trials also reflect a tiny fraction of mortality in India but the indicator is a harbinger for the safety of the drugs regulation system as well since poorly-run clinical trials have been directly linked to major safety problems and poor-quality drugs in both the public and private sector. Perhaps equally important, the regulations triggered by court

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131 Illegal Clinical Trials: India Poor ‘Duped’ Into Taking Untested Drugs 2013.
132 Jayaraman 2014.
133 There is also no good data on the total number of participants against which to compare deaths—the number of trials as a whole tells us comparatively little given that some trials enroll thousands while some enroll just a small handful. However, DCGI has responded to a set of right to information requests with at least releasing the total number and the number deemed caused by the trial.
134 Bagcchi 2015.
135 Department-Related Parliamentary Standing Committee On Health And Family Welfare 2012.
intervention also seem to be helping to rebuild a more robust clinical trials environment in the country. The number of clinical trials conducted in India dropped precipitously before the Supreme Court ruling—with industry and international funders pulling back from the country after 2010 when 500 trials were conducted to fewer than 50 in 2012 due to uncertainty about both the quality and regulatory environment after the HPV trials scandal. Since then, trials have grown back to several hundred with continued growth predicted. This reflects a return of several major industry players and, tentatively, of funders like NIH, and improved quality of trials overall as the lowest quality have largely not returned. It was, to say the least, a less-than-ideal way to reach a point of regulation—undermining the credibility of India’s scientific community in the global imagination. The Court, however, had few tools at its disposal after cajoling, and more limited orders had failed. There are also concerns among some that the improvements in regulation and quality will not stick. With the Supreme Court less engaged and health rights not reflected in any of the core regulatory documents, many public health advocates have raised concerns that these changes will be increasingly watered down in practice. Together, this case thus illustrates both the power of constitutionalization and the limitations of judicially driven instantiation—where courts drive without backstop from other branches, reform is both harder and more tenuous.

Rights & the National Rural Health Mission

“The early cases were all about a certain urgent medicine or what you should have access to if you are covered under a government insurance of a certain kind. Okay fine. But it got translated into some kind of a political demand during the push for National Rural Health Mission saying you must define the package of service under the right to health…” Physician/Public Health Leader (Interview IN-14)

Constitutionalization also played a part in the initiation of a set of the National Rural Health Mission (NRHM) through the rise of a set of health rights organizations and hearings by the National Human Rights Commission (NHRC). Founded in response to the failure to achieve the

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136 Bhave and Menon 2017.
137 Kable Intelligence 2017.
138 New government regulations water down clinical trial safety norms 2016.
Alma Ata declaration goal of “health for all by 2000,” the umbrella organization Jan Swasthya Abhiyan (JSA; people’s health movement) was created at an assembly in Kolkata of over 2,000 health activists from nineteen states representing physicians and health worker groups, NGOs providing health services, feminist and science-based policy organizations, and trade unions. The group highlighted the deterioration of public health services and stagnated budgets through the 1990s, as well as the sharp rise of the unregulated private sector. A few years later, in September of 2003, the group launched the “Right to Healthcare Campaign” out of a national consultation held in Mumbai where Justice AS Anand, chair of the National Human Rights Commission, spoke to the assembled health leaders.

“There was an openness and then we thought let us bring in our Constitution because you could see the collapsing of the public health systems has already started. The structural adjustment programs had opened the doors for the new economic policies that focused on private health over public. We thought let us use this opportunity how we can push government to stay in the public health [sic].” – Health Activist (Interview IN-03)

The group organized a series of Jan Sunwais or “health tribunals” to test the idea of documenting denial of access to services as a rights violation—holding events throughout the country from Adivasi areas to Bangalore. These “let hundreds of ordinary people testify about what they faced in the health sector and gave us a new way to talk about things through a violations lens. It worked quite well.” (Interview IN-02). JSA formally requested the help from the NHRC, which agreed to support a series of hearings the following year including funding of Rs. 834,000 (about $19,000) and using the convening power of the commission. Shortly thereafter, the UPA government came to power with support of the left, though without a particularly clear vision for what the government would do on health. There was nothing resembling what became the NRHM, for example, in the Congress elections manifesto and the Prime Minister, Manmohan Singh, had previously presided over significant disinvestment in the public sector as finance minister in the 1990s. The hearings took on a different tone in this context, however, because there were factions

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139 Jan Swasthya Abhiyan 2000.
in government who were both interested in rights and committed to a reinvigorated public health sector. On the other hand, there was a clear push both by international aid agencies and by many within government to continue the focus of many years on narrow investments in reproductive and child health (RCH) along with certain vertical disease programs. Indeed, this was the first proposal developed by the Ministry in 2004.

“You had the UPA government having the Common Minimum Program where one of the things that they said is that they would increase health care expenditure to two to three percent of GDP... Now when called upon to actually act on that promise the initial predilection was to do the minimum, to just leave an RCH Program. But there was an opening with the Sonia Gandhi faction who stood in favor of investment in the social sector and so we were active on many fronts trying to influence and the stamp of the Human Rights Commission helped…” – JSA leader (Interview IN-37)

Four regional hearings were held between August and November, framed around the idea of documenting “denial of the right to health care” with 200 people from every state testifying and a host of local politicians attending. In December 2004, a national hearing was held in Delhi which managed to attract far more political attention to health as a right than any previous gathering, especially in a context of strengthening of the public health sector. It was attended by the Union Health Minister, Anbumani Ramadoss along with the NHRC chair Justice Anand, the Union Secretary for health and the health secretaries from most of the states.141

The hearings did several important things. First, they framed health in the context of the constitution and rights, which indicated a particular obligation of the state to both provide and regulate healthcare. Second, they focused clearly on the public sector and revealed in human terms how the failures of the system as a whole were driving poor outcomes—far beyond interventions that could be fixed by vertical programs or limited intervention—which helped broaden the vision of the policy change needed outside of what was originally imagined by the Congress. Third, it added the clout of the Human Rights Commission—which, while not particularly powerful, is headed by a former Chief Justice of India and brings a not-insignificant sense of political

141 Shukla 2008, 431.
legitimacy—to this broader focus on public sector health reform. The NHRC produced a set of recommendations for a “National Action Plan to Operationalize the Right to Health Care.” The plan called for delineating essential health services and strengthening the public sector to ensure quality and availability, integrating national health programs into a broader primary health care system reform, implementing a universal community health worker program, building a system of monitoring of health services to document realization of the right to health, creation of a Charter of Patients’ Rights at the local level to increase transparency and accountability on what is supposed to be provided and what is to be free, and other key concepts.

When, in 2005, the UPA government announced the National Rural Health Mission it moved actively away from the original idea of simply building out RCH programs and instead focused on many of the priorities identified through the NHRC/JSA process. The NRHM vision focused on provision of quality healthcare to rural populations throughout the country, beginning with a focus on 18 states which had weak public health indicators and infrastructure. To be clear, there were multiple pressures and processes that shaped the NRHM including active engagement from left political leaders in the ruling coalition and a wide set of expert committees. The claim here is not that the rights hearings were definitive. Government officials interviewed, however, directly credited the right to health hearings with opening space for broader thinking and constitutionalization of health broadly with increasing the opportunities to focus on strengthening the public health sector.

“We used [the right to health] extensively to explain to people inside why we needed to build the NRHM in the way we did, looking to the Court cases like the one from West Bengal to overcome objection and explain why it needed a base set of essential services and new accountability structures.”—Former Senior Health Official (Interview IN-36)

Looking to the NHRM Framework for Implementation seems to bear this out. The document explicitly recognizes the constitutional right to health as “brought out” by the relevant rulings of

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the Supreme Court. “Therefore, providing basic Health services to all the citizens as guaranteed entitlements will be attempted under the NRHM.”

It is notable that this was hardly the consensus view in government—as one senior official from the time told me directly: “right to health is not a part of the constitution.” Yet it runs nonetheless through the document this official had to sign off on, including a long list of examples of, taking the frame of the hearings, as “denial of the right to healthcare” experienced by Indians in the public sector. This is used as a basis to justify a variety of policy moves that were also controversial within the bureaucracy including identifying specific core packages of services, requiring local patients’ rights charters, supporting community based monitoring, etc.

While the NRHM failed to achieve quite a few of its targets on time, it has been widely praised as one of the more effective health initiatives in India in recent decades. Several components called for in the NHRC hearings (as well as elsewhere) have proven effective (though in need of improvement) including wide expansion of Accredited Social Health Activists and the Village Health Sanitation and Nutrition Committees, Patient Welfare Committees, and community monitoring mechanisms have increased not just service delivery but accountability in rural health settings. Overall the program was shown to increase utilization, quality, and equity. That said, in many ways the program has proved better at diagnosing the problems than ameliorating them—public health spending has increased but remains well below what is necessary and and, after a decade, little of the rural public health infrastructure has reached a level of quality service delivery where it can radically shift the public-private dynamic. Like many programs implementation is uneven geographically and it is not yet clear how the new health policy will affect progress. As incremental change, though, NHRM stands out as clear progress and constitutionalization helped in that achievement.

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144 Interview IN-01.
146 Horton and Das 2011; Patel et al. 2015.
147 Rao et al. 2011; Sundaramanan and Gupta 2011.
148 Shukla, Scott, and Kakde 2011; Sudarshan and Prashanth 2011.
Leaders in the NRHM inside government who found the health rights framework useful also tried to build on their success and use the Constitution as a reason for action in building a wider Health Bill which, as described below, was released in draft in January 2009, but never acted upon.

“We almost got away with it in justifying why we needed a bill. We had legal experts on it. We had paid people to get a viewpoint on that. But…” Former Senior Health Official (Interview IN-36)

On the NRHM, however, constitutionalization helped provide a key framework and opportunity to engage new actors—bringing the human rights commission into health policy, providing the Jan Swasthya Abhiyan with an opportunity to shift venues, and buoying the idea of public sector investment with additional reasons for action. A handful of key NRHM provisions can be traced back to this process. That said, it also shows the implications of limited health rights institutionalization in India since, as described more below, the framework met its limits at the end of the UPA-1 government when macro political forces undercut the rights-based push.

**Other Health Issues: From Affordable Medicines and Maternal Health to the Health Bill That Wasn’t**

In total, at least eleven different policy processes in India have seen significant mobilization of the right to health across the last two decades. These ranged from HIV treatment where, as described above, the effect was clear and large, to the issue of drug pricing where rights mobilization has struggled to have an impact. Below, I briefly touch on a set of these further issues to highlight the ways in which they tell us about different aspects of constitutionalization.

**Medicines**

Three issues on medicines highlighted the complexity of constitutionalization and the varying impact it has in India. India is often referred to as the “pharmacy of the world”—home to the world’s largest generic drug industry, which supplies both the global North and South with
(mostly) high quality generic versions of key medicines. 150 This is a sea change since the 1970s, when India had among the most expensive medicine prices in the world. Then-Prime Minister Indira Gandhi made building a domestic industry a national priority and the pre-World Trade Organization patent system enabled the industry to reverse engineer a wide range of medicines. Today the industry is one of India’s most important—accounting for 20% of the global drug market and slated to cross $20 billion in exports by 2020. 151 In a context of a highly privatized health sector with low regulation and low public-sector investment, generic drug production has a complicated effect on health. On the whole, availability of low-cost, quality drugs has helped blunt some of the deficits of the health system by enabling Indians to access medicines that are often unavailable in other low- and middle-income countries. 152 While it is nearly impossible to disentangle a particular effect, affordable generic medicines have helped enable the limited public sector budgets to go further than they would and out-of-pocket access to a greater portion of the population than in many other countries. 153 Lack of regulation of the Indian Pharmaceutical industry, however, has undercut this benefit. Constitutionalization has played a part in how each of these policy processes have played out—helping ensure the continued availability of generic drugs, but having far less effect on struggles to ensure drugs are truly affordable for the poor and to address dangerous and “irrational use” of medicines.

