B and Others v Minister of Correctional Services and Others

High Court, Cape of Good Hope Provincial Division

1997 (6) BCLR 789 (C)

17/04/1997

Brand J

[1]The four applicants are inmates of the Pollsmoor Prison on the outskirts of Cape Town. First and second respondents are, respectively, the Minister and the Commissioner of Correctional Services. [*10] Third respondent is the Commander of Pollsmoor Prison and fourth respondent is the Minister of Health and Welfare of the Province of the Western Cape.

[2]Applicants all suffer from Human Immuno Deficiency Viral infection or, as it has become commonly known, they have been diagnosed as HIV positive. According to their amended notice of motion, they, inter alia, seek declaratory orders in the following terms:

"2.Declaring that the applicants and any other HIV positive prisoners while in the custody and control of the respondents have a right to proper and adequate medical attention, care and treatment on the grounds of their HIV status.

3.Declaring that the applicants and any other HIV positive prisoners have the right to consult with and be examined by appropriately qualified HIV specialists at HIV clinics in the Cape Peninsula.

4.Declaring that the right to adequate medical treatment of the applicants and the HIV prisoners infected with HIV, who have reached the symptomatic stage of the disease and whose CD4 counts are less than 500/ml, entitles them to have prescribed and to receive at State expense, appropriate anti-viral medication, including but not limited to AZT, ddI, [*11] 3TC or ddC individually or in combination."

[3]In the alternative to the declaratory order sought in terms of paragraph 4, applicants seek a mandamus to the effect that, in the event of this declarator not being granted, first, second and third respondents be ordered to release the applicants - and any other HIV positive prisoners for whom the said anti-viral medication would be appropriate - from prison.

[4]The application is opposed by first, second and third respondents. Fourth respondent abides the decision of this Court. For the sake of convenience, I will hereinafter refer to first, second and third respondents as "respondents".

[5]The matter squarely raises some of the problems related to HIV and AIDS in prisons which have attracted international research and debate n1 .

> n1 See eg: "The Dilemmas of the HIV Positive Prisoner", Howard Law Journal, (1992), Vol 31, No 2, 89; "Tort Law's Role in Preventing Prisoners' Exposure to HIV Infection while in Her Majesty's Custody", Melbourne University Law Review, (1995), Vol 20, No 2, 423; "HIV/AIDS in Prisons" - Statement by the Joint Nations Programme on HIV/AIDS (UNAIDS) - April 1996; "HIV/AIDS in Prisons" - Final Report by the Canadian AIDS Society - September 1996.

[*12]
[6]To at least one of the questions raised in this matter, the Constitution of the Republic of South Africa ("the Constitution") n2 provides a clear and final answer, more particularly in section 35(2) thereof which provides that:

n2 Act 108 of 1996.

"(2)Everyone who is detained, including any sentenced prisoner, has the right-

(e)to conditions of detention that are consistent with human dignity, including at least exercise and the provision at state expense of adequate accommodation, nutrition, reading material and medical treatment." (My emphasis) n3

n3 The application was brought before the Constitution came into operation. Section 17 of Schedule 6 - "Transitional Arrangements" - to the Constitution provides that: "All proceedings which were pending before a Court when the Constitution took effect, must be disposed of as if the new Constitution had not been enacted, unless the interest of justice require otherwise". It can, therefore, be argued that it is not the Constitution, but the Interim Constitution, Act No 200 of 1993, which should find application. Section 25(1)(b) of the Interim Constitution does, however contain a provision which - for present purposes - is exactly similar to the relevant provision of section 35(2)(e) of the Constitution. Counsel on both sides were, therefore, in agreement that I should apply the provisions of the Constitution.

[*13]
[7]In view of these provisions, it could never be argued that applicants are not entitled to the relief they seek in terms of paragraph 2 of the notice of motion. It is, therefore, not surprising that the existence of applicants' right to adequate medical treatment is not in dispute, nor has it ever been disputed by respondents at any relevant stage. Moreover, it appears to be common cause that neither applicants nor any other HIV positive prisoner have ever been denied the opportunity to consult with or to be examined by HIV specialists at HIV clinics situated in public hospitals in the Cape Peninsula. It follows, in my view, that there was no need for the declaratory orders sought in paragraphs 2 and 3 of the notice of motion.

[8]The only real dispute between the parties, therefore, revolves around the issues that arise from the declarator sought in paragraph 4 of the notice of motion, namely, whether applicants and other HIV infected prisoners - who have reached the symptomatic stage of the disease and whose CD4 counts are less than 500ml - are entitled to receive the anti-viral treatment mentioned in that paragraph, at State expense.

Factual Background

[9]The exact ambit [*14] of the issues and the background against which they fall to be determined appear from what follows.

[10]HIV infection is a viral disease that leads inexorably to immune depletion and dysfunction, though at a variable rate. The stages of progression of the disease are measured from 1 to 4 by the Centre for Disease Control ("the CDC stages"). The CDC stages are linked to the CD4 count of the patient, as well as to certain recognised clinical symptoms. CD4 is a type of lymphocyte or white blood cell which oversees or controls the CD8 cells in fighting infection. The lower the CD4 count, the less the system can detect and deal with infections. A person without HIV should have a CD4 count of between 600 and 1200 per millilitre of blood.

[11]A patient at CDC stage 1 will generally be asymptomatic and his CD4 count will be above 600. At CDC stages 2 and 3 the patient becomes symptomatic and his *CD 4* count is likely to be between 600 and 200. At CDC stage 4 the patient has developed full blown AIDS and his/her CD4 count would be below 200.

[12]There is no cure for HIV. The HIV infected patient ultimately dies of complications arising from opportunistic diseases. [*15] The treatment of HIV patients is a rapidly evolving medical field. At this stage it appears to be common cause between the medical experts, however, that the most effective treatment for HIV is combination therapy of AZT with 3TC or with cheaper alternatives, being ddI and ddC. This combination therapy retards the progress of HIV infec-

tion and the patient's susceptibility to other infections to which a patient with progressive HIV infection would normally be prone. It accordingly enhances the patient's quality of life and extends the patient's life expectancy.

[13]There is a difference in expert medical opinion as to when to initiate combination therapy. It appears to be fairly generally accepted, however, both internationally and in South Africa, that anti-viral therapy is indicated when the CD4 count is below 500 and the patient