The Indian system of drug production depends significantly on the national patent system. Since liberalization, the government itself plays little role in direct production, but private companies that grew out of the initial public investment now compete on the international market. Following a broad consensus at the time that monopolies on medicines and other essential goods were not in the public interest, the 1970 Patent Act provided for patents only on processes but not products, meaning reverse engineering medicines could be encouraged. The multinational pharmaceutical companies (MNCs), of course, opposed the policy and succeeded in their own bit

150 For a comprehensive look at the historical and political trajectory see Joseph 2016.
151 India Brand Equity Foundation 2017; Associated Chamber of Commerce & Industry 2016.
152 For example, several key cancer drugs are simply unavailable to nearly everyone in South Africa but have been available in India for years, like Imatinib for leukemia. See e.g. Generic cancer drug - access not guaranteed 2013.
153 ‘t Hoen 2016; ‘t Hoen 2015.
of venue shifting to make patents into a trade issue in WTO negotiations over the objection of Indian negotiators.\textsuperscript{154} Seeking to protect both industry and health budgets, India strategically adopted the “flexibilities” allowed under WTO rules as it revised its patent laws to comply, seeking to maintain as much space as possible for continued generic production. Section 3(d) of the new patent law, the most strongly opposed by multinationals, requiring new drugs to show increased “efficacy” to get a patent, which undercut a key MNC strategy of seeking new patents for new uses and cosmetic changes to a medicine. Generic companies and several of the key health rights organizations have since used those flexibilities to challenge pharmaceutical company patents on drugs for HIV, cancer, and other diseases. MNCs, for their part, have made overturning these provisions a key political priority—lobbying up to the level of the prime minister, lining up rich country governments to pressure India for change, and using litigation.

Constitutionalization mattered on two fronts: First, it had enabled the rise of new set of alliances between legal aid organizations and PLHIV groups linked to an international treatment activist movement that were key in pushing to keep the flexible laws. In much of the rest of the world the ideational frame used by the MNCs—of innovation and advancement in the service of public health—has been very effective in justifying very liberal patenting of drugs.\textsuperscript{155} In India, however, groups like the HIV/AIDS Unit at the Lawyers Collective developed legal expertise in intellectual property while PLHIV groups and Doctors Without Borders/Medecins Sans Frontiers mounted a strong public lobby, backed by this legal expertise, to push a different framework focused on the public health benefits of limiting patent rights and the “TRIPS compliant” laws India had enacted. These arguments carried the day in both court and with government.\textsuperscript{156} That the Indian government has not (yet) acceded to such significant pressure is surprising—especially so in an era of increasing buy-up of Indian generic companies by MNCs, which has undercut the political power of efforts to maintain the current law. Beyond the alliance of groups, however, constitutionalization has provided an important legal basis for the current laws.

\textsuperscript{154} Foster 1998.
\textsuperscript{155} Sell and Prakash 2004.
\textsuperscript{156} Bazzle 2010.
Chapter 5: India

The key test of this came when the Swiss pharmaceutical company Novartis brought suit against the Indian government for denying its patent on a highly profitable drug—Gleevec/Imatinib used to treat leukemia. Strong mobilization by health rights groups was critical to raising the profile of the case and setting out a framework of debate that centered on health—notable because this was led by PLHIV groups even as the case dealt with cancer, not HIV.157 Meanwhile, the Lawyers Collective was admitted as *amicus curiae* to argue on the side of government. This turned out to be critical as weak representation of government meant at various times the case was in danger of being lost, but Lawyers Collective mobilized a key set of arguments, respected expert testimony, and submissions from public health leaders around the world. This included strong argumentation that Section 3(d) had to be read in the context of the constitutional right to health. The Madras High Court agreed in a decision upheld by both the Supreme Court and the Intellectual Property Appellate Board:

“We have borne in mind the object which the amending Act wanted to achieve namely, to prevent evergreening; to provide easy access to the citizens of the country to life saving drugs and to discharge their constitutional obligation of providing good health care to its citizens.”158

While the final Supreme Court case which upheld India’s patent law turned on a series of highly technical matters, there is a strong argument it would have turned out quite differently without both the jurisprudential bases of the right to health used early in the case and the institutional capacity built out directly in response to constitutionalization.159

“Now with the Supreme Court judgment it’s been made very clear that health and the constitution cannot be separated from IP [intellectual property], which would not have happened without Anand Grover [of the lawyers collective] and others. That makes Indian unique and makes health a consideration where it often is not. The pharmaceutical companies worked hard to ensure otherwise, to keep it unclear and technical and out of the public, but now there is clarity.” –Senior Government Official (Interview IN-38)

157 HIV+ People and Health groups Protest Outside Novartis Headquarters 2012.
158 *Novartis AG v. Union of India & Others* 2006, para 19.
159 Analyzing the case see, e.g. Grover 2013; Chaudhuri 2013; ‘t Hoen 2013. And see Gostin and Sridhar 2014 arguing this is an example of the balancing of different norms of rights and IP inside health law.
In two other areas, however, constitutionalization has had arguably little effect. I argue this is because the venue shifting that has occurred has resulted in only very weak new allies to public health and that the nature of the program is so complex that judicially-driven constitutionalization reaches its limits.

First is the issue of regulation of dangerous and “irrational” drugs. The flip side of the ascendancy of the pharmaceutical industry in the Indian context has been a continued lack of effective regulation, which has led to a proliferation of medicines that are have either unproven efficacy or have been shown to be actually dangerous. This has been an issue that has concerned public health activists and experts for decades. “It is the never-ending saga of a state that simply refuses to use its considerable power to protect the health of citizens,” as one health leader put it (Interview IN-18).

In 2012, a scathing Parliamentary report found that regulation had for “been according primacy to the propagation and facilitation of the drugs industry, due to which, unfortunately, the interest of the biggest stakeholder i.e. the consumer has never been ensured.” As many as 85,000 different formulations are available in India, many of which have never received central approval for marketing. By comparison there are fewer than 500 drugs on the WHO’s essential medicines list. “Fixed dose combinations” (FDCs) of multiple drugs in one pill have been of particular worry. While many FDCs are safe and helpful to patients, like those in HIV that reduce large pill counts, others are ineffective or dangerous due to drug interactions or potential to compound side effects.

This issue too has been taken up extensively by legal mobilization including a set of campaigns by groups like the All India Drug Action Network (AIDAN), the Drug Action Forum in Karnataka, and others. A series of PILs dates back to the early 1980s when Vincent Panikurlangara asking the Supreme Court to break a political stalemate and order the government to use its powers to ban “harmful and injurious” medicines. While the Court issued a decision

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160 Chaudhury 2013.
162 Vincent Panikurlangara v. Union of India and Ors n.d.
that would lead to recognizing health as a right, it largely declined to force the state to ban particular medicines. A campaign followed by women’s groups focused on dangerous (but profitable) prescription and sale of high dose estrogen and progesterone in which a PIL triggered a series of Supreme Court-ordered regional public meetings and eventually a series of Supreme Court and High Court orders banning the product. However, in the absence of an effective communications and surveillance system, sales continued for years. In 1993 another PIL was filed by a set of NGOs that again sought an order for state action on irrational drugs after an advisory committee had met for 2 years without any success in advancing the issue. The case was heard over the course of 8 years and many drugs were banned under the direction of Chief Justice J.S. Varma—and these bans proved more effective and did pull dangerous drugs off the shelves.

But in many ways, it proved a drop in the bucket. The 2013 Choudhury Committee report found that many of the 85,000 formulations available in the country should not have been allowed on the market and that many banned drugs were still available. A 2015 study showed while most diabetes drugs were approved for sale, 69% of anti-depressants and 28% of pain relievers sold were not centrally approved, and pills including internationally banned/restricted drugs made up 12% of pain reliever sales.

Most recently government has finally stepped in more aggressively on the issue—banning 344 fixed-dose combinations deemed irrational or unsafe. In a deeply unfortunate turn of events, however, the High Court stayed the governments regulation at the behest of multinational pharmaceutical companies—undermining what small bit of progress seemed to have been made by the judiciary in addressing this issue. This points to a key point: the argument here is not that courts never act as critics worries—serving the interests of economic elites over public health. In this example they clearly did. It is notable, however, that such actions have been rare. For this reason, the argument of this dissertation is that constitutionalization has beneficial effects “on balance.”

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163 Wass 2011, 51.
164 McGettigan et al. 2015.
165 Pfizer Limited & Anr vs Union Of India & Anr 2016.
Price controls, meanwhile, have travelled a slightly more direct path with a series of judicial interventions that essentially acted as a check on government when it moved to deregulate pharmaceutical pricing without a rational alternative strategy to address affordability. Most major market economies (the U.S. being the outlier exception) have some more of price control on medicines to counter a widely recognized market failure.\(^\text{166}\) This is particularly important in India since, given low wages, even “affordable” medicines are out-of-reach to many poor public health system users. Until recently there was also no major public sector initiative to subsidize drugs—a reality that changed some with the advent of free-drug programs in states like Tamil Nadu and Rajasthan, extended nation-wide in 2012, and the Jan Aushadhi (Medicine for the Masses) Scheme to provide cheaper generic medicines through public stores.\(^\text{167}\) Prior to these programs, however, the major strategy to deal with this was a system of price controls that even supporters agree are not ideal as a public health strategy but without which medicines would be further out of reach.

India has a long tradition of controlling the price of drugs. A series of drug pricing orders beginning in the 1960s under the Essential Commodities Act sought to regulate the price of drugs—with an explicit policy that paired price controls with the 1970 Patent Act to build an affordable drug ecosystem. Through much of the 1980s, 347 essential medicines were subject to price control under a 1978 policy that set up the National Drug Authority.\(^\text{168}\) Industry, however, unsurprisingly pushed against price controls—one place where MNCs and domestic firms have agreed. Under liberalization in the 1990s, there was a push to gradually roll back price controls and, by the early 2000s, government announced its intention to list just 30 or so drugs for price control (Interview IN-10).

After significant negotiation back and forth, the All-India Drug Action Network and others filed a PIL in 2003 challenging these moves at the point where just 74 drugs were under price control—which included several unimportant drugs and excluded many critical ones. They asked

\(^{166}\) WHO 2015; Maynard and Bloor 2003.

\(^{167}\) See e.g. discussions in Maiti et al. 2015; Mukherjee 2017.

\(^{168}\) Srinivasan and Bhargava 2009, 14.
the Court to institute price controls on a series of drugs. The Court declined to do so, kicking the question back to the Ministry, but directed the government to bring all essential medicines under price control.\footnote{Union of India vs KS Gopinath and Ors 2003.} In 2011, government agreed and listed all 348 drugs on the National List of Essential Medicines, writing, “It is the considered view of the respondents that to make affordable healthcare a reality, all the medicines included in the NLEM, 2011 need to be brought within the ambit of price control, considering that cost of medicines constitutes over 60% of the total cost of healthcare.”\footnote{Prices of 348 essential drugs to be controlled 2011.} The subsequent policy, however, came under further criticism for setting the price ceilings too high, excluding critical drugs, and for using a “market-based” mechanism that critics argue is set up to undercut true affordability.\footnote{Jain 2013; Srinivasan and Bhargava 2009.}

“I think there is no precedent for something like this. Maybe you’ve heard of something like this in other parts of the world, but we’ve never heard of... our calculations were that for a lot of key drugs it would have an impact of less than 2% of the total market value, which worked out to less than, I think, 10 rupees per person per year in India, which is like, nothing. It’s insignificant. So, it’s a bit of an eye-wash. –Health Activist (Interview IN-10)

The court, however, declined to micromanage the details of the policy. That changed when the new NDA government moved to do away with even this price control policy. AIDAN and others were soon back in court challenging a plan to get rid of the National Drug Authority entirely.\footnote{Is the govt mulling a surgical strike on medicines? 2016.} The Court called the government’s policy “unreasonable and irrational” and sent them back to negotiations with AIDAN.\footnote{Supreme Court seeks review of drug pricing policy 2015.} Just a few days before this writing, government produced a new policy which maintains and even strengthens price controls with policies that may actually make greater use of international best practice standards and encourage use of generic over branded drugs.

Medicines policy in India thus provides an important insight into the functioning of the right to health: it has been most effective when the policy in question is responsive to a fairly blunt intervention, but the judicially-led model struggles where detailed pro-active steps are needed by a
bureaucracy that is not actually under the control of the judiciary. Unlike in Latin America, there is little evidence of the Judiciary ordering government to provide high priced medicines or issuing detailed orders that undercut balanced public health policymaking. On the other hand, the impact of India’s judicially-driven constitutionalization has also varied—from fairly strong in ensuring the maintenance of perhaps India’s most important medicines policy embedded in its patent law to very little impact on ensuring safety of the medicines that exist. Drug pricing has fallen in between.

**Maternal Health**

One of the clearest areas where right to health mobilization has thus far had a lower level of impact is in the area of maternal health. With one of the highest burdens of maternal mortality in the world, India has crafted quite a few national programs and schemes to support pregnant and lactating women like the Janani Suraksha Yojana (JSY) promoting institutional delivery through the NRHM and the National Maternity Benefit Scheme (NMBS), providing women below the poverty line financial assistance for pre- and post-pregnancy care. The problem, however, has come in the implementation of the programs, which are often inaccessible to the very women who need them most. Constitutionalization of health has provided an opportunity for a unique partnership between the legal aid organization Human Rights Law Network (HRLN) and the international NGO Center for Reproductive Rights, who have partnered in a research and litigation effort to address the issue. Perhaps the most well-known case has been Laxmi Mandal, the consolidated case of two women—one of whom died shortly after childbirth, the other of whom was forced to give birth outside a hospital; both denied access to healthcare and financial support because they lacked Poverty Line (BPL) cards.\(^\text{174}\) The Court found that despite the existence of services there was as “systemic failure resulting in denial of benefits to two mothers below the poverty line (BPL) during their pregnancy and immediately thereafter.”\(^\text{175}\) In an internationally noted decision, the Court ordered compensation and significant changes to the schemes to ensure they were portable between

\(^{174}\) Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors 2010.

\(^{175}\) Ibid., para 1.
states and actually faithfully implemented. Shortly thereafter, the same Court took heard a case of a woman who, homeless and pregnant, died on the streets of Delhi while giving birth. The Delhi High Court took the case *suo moto* after a high-profile article in the Hindustan Times\(^\text{176}\) caught the judges’ attention and ordered the NCT Delhi government to create at least two homeless shelters for pregnant and lactating women.\(^\text{177}\)

Implementation of both orders has been challenging. While the Court has made a rather scathing statement, the bureaucracy has not embraced it and few politicians have taken up the rights based framework in thinking about the maternity schemes. Compensation has been paid in full, which theoretically should act as an incentive to change policy. Years afterward, however, the Delhi government was still dragging its feet implementation of the Laxmi Mandal case with respect to the maternal health schemes, with the Court finding government in contempt, and the policy changes ordered have largely not been implemented.\(^\text{178}\) Meanwhile, a fact-finding mission by the HRLN found that while there were technically two shelters functioning, they were terribly managed and failed to meet basic standards.\(^\text{179}\) A similar predicament faces a set of cases in Madhya Pradesh.\(^\text{180}\)

In this way, maternal health issues reflect a limitation to judicially-driven constitutionalization—in which a recalcitrant government facing complex policy change does have the ability to wave off the judicial branch with only limited ability of courts to control the bureaucracy via court order. In the coming years, it will be interesting to see if the Court moves toward using some of its more creative mechanisms to address the issue or if further venue shifting to the Supreme Court changes that dynamic.

*Regulating Private Health and Private Lives*

Without belaboring the point, constitutionalization has mattered in a range of other issues as well that run the gamut. PILs have been brought out to try to address other areas of

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\(^{176}\) She gave birth, died. Delhi walked by... 2010.  
\(^{177}\) *Court of its own Motion v. Union of India* 2010.  
\(^{178}\) Cabal and Phillips 2017, 417.  
\(^{179}\) Human Rights Law Network 2013.  
\(^{180}\) Cabal and Phillips 2017, 417.
regulation of the private health sector and to force rules about hospitals reserving a portion of their beds for the poor to be enforced. Neither has been particularly effective. Rights mobilization has been slightly more effective in forcing the issue on emergency access to healthcare—which is among the clearest constitutional rights. While there have been some successful PILs, the very nature of emergency need largely means the cases are about restitution rather than policy change, which has meant little change in the system as a whole.

On the other hand, the right to health was a piece of the argumentation in the case the overturned the ban on sodomy. Arguing that the constitutional protection of health meant that infamous section 377 of the Indian penal code banning gay sex had the effect of driving LGBT communities underground and away from healthcare, with particular effect on HIV. This piece was an important part of the background arguments in what would become the landmark decision to strike down the section in the Delhi High Court in 2009.\footnote{Naz Foundation v. Govt. of NCT of Delhi 2009.} However, in a sign of both the limits of judiciaries and the particular challenges of the Indian judiciary, a two-judge bench of the Supreme Court in 2013 overturned the lower court ruling and reinstated the law—with no reference to the health effects. In 2016 Chief Justice TS Thakur led a decision to revisit the case with a 5-judge constitutional bench, which may yet reinstate the lower court’s ruling. In a landmark Supreme Court judgement in 2017, a 9-judge constitutional bench ruled unanimously that privacy is a fundamental right under Article 21 of the Constitution—which lays a path for a constitutional bench to overturn the smaller bench ruling. One key argument on the part of petitioners is likely to be the way in which the previous bench ignored the health implications of section 377.

A Right to Health Bill

Finally, I turn to the “issue” of whether to enact a broader health bill that might include a legislatively recognized judiciable right to health. During the UPA 1 government a bill was drafted by leaders in public health inside and outside the Ministry that would have sought to provide a new overarching framework to the Indian health system. Constitutionalization was a key rationale.
“We almost got away with using [the Constitution] in justifying why we needed a bill. We had to actually build the rationale and justification on right to health. This is one of the major justifications that we did use. We had legal experts on it. We had paid people to get a viewpoint on that. One justification was that it in effect was required by Supreme Court judgments, and we read a number of judgments together that the right to life implies a right to health. This was one key argument.

The National Health Bill was tabled in parliament in 2009. It included language recognizing that “the Constitution of India places obligations on the Government to ensure protection and fulfilment of right to health for all” and noting:

“And whereas the Honorable Supreme Court of India has, in several judgments, exhorted the Government of India to accord legal recognition to the health rights as vital component of the fundamental right to life; and the National Human Rights Commission has also directed the Government of India to enact a health law;” (p.7)

The bill would have created a substantive cause of action for multiple levels of judicial intervention and made denial of quality health services a clearly legalized question.

“But… UPA 1, it was on the agenda. UPA 2 came, it fell off.” –Former Senior Health Official (Interview IN-36)

In India, constitutionalization does provide ideational reasons for action and it does enable venue shifting which opens room for policy change. New actors are engaged. But this only goes so far; with the Left in government there was a strong “interaction effect” with constitutionalization—making several things possible and making the rights frame powerful. When the Left Front pulled out during UPA-2, it had less power. This is the reality of partial constitutionalization.

In 2015 the Modi government circulated a draft National Health Policy that proposed some of the same key elements from the previous government’s bill including formally recognizing health as a judiciable right in legislation. By 2017, however, this did not make it into the bill.

Thus for the time being it will continue to be true that social science researchers, when asking whether India has a constitutional right to health, will most often hear an answer that begins “It depends…”
Conclusion

India reflects one of the most complex health policy environments in the world—with massive health needs and distinct political and institutional weaknesses alongside remarkable human capacity and pockets of excellence. The particular political history of the country has driven decades of under-investment in the public sector and growth of a powerful, unregulated private sector. It is in this context the Indian Supreme Court has led a move toward constitutionalization that has shifted the institutional environment for health policy. To understand if and how this has mattered for health policy we have to start with this reality and resist decontextualizing the poor health outcomes in the country, which leads to quickly to a conclusion that constitutionalization matters not at all. By instead tracing policy issues where the right to health has been mobilized through time we can understand how this institutionalization of the right to health has impacted policy. Overall, we can see the key elements outlined in chapter 3 at work in India as constitutionalization provides an increasingly strong anchor from which policy entrepreneurs push for change. This includes those inside government like NACO leaders engaging the constitutionalized environment for bureaucratic bargaining and those outside government like public health leaders pushing for greater regulation on medicines and clinical trials that engaged the judiciary as one part of a broader policy change effort. Venue shifts to the courts and to the Human Rights Council have been accompanied by the mobilization of the ideational power of rights to interrupt the intransient and negligent status quo. For the most part the issues that have seen rights mobilization reflect neglect rather than avarice—policy monopolies on HIV unwilling to reconsider assumptions about treatment cost-effectiveness or those on maternal health unwilling or unable to address the disconnect between policy and practice. In the background, however, the interests of the Indian private health sector—providers, pharmaceutical companies—discourage disruption of this status quo in overt and covert ways. Constitutionalization has had an agenda-setting function—attracting the attention of Ministers and Union Secretaries to the actions of those below and beside them and reframing the health policy question in ways that prevent dismantling drug price controls without an alternative or empower those promoting strengthening the rural
public health infrastructure and building new accountability structures. There are some limited examples of the courts acting counter to public health—as in the recent High Court decision to stay government action against ineffective drug formulations. But these are few and, on balance, the impact of this constitutionalization has been positive.

The Indian policy issues explored also illuminate the mechanisms through which constitutionalization matters by illustrating the limits of only partial constitutionalizing. Because the right to health comes through judicial interpretation rather than an overt political bargain, it has a more limited impact. Issues like the complex health system failures in maternal health, where the right has struggled to achieve impact, show how the right works—drawing attention and briefly disrupting the status quo, but struggling to maintain that attention long enough to resettle on an improved policy space without clearer and wider recognition of the right. Judges are, of course, political actors and constitutionalizes. The issues explored here, however, give us reason to believe that not passing the right to health bill and removing the right to health from the National Health Policy were missed opportunities that might have deepened the efficacy of constitutionalization.
CHAPTER 6: CONCLUSION

Constitutionalizing health is a significant development in the institutions of health governance and can contribute to improved wellbeing. Over forty years of global health data, we can observe a small but significant health dividend for countries that have adopted the right to health, when controlling for the major alternative explanations of cross-national variation in mortality. Tracing health policy issues in South Africa and India reveals a right that operates as a policy anchor—tying health to the fundamental national political bargain and providing an innovation in the institutions of governance that helps policy entrepreneurs gain a foothold from which to drive policy that expands health capabilities. These findings contribute to literature on law and rights, improves understandings of the public policy process, and responds to the need for understanding the broader set of institutions in the political economy of development that drive improvements in population health. In a broader context, this study suggests that greater attention
to constitutions and the substance and process of health rights is warranted in global health, but with implications for the U.S. and other countries of the global North as well.

In the conclusion I will review the contributions to these three key literatures and then conclude with the important scope conditions for my findings and other limitations and the potential for future extensions.

Contributions to the Literature: Rights, Policy, and Political Economy of Development

Politics of Rights (Or, why rights are not trumps; Norway may not need rights but South Africa does)

This study contributes to debates about rights and their realization in law—analyzing the move from a right to health as an ethical claim and normative framework into the form of a constitutionalized right. Two prominent ideas in law and political science scholarship have encouraged what I label the “skeptical” and the “pessimistic” views on this move—the conceptualization of rights as trumps and veneration of development paths epitomized by Nordic countries. I argue that both of these views misunderstand the impact of the constitutionalization of health. Based on the empirical analysis above—both quantitative and qualitative—we should instead understand the right to health as a “policy anchor” that functions as a part of the political economy of health policy, not apart from it. In so doing, we can better understand both why constitutionalization can be beneficial on balance, and how its impact can be deepened.

First, the view of “rights as trumps” associated with Ronald Dworkin suggests that constitutionally protected rights are best understood as an attempt to protect certain individual interests, even if some social aim would be served by doing otherwise. This implies that rights have a power to supersede political bargaining, cutting through processes aimed at balancing the interests of the different segments of society to focus in the individual rights holder. On

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1 e.g. Ruger 2006; Sen 2008.
2 See Dworkin 1978. This conceptualization has been hotly debated and Waldron argues that, in its simplest form, this is actually a misrepresentation of Dworkin’s conceptualization (Waldron 2000). The idea, however, lies explicitly or implicitly behind many of the critiques of socioeconomic rights. Justice Albie Sachs reports Dworkin himself was against adding such rights to the South African Constitution (Sachs 2009, 169).
consequentialist grounds, this has led Dworkin and others to argue against inclusion of socioeconomic rights in constitutions. Enforced by courts, if rights are primarily aimed at shielding individuals from the intrusion of social forces, then case-by-case intervention into health policy on behalf of individuals is understandably worrying. This “pessimistic” view of constitutionalization reflects a rightly worrying possibility that applying such a rights-based framework might undermine effective policymaking and could actually worsen the health of populations by diverting resources and hobbling public health officials’ capacity. Legal scholar Amy Kapczynski has argued for a right to health, but against instantiations she labels a “neoliberal right to medicines” through judicial intervention in favor of those who demand access to high priced drugs.\(^3\) This could deliver on long-held goals of multinational pharmaceutical companies to capture a larger share of health budgets, without regard to the impact on budgets for other public health issues or even the effectiveness of the treatments in question.

The second “skeptical” set of ideas is best epitomized in the influential work of Ran Hirschl who challenges the proclivity in South Africa, India, and other countries to pin hopes for improvements in wellbeing on courts and constitutional frameworks, when the most successful countries in health and development (e.g. Nordics, Canada) have explicitly avoided constitutionalization.\(^4\) In his view, the turn toward constitutional rights frameworks and judicial empowerment serves primarily to preserve the power of hegemonic elites against the growing demands of mass publics for redistribution under democracy.\(^5\) This suggests rights are largely a distraction from the “government policy—shaped, in turn, by political factors” that matter most for improving wellbeing. “In addition to moderate population size and stable electoral processes, the existence of a developed market economy combined with centralized planning that cherishes public investment in science, education, and health care appears to be the winning formula here. A large middle class and a well-developed civil society—precisely what the Nordic countries

\(^3\) Kapczynski 2018. Note, Kapczynski ultimately spells out a tentatively optimistic view of the potential for a progressive right to health to address the intellectual property issues that drive pricing and accessibility, citing cases in India and Kenya as potential exemplars.


\(^5\) Hirschl 2004.
exemplify—are key societal factors. And what is the net impact of the variance on the constitutionalism axis? Quite negligible, frankly."6 This matches a concern, more nuanced in the political economy of the global South, that political leaders may turn to rights talk and constitutions to project progressive commitments and garner support from human rights actors to distract from their failures to address the core drivers of poor public goods provision.7

If rights functioned only or primarily as trumps it might well be bad for health. But in the context of health, I show that rights function in a far more complex way as a part of the health policy cycle—opening new opportunities for policy change. This is not to say problematic instantiations never occur or that those expressing concern about certain judicial decisions and/or the potential for neoliberal capture are wrong. On balance, however, there is evidence that supports the benefits of constitutionalization. Similarly, I take only minor issue with the idea that wellbeing is driven by complex issues of state capacity, social structures, and effective institutions—and my claim here is certainly not that constitutionalization is a silver bullet. Courts are, indeed, often conservative forces in society and unlikely to spark change on their own. However, in taking up Hirschl’s call to move “beyond idealistic normative accounts or insular case law discourse to understand social rights as part of larger matrix of public policy, economics, and politics…” I find that his claims about constitutionalization do not hold up. In the complex, thorny worlds of health policy in South Africa, India, Thailand, and Malawi—far from the Nordic realities in more ways that can be discussed here—Constitutionalization is beneficial precisely because it affects policy and governance rather than acting through judicial order divorced from them. Perhaps Norway and Sweden, with their particular assets, have no need for constitutionalization, which I note below has risen in the context of the failure of successive development paradigms to drive better health and accountability. But in the environments explored in this study it is helpful.

The quantitative analysis in chapter 2 supports these views. If hegemonic preservation were the only function of constitutionalization, which served primarily as a check against the demands

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6 Hirschl 2011, 455.
7 Kapur 2013.
of the poor, we would expect to see better provision of public health goods where constitutionalization has been avoided. If rights functioned as trumps, we would expect to see that skewed priorities undermine public health. Wealthy, homogenous countries like the Nordics, of course, have the benefit of resources and social cohesion that make direct comparisons misleading—many of the non-constitutional assets of such countries are neither quickly nor easily emulated by others. To truly consider the impact of constitutionalization we need to control for such factors; when I do so in chapter 2, we see that countries with a right to health have better health outcomes. Constitutionalizing countries also show better service delivery—higher rates of births attended by a skilled health worker, higher immunization rates, and wider availability of essential medicines in the public sector. This is the opposite of what we would expect if constitutionalization were skewing priorities and encouraging widespread diversion of resources.

Meanwhile, a central claim rising from the qualitative findings of this project is that constitutionalizing health can act, through a clear set of mechanisms, to address long-recognized realities that inhibit policy change. As a “policy anchor,” the constitutional right roots health in the fundamental legal and political bargain governing the state.

This changes the institutional environment in which policy is made—creating the opportunity for policy entrepreneurs to shift the venue of policymaking to new settings like courts and human rights commissions or to threaten to do so. Clinicians and people living with HIV in both India and South Africa, for example, shifted away from intransigent bureaucracies in the Ministries of Health to the nations’ apex courts. If constitutionalization only happened in constitutional courts, however, it would be hard for it to have significant broader effect on health policy. Instead, we see a variety of other venues coming into play: Health activists and public health leaders in South Africa shifted to the Competition Commission to gain access to information about private healthcare and access to key medicines. In the Eastern Cape, the shift was to the Human Rights Commission on emergency medical care. And in India, substantial use of the lower courts was key to policies on affordable medicines. In Thailand, the constitutional right to health helped create an entirely new venue in the National Health Security Office’s adjudication structures, which
illustrates how constitutionalization can enable venue shifting even in the absence of judicialization of health. This possibility of venue shift enables policy entrepreneurs to expand the conflict in the classic political science sense—bringing in new, powerful allies. In the United States, legal service organizations are rarely involved in health policy in the ways that SECTION 27 in South Africa or the Lawyers Collective in India are. As judges, lawyers, human rights commissioners, and the legal complex become involved in key health issues, consequential health policy issues that have previously been stuck begin to move.

To understand this effect requires insights from both law and public policy scholarship. Rights and constitutions interact with well-known phenomena in public policy where, as policy questions are settled at one point in time, a policy monopoly (or “iron triangle” or “sub-system”) develops around that issue to defend the status quo going forward, even as policy change may be sorely needed. What I show here is that a primary function of the right to health is the enabling of disruption of policy monopolies on key issues through expanding the conflict. None of the policy issues I trace here start in the courts, contrary to the concerns of those who are worried about judicial activism. Courts are, it is worth noting, hardly ideal venues for policy entrepreneurs given the cost, ethos, and uncertain outcomes. Instead, the issues start with moves by policy entrepreneurs inside or outside government to shift policy that come up against a wall. Silicosis and TB in the mines of South Africa has been a century-long issue. Key policy questions have shifted to the judicial space only after hopes it could be addressed through increased miner organizing, majority rule, and COSATU’s role in government were not realized and the ANC government proved unwilling to act on urgent reforms that would better protect public health. Unregulated clinical trials in India were agreed to be a problem, even within the Ministry, but the issue was stuck in a series of commissions and bureaucratic exercises across several governments that gave the illusion of progress without actual reform until the Supreme Court order temporarily halted trials and shocked the system. One of the key functions here is to capture the attention of macro political actors—interrupting the impression (or excuse) that the expert/bureaucratic/interest group monopoly currently setting policy is handling things appropriately.
Importantly, much as courts do not start the policy issue, court orders also do not end it. The concern that inexpert inference by judges in key health policy issues will harm or simply distract from health policymaking does not capture the complexity of what is happening in practice. Instead, bargaining begins well before the case and continues well afterward. The clinical trials case in India, for example, has been among the most criticized decisions as high-profile actors like the Gates Foundation and prominent universities raised alarm that the Court was not properly considering the public health benefit of clinical trials. The halt was quickly lifted, however, as the ministry rapidly moved to address the competing concerns of pharmaceutical companies, researchers, public health officials, and activists with new systems and regulations that were long overdue. Bureaucratic resistance to changing the status quo inside the Ministry, interested parties among pharmaceutical companies, researchers concerned over regulation, and limited capacity to coordinate were each overcome. Though sparked by judicial intervention, the policy outcome was the subject of bargaining. There are also multiple examples in which courts are not involved, yet rights matter nonetheless—like in the Eastern Cape example—with policy change sometimes driven by other rights bodies like the human rights commission and other times by the threat of litigation alone.

On several issues, the intervention of the legal complex served a primarily information and accountability function—raising attention to, and spurring actors to make good on, promises and intentions that might be held up by the many frictions that inhibit policy change. The promise of ambulances to Xhora Mouth and other rural parts of the Eastern Cape were repeated over years, but zero-sum budgets and self-interested actors maintained the status quo. Change came after the Human Rights Commission made it evident that the health department was essentially planning to fail, and forced officials to justify irrational resource allocation.

Again and again this cycle repeats in the issues studied here—judicial orders are a part of the story, but focusing too closely on them misses the broader impact of constitutionalization.
Understanding the right to health as a policy anchor helps focus attention on the ways in which constitutionalization centers health policy on the health capabilities of people—including both the opportunities individuals in a society have to achieve wellbeing and the process through which health policy is made. Indeed, some of the concern about the focus on the individual in legal contexts from skeptics seems to help here—allowing individuals to raise concerns about how health policies may be undermining their health capabilities and those of similarly situated individuals; creating opportunities to address those issues where monopolistic policy ideas deflected attention from them. This policy anchor grounds a long-term commitment by the state to the achievement of wellbeing and an institutional change that enables realization. Following the metaphor, there is room for the policy process to drift with the current in multiple directions as the state considers the particular health realities of the society at a given moment and reaches agreement on the necessary requirements for “flourishing” that all people must be afforded. The anchor, however, provides both ideational and institutional mechanisms to return health policy debates to the individual, and force reconsideration of whether policy is effectively oriented toward this agreement. Facing opposition, post-Apartheid South African health officials used the Constitution to focus attention of health workers on the individual to drive user fee abolition and push forward a single-payer health system. People living with HIV were able to challenge those same officials’ decisions on HIV policy and be heard by the state, identifying the anti-treatment stance as contrary to the health capabilities the state committed to support.

Perusing the health issues that have seen rights mobilization reveals a variety of issue areas—addressing both healthcare and public health. More of issues in which constitutionalization matters most deal with healthcare. This is not particularly surprising since these are both the more straightforward issues in terms of complexity and the issues which do not require overcoming powerful, coordinated, cohesive opponents to change (e.g. South African mining companies). While healthcare is not the only driver of wellbeing and, in most wealthy countries differences in

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8 See Ruger 2010; Sen 1999 for a fuller discussion of capabilities.
health are decreasingly due to differential access to healthcare, modern medicine remains important. The prominent McKeown thesis suggested that vast improvements in health in the North had little to do with healthcare, but this dismissal of the value of modern medicine has since been convincing challenged and the translation of germ theory into effective public health interventions remain an important path to improving health in much of the world.  

As documented in chapters 4 and 5, most of the major drivers of death in South Africa and India are amenable to basic medical intervention—as are those in many countries in the global South, especially among the poor. As such, the dominance of healthcare is understandable and may also be an artifact of case selection in the qualitative section here. A handful of issues—legalization of sodomy or Silicosis & TB in mines for example—have begun to expand the focus to broader issues affecting health capabilities. With just two decades of experience, it is hard to assess the degree to which the broader conceptualization will take hold, though for truly addressing health capabilities it is necessary.

One thing that is clear is that Epp’s finding that support structures are necessary for triggering a “rights revolution” holds true for socioeconomic rights as well. As the Malawi case makes clear, moving beyond a core government commitment to health and to a constitutionalized space requires a threshold level of legal aid and financial support to rights-based organizations—without that venue shifting is not possible, even where the constitutional language is good and the courts are willing. That said, as seen in the cases here, the legal complex is an important, but not isolated, piece of the constitutionalization matrix. Activists, social movements, public health officials, politicians, and others all operate within a different opportunity structure when health is constitutionalized. The Indian case illustrates how judicially-driven constitutionalization has limits and, while providing significant and beneficial impact, has been smaller and less systemic than in South Africa where a broader politics of constitutionalization drives political action.

Many authors have written on social and economic rights, including the right to health—several tackling key empirical questions about the function of courts that challenge both the

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Dworkin and the Hirschl conceptualizations.\textsuperscript{10} By focusing on constitutionalization as a broader phenomenon, of which litigation is just one piece, and tracing health policy issues before and after rights mobilization (most over at least a decade) I build on that work to show that a consistent “policy anchor” model can help describe the mechanisms of action for health as a right in constitutions. This might help us think as well about how to increase the efficacy of these mechanisms for greater impact.

\textit{Public Policy—Constitutionalization Matters}

This project also contributes to literature on the process of public policymaking. Within the public policy frame we can also understand \textit{when} and \textit{how} the right to health has an impact and explain why some issues see a high level of impact while others see a lower level.

A core question in public policy studies is, to put it simply: how and when do policies change? I have traced the process of a wide set of health policy issues that demonstrate significant alignment with leading theories of the policy process. Missing from many previous accounts, however, is the role of constitutionalization. I show that constitutional recognition of health as a right has an important function and facilitates health policy change through mechanisms that have not been explored to this point.

Rights largely do not figure into political science theories of the public policy process. An influential recent article by Baumgartner et al., for example, starts with the question of how constitutional design affects the public policy process, but then does not consider rights as a relevant part of the constitution in relation to policymaking.\textsuperscript{11} This seems to stem, in part, from the reality described by Béland and Powell that “much of the scholarship on social policy continuity and change focuses on one policy area, one country, one continent (mainly Europe), or one welfare


\textsuperscript{11} Baumgartner et al. 2009.
The antipathy to socioeconomic rights in the global North has contributed to undertheorizing rights impact in policy. Insofar as civil and political rights are the model for political scientists, this is not surprising. The impact of free speech or religious exercise rights, for example, on the issues studied by most policy scholars (e.g. welfare state spending) is minimal. Meanwhile, as an institution that has emerged largely from the global South, the over-reliance on cases from the U.S. and Europe has also contributed to the studies that miss the impact of constitutionalization as a phenomenon.

If we look South, however, we can see that constitutionalization matters.

Debates around policy change and continuity in the literature have largely centered around the question of how best to characterize change. Peter Hall’s seminal work on policy change described three orders of magnitude—changes to the settings of policy instruments, changes to the instruments themselves, and changes to the hierarchy of goals behind policy.\textsuperscript{13} Pierson’s exploration of path dependence built on a long literature that drew attention to the relative stability of policy over time and helped focus attention on the need to explain continuity and change together.\textsuperscript{14} Scholars have since come to some agreement that policy change takes the shape of a broadly punctuated equilibrium, as the theory pioneered by Baumgartner and Jones explains.\textsuperscript{15} Some historical institutionalists, though, have challenged this theory with Thelen, Hacker, and others arguing that more common than big punctuations is gradual change or “cumulative, but transformative” change in both policy and institutions with seemingly small adjustments adding up to transformation.\textsuperscript{16} This analysis has been criticized, however, as more descriptive than explanatory and the distinction between path-departing change and incremental change as perhaps overplayed.\textsuperscript{17}

\begin{flushleft}
\textsuperscript{12} Béland and Powell 2016.  
\textsuperscript{13} Hall 1993.  
\textsuperscript{14} Pierson 2004.  
\textsuperscript{15} Baumgartner and Jones 1993; Baumgartner et al. 2009.  
\textsuperscript{16} Thelen 2004; Hacker 2004.  
\textsuperscript{17} Béland and Powell 2016.  
\end{flushleft}
In tracing over twenty health policy processes in two global South country contexts, this study finds examples that might fit multiple definitions and magnitudes of change. Path-dependent processes are found in abundance. The decision under Apartheid to focus on tertiary medical services and a variety of facilities in white areas made it nearly impossible to shift resources later, as white residents protested curtailing of services and specialty physicians opposed lay-offs or relocation to Black areas. In a constrained budget environment, these prior choices inhibited expansion of emergency health services in the Eastern Cape to reach Black rural residents and prior placement of clinics meant the infrastructure to support ambulances was missing as well—resulting in the need for rights mobilization.

Indeed, nearly all of the policy processes in which health rights were mobilized in India and South Africa can be described as examples where policy stasis was the reality, even as it inhibited public health improvement. This consistency across issues is interesting, perhaps even surprising, since the issues were chosen based on initial interviews identifying where rights mobilization took place. I did not set out to develop a set of cases of policy stability. It seemed just as possible, at the outset, that some significant portion of issues where the right to health might be mobilized would be defensive. In the context of the U.S. and other OECD countries, health and welfare state retrenchment is often the question under study.\(^\text{18}\) In the global North, Scheppele’s work on socioeconomic rights in Eastern Europe focuses on defense against retrenchment.\(^\text{19}\) Meanwhile, a significant portion of the theoretical work on the right to health as well as some of the most celebrated cases deal with rules of “non-retrogression” (backsliding).\(^\text{20}\) Yet while I identified a few cases of constitutionalization affecting questions of pull-backs in policy (e.g. struggles over price controls in India) these are the exception in the sample of issues studied here. This surely stems in part from case selection—focusing mostly on a set of middle-income countries in Africa and Asia. However, as Rudra, Haggard & Kauffman, and MacLean have all shown, struggles over

\(^{18}\) Pierson 2004; Hacker 2004; Böhm 2016.
\(^{19}\) Scheppele 2005.
retrenchment in health and welfare have been part to the politics of neoliberal reforms in the South from the late 1990s to the present. Further study is needed to fully understand this phenomenon—whether it is particular to the cases or part of the nature of health rights. Overall, however, the reality of rights being mobilized in a context of policy stasis makes a great deal of sense from a policy process perspective that understands continuity is far more common than change, even in the face of urgent needs and new information. In this way, the health issues traced here support the punctuated equilibrium theory, though with greater suggestion that punctuations will be more mundane than grand and dramatic.

Policy change in health, however, is especially important given the close alignment explained by Deaton between the progress of both medical and public health science and improvements in wellbeing. I show here that constitutionalization changes the institutional terrain of policy change. By providing policy entrepreneurs the opportunity to shift the venue of policymaking into legal spaces, constitutionalization encourages policy change. This too supports the idea of punctuated equilibrium—as this venue shift pierces the kinds of policy monopolies expected to maintain the status quo in the theory. Understanding this shift, however, is impossible without considering the constitutional rights context. Again and again on these issues, I show that the expected mechanisms from social movements to electoral change fail to bring about health-enhancing policy change—a reality that will surprise few observers of health policy—but that rights mobilization shifts the political power dynamics and opens space for change. The issue of emergency health services in the Eastern Cape received front page media coverage and politicians raced to pledge change—yet the policy monopoly there was strong and the beneficiaries of policy change were comparatively weak. When the HRC entered the conflict, however, power dynamics shifted and new information came out about the budgets, officials were forced to justify the policy, and the monopoly was undercut. This mechanism holds in both incremental change (drug price controls in India, for example) and in some more paradigm-shifting changes in which the

21 Haggard and Kaufman 2008; MacLean 2011; Rudra 2007.
22 Deaton 2003.
instruments and the levels of policy shifted such as the move to an ARV treatment program in both India and South Africa or removal of user fees in primary healthcare in South Africa.

Policy entrepreneurs make these venue-shifting moves—turning to courts and rights bodies—largely as a fallback position when issues get “stuck.” This stems in part from the very significant investment needed to use these rights bodies as venues for change. Given this reality, it seems likely that the right to health will continue to play a similar role—that even as constitutionalization deepens, it will continue to be a second-order choice for policy entrepreneurs. It may, on the other hand, become more important—with rights mobilization on a wider range of issues and with increased frequency if it proves efficacious and avoids backlash from powerful political actors. However, the likelihood of courts running everything, as critics worry, seems very far off.

The existence of that second-order option, however, needs to be better considered in models of how policy works, because it changes the power structures of policymaking. Public health leaders fighting “irrational” medicines in India, for example, had neither a powerful social movement behind them nor significant political support, yet their ability to move to the courts changed how they structured their campaigns, constructed their arguments, and interacted with the bureaucracy. In that case, rights mobilization bore only limited fruit—and considering why and how in relation to the rest of the policy cycle helps us understand the relative strength of the policy monopoly on that issue and has bearing for how the entire policy cycle has functioned over a decade through back-and-forth negotiations with the Court. In clinical trials, on the other hand, policy change was directly sparked because a set of very small NGOs that were unable to break through bureaucratic deadlock were able to secure the sustained attention of the Supreme Court, through which policy change was then brokered, significantly changing the players and the power on different sides of the issue.

What we see is that the constitutional context shifts but does not fundamentally disrupt the policy process. Neither bureaucrats nor public health experts become irrelevant in our cases, and bargaining within the public health policy infrastructure does not end. Policies are not in a state of
constant disruptions, but instead they return to a state of continuity much as the literature would expect. Today in South Africa, the courts have very little to do with the HIV treatment program despite its high-profile role in the program’s birth—and complex negotiations over how the program is run, which drugs are used, who is eligible to start treatment, etc. are largely negotiated through a set of bureaucratic structures in the National AIDS Council and the Ministry. Instead, I would argue that the health system becomes more nimble and responsive to information. The “politics of attention” and “information process” described by Jones & Baumgartner now includes new and different players that, in some cases, help speed the translation of information and evidence into state action.²³ My findings predict, for example, that constitutionalization is likely to lead to more and more frequent punctuations—an empirically testable hypothesis that could be explored in future work using the tools developed by policy scholars like budget tracking and media content analysis.²⁴

Meanwhile, a growing body of literature has identified the key role of ideas in promoting policy change—yet rights rarely figure in this analysis.²⁵ The beliefs and conceptual frameworks of political actors shape both the range of policy options they can imagine and the degree to which they see policy change as feasible and necessary. Constitutions, in this light, are as much ideational instruments as they are institution-building. I argue that constitutionalizing health provides a particularly robust constellation of ideas—“reasons for action”—that I show have real power in the policy process. These reasons for action provide three key functions: First, they provide a counter to ideas that support the monopolistic policymaking processes and deflect the attention of macro political actors. People living with HIV in India countered the powerful idea of unaffordability and cost effectiveness while rural residents in South Africa countered the ANC’s narrative of slow but steady progress toward liberation—both with rights claims. Second, the rights framework is particularly oriented toward action over inaction—important in a health policy

²³ Jones and Baumgartner 2005.
²⁴ Green-Pedersen and Walgrave 2014.
²⁵ Béland and Cox 2010; Carstensen and Schmidt 2016; Campbell 2004; Schmidt 2008.
context in which the question is often whether or not to change the current status quo in light of new information or insights. Not providing HIV treatment had to be justified in both India and South Africa after rights mobilization, which flipped the script from the previous debates in which resistant leaders had sustained inaction by continually raising questions about the effectiveness of an anti-retroviral program and offering more study. Finally, rights act as what Béland and Cox call “coalition magnets”—attracting a set of partners for policy change.\(^\text{26}\) This is related to, but distinct from the point about engaging the legal complex noted previously. Some allies that are part of, and needed for, the venue shift into rights bodies are directly attracted by the rights framing. In addition, some allies are attracted by the framing of the issue as a rights issue. In the Eastern Cape, for example, the human rights group Black Sash was attracted through the rights framing to the EMS issue and proved an important ally that brought anti-Apartheid struggle legitimacy to help counter the ANC resistance.

In these ways, this study contributes to moving scholarship from description to causality in studying policy change. The constitutional framework plays a causal role and needs to be considered as part of the framework within which policy is made. This study also provides a corrective to research that rarely includes the legal complex as a key player in health and social policy, helping update the theories developed in OECD countries in a time before significant moves on socio-economic rights to reflect the current political context in comparative perspective.

*Constitutionalization—Public Policy Explains When Constitutionalization Matters*

Table 3.1 in Chapter 3 arrays the list set of health policy issues covered in this project from low- to high-impact. This is a notional order, not meant to be exact, but instead to reflect the reality that some issues saw greater impact than others. While this study was not set up to compare policy

\(^{26}\) Béland and Cox 2016.
issues to each other, in the end, a notional rank order was clearly discernable in the issue case studies.

For most of the issues we see a clear policy monopoly in operation in one form or another—with monopoly actors ranging from the reaches of apex politics as in HIV treatment in South Africa to the technocrats of the small subsystem engaged in policy debates on medicines’ quality and rational use in India. What matters most for impact, however, is the character of the policy monopoly and the policy entrepreneurs. The opportunity to venue shift, new allies, and ideational power that are available under constitutionalization change the opportunity structure for policy change—but it is not assured. When monopoly actors are strong and cohesive or when the ideas backing the policy monopoly are particularly powerful then policy change with major impact is less likely to occur. The archetypal example here is Tuberculosis in prisons in South Africa. Justice Cameron’s visit to Pollsmoor prison and the data on TB infections described in chapter 4 showed that little has changed in practice, despite the intervention of the Constitutional Court and continued bargaining by pro-health actors in recent years that has been similar to that in other cases. Prison authorities represent a paramilitary authority over what happens in the prison and thus their monopoly over policy is simple and nearly incontestable, while the paradigmatic idea that security in the prisons trumps all other concerns has proved resistant to challenge. The character of the policy entrepreneurs is also critical. Constitutionalization created a critical opportunity for the small group of public health actors and ex-prisoners concerned about the issue to attract new allies—from the Treatment Action Campaign to leading lawyers. Nonetheless, the main beneficiaries—prisoners—remained among the least powerful political actors in the country and, as the policy process settled back into bargaining, even the backing of the Constitutional Court was insufficient to increase their political power enough to counter resistance from prison authorities. Finally, the nature of the policy change needed matters—Peter Hall’s three levels of change are illustrative. To truly address TB in prisons requires more than just changing the

\[27\text{ Hall 1993.}\]
“levels” of change (e.g. better health services) or the instruments (e.g. bringing in a whole new set of actors and programs like the NGO-led TB program). Instead, it truly required changing the underlying goals of the policy—with changes like vastly more time outside, renovating prisons with new designs and layouts, or reducing overcrowding by imprisoning fewer people each requiring prioritizing health over (or at least alongside) control and punishment. These kinds of changes need more power and sustained attention than was marshalled by policy entrepreneurs, even under constitutionalization. This does not mean this level of change is not impenetrable to rights mobilization. I would argue changes like the shape of the National Health Insurance in SA or National Rural Health Mission in India are paradigm-shifting as were some of the drug pricing cases in South Africa. It does seem fair to say, however, that where a strong, coherent policy monopoly faces off against a relatively weak entrepreneurial coalition demanding paradigm-shifting change, the mechanisms of constitutionalization are unlikely to foster change. On the other hand, most health policy issues do not face such odds—there are usually dissenting voices inside the monopolistic structures (e.g. officials in the SA Department of Health who opposed the Minister’s stance on AIDS), health policy monopolies are rarely so strong as control over prisons, and often an entrepreneurial coalition can be crafted that is able to make use of opportunities under constitutionalization. Where this is true, the right to health provides the anchor they can grasp as they work toward policy change.

*Political Economy of Development & Democracy*

Finally, the third set of literature to which this project contributes is in the political economy of development. When applied to the global South, debates over the determinants of mortality are fundamentally about theories of development. Despite remarkable economic growth rates in some countries, market-driven development models that dominated the 1980s and 1990s did little to help countries in the global South catch up to the global North—with disparities in
health and mortality growing rather than shrinking between countries. The move toward constitutionalization needs to be seen, therefore, in light of the failure of both neoliberal development and its statist predecessor to globalize the kind of revolutions in wellbeing seen in the North in the post-war period. Meanwhile, while the “wealthier is healthier” paradigm still holds some explanatory power, in recent decades a growing number of countries reached the top of the Preston curve in which increasing national income does not drive increases in population health. In this context, the institutional turn in political economy helps make sense of some of these realities, though the “Northian” over-focus on institutions related to private property and markets risks providing little more leverage over the institutions that drive wellbeing than previous work. Evans, in this context, calls for a “successful societies institutionalism” capable of exploring a far wider set of socio-political institutions to understand when and how improvements in health are produced.

This project is, in part, and attempt to do just that. Our case studies show that the right to health is more than a conceptual frame and that embedding such a right in a national constitution has the power to shift the institutional environment in ways that foster health. When health is constitutionalized, the new “rules of the game” change what constitutes appropriate action for different actors—judges and lawyers, human right commissions, and even the Competition Commission all take part in health policy in South Africa and India. In Thailand, the NHSO adopts an adjudicative model that allows individuals to petition for inclusion of drugs and services in the national health system. New organizations arise to take advantage of the institutional shifts and existing organizations respond to shifting incentives. The Treatment Action Campaign is born as a rights-based organization wrapping itself in the Constitution so tightly that learning the Constitution becomes a key activity of grassroots members and a relationship with the AIDS Law

29 North 1990.
30 Evans 2009.
Project becomes integral to the organizations functioning. The Lawyers Collective in India, a decades old legal organization, becomes a leading actor in HIV policy.

Democracy, meanwhile, has been arguably the leading political institution studied with respect to health. While many scholars have little expectation that electoral democracy will drive health policy (especially those focused on the global North), the political economy literature includes robust debates over whether democracy drives wellbeing.\(^\text{31}\) This links to Hirschl’s concern that constitutionalization might be a distraction, diverting focus from building strong social democratic institutions that are far more likely to drive redistributive policies than courts, which serve hegemonic interests. Yet Peter Hall and Michele Lamont note that “the deliberative processes fostered by democratic institutions have a role to play but are insufficient to generate large improvements in health.”\(^\text{32}\) The issues examined here support this contention. In the subset of issues here, there is little evidence of robust electoral democracy and related political freedoms, even engaging avowed social democratic actors, fostering redistribution or addressing obvious barriers to improvements in health. These issues are, of course, identified based on where rights mobilization occurs in order to understand its impact—so it is not surprising these would be issues where other forms of politics have not produced results. They nonetheless suggest the clear limitations of electoral democracy alone. In the Eastern Cape neither competitive elections nor criticism from opposition politicians, front-page headlines, nor demonstrations broke through the policy inertia to expand emergency health services—but the constitutionalized environment created alternative paths to policy change.

The quantitative findings in Chapter 2 support this—suggesting only a weak relationship between electoral democracy and wellbeing, but with a clear interaction between democracy and health rights that enhances impact. That the TAC can engage in mass protest and win over public opinion through strategic use of media mattered for addressing the AIDS treatment policy

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\(^{31}\) For example just in the last few years, see Gerring et al. 2016; Acemoglu et al. 2014; McGuire 2013; Wullert and Williamson 2016; Pieters et al. 2016; Welander, Lytkens, and Nilsson 2015.

\(^{32}\) Hall and Lamont 2009, 15.
debacle—but it was not enough. By going to court, the TAC created a different opening, reframed the issue, and gained important allies that helped amplify the other pieces of their activism.

I show here that constitutionalization actually mobilized many of the mechanisms suggested by Sen and other political economists as the keys to democratic impact on wellbeing. It fosters information flows both to and from government about health issues—whether exposing the failure to plan for success in the Eastern Cape or exposing and politicizing rural health issues in India, the “discovery” power of rights bodies can compel information flows. Accountability is a key function of rights bodies that can augment the far blunter power of elections—forcing decision-makers in the Eastern Cape Department of Health to justify their plan to fail, for example. And while elections and free media can shift the incentives of politicians to deliver on public goods—so too can the reality or threat of being hauled into court or human rights body.

One of the most important findings of this work relates to this interaction and the power of constitutionalization where there is nothing approaching a strong social movement on the issue. Health-related social movements have had powerful effects in some countries and transformed health politics.33 Critiques from the left worry that moving toward a rights framework will defang these movements—diverting time and energy to the law. It is clear from the case studies here that engaging in litigation is expensive, time-consuming, and while rights frameworks can help provide reasons for actions, judges need not take them up amidst the myriad alternative frameworks within the law. However, on most of the issues examined here there is nothing approaching a movement. The People’s Health Movement in India used the human rights commission to help drive policy change on broad health system changes, but on the issues of regulating medicines or clinical trials the key actors were not movements but small groups, NGOs, and civil servants inside government acting in traditional policy entrepreneur form. Up against more powerful interests dedicated to the status quo, their uses of democratic pressures were largely unable to break through. Here,

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33 See e.g. Brown et al. 2010.
institutionalization of health as a right structured the opportunity for policy change—new rules of the game changed the possibilities and the power for change.

Understanding constitutionalization thus expands our understanding of the political economy of health policy and seeing rights in institutionalist terms helps us better understand how it is possible that words in the constitution might matter for population health.

**Limitations & Extensions**

This study seeks to combine multiple levels of analysis and types of data to understand how and when constitutionalization matters for wellbeing. The quantitative analysis in chapter 2 uses 40 years of health data to show it matters and the qualitative case studies augment this with process tracing in two countries and two short shadow cases. There is, however, a clear limitation to how far these findings can be said to travel.

**Scope Conditions**

The findings of this study are driven by work in a set of middle-income countries—with the main paired comparison centered on countries with strong electoral democracies and relatively robust civil society. While the quantitative data presented in Chapter 2 is global, further work will be needed to understand the degree to which the effect and mechanisms travel.

Middle-income status matters because these countries share elements of a political economy in which limited capital undercut early visions of a universal health system akin to those in Europe, but recent rapid economic growth has expanded both the resources available to address health and the expectations of the population. Both the growing middle class in India and South Africa and the increasing living standards of the poor have created complex pressures on the health system—driving growth in the private sector as well as demands for transformation in the public sector. Constitutionalization in this context has, not surprisingly, been enmeshed in that process and so the particular mechanisms and effects I find cannot be separated from them. It is possible,
therefore, that constitutionalization in a context of middle-income growth is far different than it is elsewhere. While these mechanisms travel well to Thailand and they might do so as well in Nigeria or Malaysia, they may not travel to upper-income Korea or to North American and European powers. Low-income countries, as noted, are also less likely to see the benefits of constitutionalization—though more work is needed to understand how these dynamics play out outside of places like Malawi that are at the very bottom of the least-developed-country list. Even if these results only travel to middle-income countries, however, they are still significantly worth paying attention to—5 of the world's 7 billion people live here and they represent many of the world's rising powers and most dynamic economies.  

In terms of the higher-income countries often prized for their institutions and successful health systems, it may well be that they simply do not need rights mobilization to address challenges in health. As we have seen, most of the health issues where rights have been effective in mobilizing positive policy change are not the kind of deeply complex questions where there is genuine scientific equipoise about how to improve mortality. Instead, constitutionalization generally seems to work by driving policy change toward where evidence is relatively uncontroversial, pushing expansion of effective programs through intransient bureaucracies, increasing accountability for planning to succeed, and shifting resources toward the health needs of those who may not be well served by the extant distributive politics. Where these are not at issue, then, it is not clear whether constitutionalization would help. I would note, however, that it is a relatively rare polity in which these are not the issue—certainly the U.S. is not on that optimal list. Hungary, Spain, several post-Soviet states, and others among high-income countries have adopted a right to health, but very little is written about the effects and future work looking at how the right to health plays out in the global North would be worthwhile.

The main comparison countries here are also atop the democratic spectrum and, while my findings travel well to Thailand, which has far more mixed democratic institutions, the

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34 World Bank 2017.
instantiation is different. Some level of democratic space is clearly necessary for the exact mechanisms I describe here since, by their very nature, fully autocratic states have no possibility for venue shifting. Independent courts play an important role in the story too, as does a threshold level of freedom of association that enables civil society and media to engage as key actors in policy change. That said, one can make too much of the distinction between democracy and non-democracy. Ginsburg and collaborators have shown that courts can be highly consequential even where elections are far from free and media has limited freedom. Political science has also long shown that the most countries, especially in recent decades, are characterized by complicated degrees of political freedom such that even countries that may not meet the threshold scores on various indexes as democracies might well allow venue shifting, conflict expansion, and the mobilization of rights as ideas. Health policy in many cases is driven more by bureaucratic politics than by macro politics and, as I show here, on the issues where rights are mobilized, democratic pressures have largely failed to secure change. Nonetheless, further research is needed before we can know how far the effects I describe here travel along the relative democracy spectrum.

Finally, this study does not touch on Latin America—which is worthy of note since there has been significant debate over the effect of constitutionalization in the region. With a very different model of judicial engagement with the right to health (driven in part by the civil law systems), Brazil and Colombia have both seen tens of thousands of cases brought before the courts for access to medicines and other health issues through low-barrier petitions that make judicialization easy. Several scholars have raised serious concerns about this—worrying that some of the concerns which I have countered here, including diversion of resources and individualist decision-making raise their heads in these countries. Ferraz argues that litigation is harming the poor in Brazil by favoring privileged litigants over the rest of the population and undercutting balanced public health funding. Biehl’s work, however, challenges some of Ferraz’s findings—

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38 E.g. Ferraz 2010.
showing that litigants are largely poor and often litigating to gain access to drugs that government has already committed to funding.\textsuperscript{39} Tracing the Colombian Supreme Court’s T-760/08 decision that examined systemic failures in the health system and called for significant restructuring, Yamin and Parra-Vera depict a court seeking ways to focus on the macro-level issues over the individualist.\textsuperscript{40} These researchers’ work fits, at least broadly, with the findings from my case studies that a shift in the political economy of health policy is at the heart of constitutionalization and that venue-shifting may well be functioning to address accountability deficits in the existing system. That said, there are clearly different political forces at work in Latin American and it is hard to know without replicating the same kind of process tracing on health policy over time whether the mechanisms I see here would travel to Latin America.

\textit{The Role of International Politics}

This story has been primarily one of domestic politics and domestic institutions—drawing on the literature in comparative politics to ground an analysis of constitutionalization; this has to significant degree been by design. While much of the work in health and human rights is focused at the international level—analyzing global norms and engaging with UN processes—the goal here was to understand far better how the increasingly common move to include right to health in national constitutions affects the actors, ideas, and institutions of national health policy. I did, however, expect that international forces would be come into my qualitative data far more strongly than it has. Throughout my interviews, with the significant exception of the international pharmaceutical industry, international actors were often absent or background players in the processes described to me—even when multiple interview participants described the same processes. In retrospect, this reflects far more on my research design and interview protocols than it does on the actual influence of international actors. The UN and international structures, for

\textsuperscript{39} Biehl 2015; Biehl et al. 2012.
\textsuperscript{40} Yamin and Parra-Vera 2009.
example, have played a critical role in facilitating constitution-making processes around the world—with international advisors working alongside (and occasionally in place of) national leaders in the drafting of written constitutions. Since I did not focus on the constitution-writing process, however, these important actors are absent from my analysis. Meanwhile, public and private international funding agencies like the Global Fund to Fight AIDS, TB, and Malaria, and the Bill & Melinda Gates Foundation have played an outsized role in health policy in low- and middle-income countries in the last decade—including on key health issues like HIV, tuberculosis, maternal health, and several other issues explored here.

In a story significantly about agenda-setting, the absence of these players and processes like the Millennium Development Goals is a weakness in this analysis. In retrospect this reflects the reality that they act not as principles in policy negotiation but far more in the background—and thus are less visible in my data. Finally, the international financial institutions including the IMF, World Bank, and regional development banks play another key, but background role, in setting the stage for what is possible in health policy. While the pressures of IFIs can sometimes be exaggerated—including by domestic actors looking to blame external forces for unpopular decisions they themselves are taking—there is no doubt that structural adjustment programs and related ideas and instruments of the IFIs have had major impact on the development of welfare states and health systems. Their primary interaction, however, is with finance ministers. Thus, while I interviewed with high-level government leaders including the former or current Ministers of Health of each country, by focusing on health actors my design failed to draw out data on the IFIs and other international economic pressures. More work is therefore needed to build an additional layer of analysis at the international level to ensure this work is not seen as decontextualizing health from the very processes of globalization that have helped diffuse the idea of health as a right into national constitutions.
Extensions & Future Work

As I have mentioned, further work in understanding the constitutionalization of health is worthwhile on a number of fronts—some of which I propose to take forward in future adaptations of this project and future projects. First and foremost, as I move this project into a book project I will focus on fleshing out the shadow cases on Malawi and Thailand—which the limitations of time and brain-space have left insufficiently dealt with. Interviews conducted for this project will allow me to expand these to include several mini-issue studies that illuminate the ways in which the right to health functions under conditions of more limited democracy, limited judicial engagement, and limited national income.

I will also expand the shadow cases to include at least one Latin American case—likely Brazil, which could be conducted through secondary sources and a few primary interviews. For all the reasons described above, bringing Latin America into the analysis would strengthen it and provide an important further test to the theory. At this stage, I do not foresee seeking to bridge further into advanced industrial countries for this study—and so my scope conditions will remain largely the same. The dynamics, issues, and processes of health policy are distinct enough in AICs that they warrant a separate examination. It is one that is worthwhile, however, and in a later project I will seek a research partner with greater knowledge of AIC politics to look at those countries in the global North that have adopted the constitutional right like Hungary to see if and how it matters.

Finally, I will seek to address the international issues by expanding my research design with another set of interviews in at least one of my cases that focus in on international actors. Interviews with actors in the finance ministry would improve the analysis overall by giving a second perspective on the bureaucratic negotiations like those over financing HIV treatment described in chapter 5. They would also help bring into greater clarity the role of international forces in these key policy areas. Meanwhile interviews with officials at the Global Fund, World Bank, Gates Foundation, and elsewhere will help clarify how they saw constitutionality and will be paired with
second interview with a few of my original sources with new questions focused at this international level.

**Implications for Global and U.S. Health**

Finally, I turn to the question of what this work suggests for those whose core interest is in improving population health. The clearest finding in this work is that constitution-making is public health policymaking. In the long term, building a nimble, accountable health system able to adapt to changes is helped by constitutionalizing health. This suggests that far more attention from public health actors to the constitution is warranted. Since globally the average constitution lasts fewer than 20 years before it is replaced or substantially revised, there are actually far more opportunities for this attention than might be suggested by observing the U.S. context. Yet public health actors are rarely involved in constitution-writing and I am aware of only a few campaigns at the national level for the adoption of a right to health. This is a missed opportunity to improve wellbeing through building a policy anchor that can help drive health policy toward better and more equitable impact.

Meanwhile, each year billions of dollars are spent by foundations and aid agencies on improving health outcomes in low- and middle-income countries—from the Global Fund to Fight AIDS, TB, and Malaria to the Gate Foundations’ high-profile efforts to eradicate polio and address a host of other health issues to the European efforts through the International Health Partnership. Perhaps even more important than the external funding, governments put large portions of their budgets into building and regulating health systems. In all of this, however, only a smattering of resources has been dedicated to building the kind of support structures that I show are critical for maximizing the impact of constitutionalization. There is no Section 27 or Lawyers Collective in Malawi—which is a question of resources rather than will. I suggest that public- and private-sector resources need to be invested in building the nexus between the health system and the legal complex—supporting non-governmental organizations and public-sector legal aid efforts that

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enable utilization of the right to health. Human Rights Commissions too could be better connected and resourced to engage with health systems—as I show here in both India and South Africa, this has helped improve the accountability of and vision for health.

Finally, while this study does not touch on the U.S., it does hold potential lessons. As of this writing it seems rather hard to imagine a constitutional amendment on the right to health. Yet there is reason to believe that this is not the only opportunity to realize some of the benefits I document here. The mechanisms through which constitutionalization works—venue shifting, expansion of actors, ideational tools, etc.—might also be realized in some form through legislated rights. There were proposals for including fuller substantive and procedural rights as part of the Affordable Care Act in 2010. It seems few took them seriously, perhaps because even sympathetic leaders did not see the issue as particularly important compared with other priorities in the bill. Today, as the debate continues over the potential repeal of the ACA, the case studies here suggest that too was a missed opportunity. Perhaps structuring some sort of enforceable right thought legislation could have more effectively harnessed the legal complex and other actors toward pro-health aims beyond simply rejecting (so far) challenges seeking to strike down the law.

Rights matter. Constitutionalizing those rights—moving them from ethical demands toward political institutions with sufficient substance to change the environment in which health policy is made—is both increasingly common and increasingly complex. This is a relatively new phenomenon—with just a few decades to show impact. As this institutionalization deepens, it will become layered with different meanings, practical instantiations, and be used by new actors in the service of increasingly complex interests. We can see some of this already. The early policy issues where rights were mobilized in South Africa were far more straightforward than the multifaceted issues of more recent mobilization from migrants’ rights to National Health Insurance. Time will tell how this complexity will drive what is, today, an important emerging institutional option for addressing health and health equity in the twenty-first century.
### Annex A:

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>(1) FGLS</th>
<th>(2) PCSE</th>
<th>(3) ML</th>
<th>(4) ADL model w EC</th>
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<tr>
<td>DV: Log Under 5 Mortality (per 1,000 live births) 1970-2010</td>
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<td></td>
<td></td>
<td></td>
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<td>-0.019+</td>
<td>-0.086**</td>
<td>-0.012**</td>
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<td>(0.011)</td>
<td>(0.011)</td>
<td>(0.004)</td>
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<td>(0.001)</td>
<td>(0.000)</td>
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<td>0.007**</td>
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<td>yes</td>
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** p<0.01, * p<0.05, + p<0.1

All independent variables are lagged one year. ADL based on 0 & 1 year lag. Standard errors are listed in parentheses. Constants not reported.
### Annex B: Health Rights & Under 5 Mortality + Spending & Services Variables

#### DV: Log Under 5 Mortality (per 1,000 live births) 1970-2010

<table>
<thead>
<tr>
<th>Model B.1</th>
<th>Model B.2</th>
<th>Model B.3</th>
<th>Model B.4</th>
<th>Model B.5</th>
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<td>Public Health Expenditure</td>
<td>Out of Pocket Exp</td>
<td>Attended</td>
<td>Immunization</td>
</tr>
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<td>-0.010</td>
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<td>0.002</td>
<td>0.002</td>
<td>-0.000</td>
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<td>-0.353***</td>
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<td>-0.024*</td>
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<td>-0.001</td>
<td>0.005**</td>
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<td>-0.000**</td>
<td>-0.000*</td>
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<td>Public Health Expenditures (% GDP)</td>
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<tr>
<td>Public Health Expenditures (% Total Health Exp)</td>
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<td>(0.000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of Pocket Exp (% Total Health Exp)</td>
<td>0.000</td>
<td>(0.000)</td>
<td></td>
<td></td>
</tr>
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<td>Skilled Birth (% Attended)</td>
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<td>(0.001)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization (% 1-year DTP3)</td>
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<td>(0.000)</td>
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<td></td>
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<tr>
<td>Year Control</td>
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<td>Regional Fixed Effects</td>
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<td>yes</td>
</tr>
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<td>Number of Countries</td>
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<td>142</td>
<td>112</td>
<td>124</td>
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<tr>
<td>$R^2$</td>
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<td>0.903</td>
<td>0.917</td>
<td>0.861</td>
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</table>

**p<0.01, * p<0.05

All independent variables are lagged one year. Standard errors are listed in parentheses.
### Annex C: Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description/Transformation</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right to Health</td>
<td>Text of constitutions in answer to the question, “Does the constitution mention the right to health care?” Transformed to 0/1 and all “other” or “unable to determine” cases identified in original dataset were examined and recoded by the author.</td>
<td>The Comparative Constitutions Project: A Cross-National Historical Dataset of Written Constitutions. 2011. Available from: <a href="http://www.comparativeconstitutionsproject.org">http://www.comparativeconstitutionsproject.org</a> Country/year data received, personal correspondence, Tom Ginsburg, 25 March 2013.</td>
</tr>
<tr>
<td>Under-5 mortality</td>
<td>The probability of death between birth and age 5 years, expressed per 1,000 live births, using logged data for estimation.</td>
<td>Institute for Health Metrics and Evaluation Estimates published in (Rajaratnam et al. 2010)</td>
</tr>
<tr>
<td>GDP per capita (log)</td>
<td>Published GDP estimates in dollar conversions, using logged data for estimation.</td>
<td>Institute for Health Metrics and Evaluation Estimates published in (James et al. 2012)</td>
</tr>
<tr>
<td>Women’s Education</td>
<td>A-standardized mean years of education for men and women aged 25 years or older</td>
<td>Institute for Health Metrics and Evaluation Estimates published in (Gakidou et al. 2010)</td>
</tr>
<tr>
<td>Inequality (gini)</td>
<td>The gini coefficient represents how far countries deviate from a perfectly equitable distribution of income among individuals or households, ranging from 0 (perfect equality) to 100 (perfect inequality).</td>
<td>World Income Inequality Database, <a href="http://website1.wider.unu.edu/wiid/wiid-documentation1.php">http://website1.wider.unu.edu/wiid/wiid-documentation1.php</a></td>
</tr>
<tr>
<td>Ethno-Linguistic Fractionalizati on</td>
<td><em>Probability that two randomly selected individuals in a country belong</em> to different ethnolinguistic groups, based on the 1985 measure as recalculated 2005.</td>
<td>Montalvo and Reynal-Querol 2005 supplemented by Alesina et al. 2003</td>
</tr>
<tr>
<td>Urbanization</td>
<td>People living in urban areas as defined by national statistical offices. It is calculated using World Bank. World Development Indicators, 2013</td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>Description</td>
<td>Source</td>
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<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Conflict</td>
<td>Magnitude score of episode(s) of civil and ethnic violence and warfare in a state</td>
<td>Center for Systemic Peace, Major Episodes of Political Violence, 1946-2013, Total (Marshall 2014)</td>
</tr>
<tr>
<td>Legal Tradition</td>
<td>Categorization based on seven options: Muslim, Common, Civil, Customary, Mixed Common, Mixed Civil, or Mixed Common/Civil. Collapsed mixed categories into the civil or common category.</td>
<td>University of Ottawa</td>
</tr>
<tr>
<td>Government Expenditure</td>
<td>General government expenditure on health as % of GDP</td>
<td>World Health Organization. Global Health Expenditure Database.</td>
</tr>
<tr>
<td>Out of Pocket Expenses</td>
<td>Out of pocket expenditure as % of total health expenses</td>
<td>World Health Organization. Global Health Expenditure Database.</td>
</tr>
<tr>
<td>Skilled Birth Attendance</td>
<td>Births attended by skilled health personnel (%)</td>
<td>World Bank. World Development Indicators, 2013.</td>
</tr>
<tr>
<td>Immunization</td>
<td>Diphtheria-tetanus-pertussis (DTP3) immunization coverage among 1-year-olds (%)</td>
<td>World Health Organization, Global Health Observatory</td>
</tr>
<tr>
<td>Availability of Medicines-Pub Sector</td>
<td>Median availability of selected generic medicines (%) in the public sector.</td>
<td>World Health Organization, Global Health Observatory</td>
</tr>
</tbody>
</table>
The drafting of a new, democratic Constitution in Malawi in 1994 was reason for celebration. For thirty years prior, Malawi had been under one-party rule by Hastings Banda and the new Constitution reflected a progressive shift toward protection of human rights and the rule of law. The new Constitution includes in Section 30 a right to development that states:

“All persons and peoples have a right to development and therefore to the enjoyment of economic, social, cultural and political development … [which] include, amongst other things…health services…. The State shall take measures to introduce reforms aimed at eradicating social injustices and inequalities. The State has a responsibility to respect the right to development and to justify its policies in accordance with this responsibility.”

There is some debate amongst legal scholars about how to interpret this provision. Chirwa notes that the Constitution, on its face, is not particularly coherent and bifurcates entrenched rights that are judiciable from Directive Principles of State Policy which are not, with health rights in both sections.¹ Others, however, have argued that even a marginally creative legal team could easily make the case that the combination of the directive principle and right to development grant Malawians a judiciable right to health.²

Yet there have been no substantive rulings supporting a right to health to date from Malawian courts and the right to health plays very little role in the politics of health in the country. Why?

There is a clearly a need—Malawians have one of the lowest life expectancies in the world at just 64 years, with high rates of HIV, child mortality, and maternal mortality driven by causes that are clearly amenable to medical intervention.³ Of particular note is the situation of access to

¹ Chirwa 2005.
medicines in the country. Malawi has seen a documented drug shortage crisis that is going on five years now. It started in 2013 when it was revealed that some public sector facilities had just 5% of the essential medicines they needed. Health service delivery at public hospitals and clinics came to a near standstill and there were widespread reports of deaths in hospitals due to lack of basic medicines.4 Doctors at Kamuzu Central Hospital in Lilongwe sent the President at the time Joyce Banda a letter calling their workplace a “waiting rooms for death.”5 Years later, however, the situation remains a problem that is not simply attributable to insufficient funds as donors have stepped in to ensure money is available. Instead widespread corruption and mismanagement have been revealed but little action has been taken under two different presidents.6 So why no rights mobilization?

It is tempting to simply assume that Malawi, the second poorest country in the world, lacks an independent judiciary capable of tackling the issue, but this is not the case. The Malawian judiciary, which had been marginal and lacking independence under Banda’s authoritarian rule, quickly gained a reputation as a surprisingly strong institution—asserting independence and weighing in on contentious political issues. One indicator of the judiciary’s independence can be seen in one study that showed Malawi’s high court ruled against the government more than half the time and was no less likely to do so even if the President was involved in the case.7 The courts have weighed in strongly and effectively on civil and political rights—overruling executive rules designed to stop demonstrations, ordered the Electoral Commission (MEC) to register prisoners as voters, and played an important role in preventing the amendment of the constitution to allow the sitting president to stand for a third term.8 They have also shown willingness to wade into question of fraud and the intervene directly in the executive’s function—most recently effectively suspending of the Minister of Agriculture over the objection of the president in the so-called Maize-gate scandal. As one commentator notes with relatively surprise, “Malawi’s judges appear relatively fearless.”9

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4 Malawi drug shortage still high: Now at 80 percent 2013.
5 Stop mass murder of poor people 2013.
6 Drug shortage now at 65% 2015; Goodall silent on drug shortages 2016.
7 Vondoepp 2006.
8 Gloppen and Kanyongolo 2012; VonDoepp 2013.
9 Vondoepp 2006.
Another explanation is that the judiciary simply does not see the right to health as judiciable. Interviews conducted with judges on the Supreme Court of Appeals and the High Court suggest otherwise, however. I conducted semi-structured interviews with eight justices and each voiced their sense that there was a judicially enforceable right to health in the Malawian Constitution.

“Yes, that’s in the Constitution. I think if government was seen to be really violating the right of the people in terms of this provision, it’s a matter that could be taken up, and which the court should be able to enforce. Say assuming they had the ability to give higher quality health service, but they were prioritizing things other than that. One was able to demonstrate to the court that the only shortfall in terms of the provision of quality healthcare, is because government is concentrating on wrong things, and not on this area, is a thing which I think, as courts, we should be able to come in to help the citizens to enforce.” –Justice, Supreme Court of Appeals (Interview MW-13)

Yet while a few cases have touched on the right to health but have not explicitly ruled on a positive right to health. The court, in the 2007 Masango case explicitly rejected the argument that socio-economic rights were not judiciable in a case dealing with denial of healthcare, among other rights, for a prisoner.\textsuperscript{10} The grounding, however, for the litigation was not in a positive social right and Section 30 but instead based on violations of dignity of prisoners. In another prisoner related case, Chimwemwe Mphembedzu v. The Republic, the court directly identified the constitutional provisions protecting health rights and placing a duty on the state to ensure health when deciding whether to release a sick person on bail.\textsuperscript{11} But the courts have not ruled firmly on an affirmative right to health not because they are unwilling but because they have not been asked to do so by any plaintiff.

There is also a growing civil society willing to take up both health and rights cases. Groups like the Malawi Health Equity Network have challenged government’s decision to require payment for some health services and the Center for the Development of People (CEDEP) have challenged the government’s criminalization of men who have sex with men on health grounds. Some of these groups have even gone to court—but only on political rights grounds, as when they fought to ensure the right to demonstrate against corruption on the National AIDS Commission. In their health

\textsuperscript{10} Gable Masango and Others v Attorney-General and Another 2007.
\textsuperscript{11} Chimwemwe Mphembedzu v The Republic 2011.
work, these groups rarely make rights claims and they have never approached the court to address their health policy claims.

The missing link is what Epp labels the “support structure”—the lawyers, legal aid groups, and funding sources—to support litigation.\(^\text{12}\) There had previously been a donor-funded effort to support lawyers to work with NGOs on rights claims through the Civil Liberties Committee. At its height around 2000 that attracted roughly 40 lawyers to work on rights cases. All of these cases were civil and political rights as driven by the mission of the CLC and the donor interest. Today, however, even that initiative has gone due to “donor fatigue” and an estimate by the head of the Malawi Law Society is that there are no more than 10 lawyers in the country engaged in rights litigation of any type—and all do so part time (Interview MW-11). None of the major health groups have attorneys on staff or on their main boards.

This limited engagement by the legal complex together with the relatively formal locus standi rules and lack of a mechanism for public interest litigation that lowers the barriers to entry is what is driving the lack of judicial action. In the absence of that support structure, the constitutional structure means nothing for health or health policy in Malawi. It is worth noting, however, that support structure is something that can be built and funded.

Annex D.2

THAILAND: Non-Judicial Constitutionalization of Health

Thailand has had twenty constitutions, interim constitutions and charters since the end of absolute monarchy in 1932. This high number reflects the political instability of the country, with most of the constitutions being replaced due to a coup or upon return to democratic rule. The 1997 “people’s constitution” was the first to be drafted through an inclusive process led by an elected drafting assembly. The new constitution introduced a host of reforms that led directly to a variety of health reforms that have been widely lauded in the country.

The new constitution mattered most directly because it introduced a new electoral system that dramatically changed the landscape of parties in the country. The new 1997 electoral framework included a mix of proportional representation and single member districts, which Selway credits for shifting the way parties formulated and targeted their health policies. Opening the door for the birth of the Thai Rak Thai (TRT) Party led by billionaire Thaksin Shinawatra, these new electoral rules also incentivized Thaksin’s party to support a sweeping new Universal Health Care (UHC) program known as the “30-baht scheme” for the low price charged for each visit. This system bucked the advice of international financial institutions and has since been widely praised as a bold and effective expansion of access for the poor. Even as the era of open democracy and populist politics in Thailand has waned the 30-baht scheme (now free) has remained.

Less explored is the other change to the constitution—the introduction of a right to health. The 1997 constitution included an explicit right to health:

Article 52: A person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from public health centers of the State, as provided by law. The public health service by the State shall be provided thoroughly and efficiently and, for this purpose, participation by local government organizations and the private sector shall also be promoted insofar as it is possible. The State shall prevent and eradicate harmful contagious diseases for the public without charge, as provided by law.

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13 Selway 2015.
15 Thaiprayoon and Wibulpolprasert 2017.
Since 1997 there have been a series of new constitutions—two interim constitutions and the full constitutions of 2007 and 2017. Each of these has retained similar language, keeping the right to health in place even as the electoral rules that gave rise to the universal health system have long since passed and both the Thai Rak Thai party and its successors are no more.

On the one hand, one struggles to identify the impact of the Thai constitution. As one interviewee noted:

“Constitutions come and go. What does the King want? What will the military allow? These are the key questions. Only then do we get to the constitution.” (Interview TH-16)

It is certainly true that the right to health has not had the kind of impact on macro politics in Thailand as it has in India or South Africa.

Even more notable is that the courts in Thailand have no role in socioeconomic rights to speak of. On the one hand the judiciary seems quite powerful—it has twice dissolved the ruling party and has been highly active in politics. They represent, however, a classic example of a conservative power focused on hegemonic preservation in the clearest sense—leading scholars to refer to the apex Thai courts as practicing ‘rule by law’.\(^\text{16}\)

However, as Harris has documented the actual story of the expansion of health policy in Thailand has as much to do with bureaucratic entrepreneurialism and the initiative of a set of progressive doctors inside government as it did with the TRT party per se.\(^\text{17}\) Leaders from the Rural Doctors Society and the subsequently formed Sampran Forum have become critical players in the health politics of Thailand by securing key positions of technocratic leadership in the country and using those to launch progressive health policies on several levels. They helped set in place the dynamics that led to the UHC system—having sought for years the political leadership needed to make it happen without success until the appearance of Thaksin who adopted their platform based on a political instinct and personal connections (Interview TH-24, TH-28 & Harris 2015). It was

\(^{16}\) Dressel 2010.
\(^{17}\) Harris 2015.
these doctors and their associates who helped craft and push for the inclusion of the right to health in the 1997 constitution and they have played a central role in defending it since then.

While far less visible, these doctors and other policy entrepreneurs inside and outside government have strategically used the constitution to help drive critical parts of the UHC system. It was not a mistake that article 52 of the constitution includes the language “as provided by law.” Having pushed for the right to health provision, public health leaders proceeded to draft a bill to enact the law it called for, which took shape well before Thaksin came to power. While TRT was building its platform and before the new elections that would bring the party to power was called, health activists and physicians together started drafting a bill. With explicit reference to the constitution, the bill fleshed out what a system would look like based in principles of universalism that directly challenged the advice of the World Bank and others at the time. Then, with funding from the ministry of public health itself, secured by leaders from the Rural doctors, civil society groups began a petition drive to support a new National Health Security Bill which eventually garnered over 60,000 signatures. They then used a provision from Section 170 of the 1997 constitution that required any bill introduced with 50,000 or more signatures to move to a vote automatically. By this point Thaksin had been elected and the external bill was joined by a series of other bills on the issue submitted by cabinet and from other parties and, in the end, what was passed reflected a mix of the proposals with strong influence from the original externally drafted bill.

One of the key elements it created was the National Health Security Office—a separate body charged with financing the UHC system. Inside this new institution was created a set of rights-based processes aimed at identifying what should be covered under the UHC system and providing accountably for services. The first unique feature—built into the institutional design and justified explicitly on the grounds that health was now a constitutional right—is an adjudication system in which individual Thais and NGOs can petition for coverage of different drugs, laboratory tests, and medical interventions that may not be already covered. Originally, for example, antiretroviral drugs to treat HIV were not covered under the NHSO scheme. After a complex process of review sparked by a formal petition, today they are covered—which in part later spared an important push to lower

Siriwan Pitayarangsarit 2010.
the price of these drugs as well as expand spending on not just HIV but a small handful of deadly but neglected diseases. This system is not adversarial but it is adjudicative—mobilizing the key mechanisms of a court—and allows petitioners to challenge the decisions of the NHSO directly. A second similar system has also been set up to allow petitions for redress when the right to health has not been met by the health system for individual Thais. As the 2008 NHSO annual report notes, “following the declaration in the Thai constitution several measures to guarantee the right to health for all Thais have been developed.” These include an investigative team and sub-committee to adjudicate claims where core health services are not provided for free, substandard services are provided, or access to care is not meaningfully available because of distance, accessibility issues, or discrimination. These adjudication mechanisms have been used by drug users to get access to treatment and harm reduction services, by rural women to push for maternal health services closer to where they live, and by advocates for the urban poor to call attention to corrupt providers who charged extra fees to customers. Even as space for electoral politics has closed and the courts have become less and less reliable, especially for poor Thais, these processes have continued—shifting how health services are governed in the country.
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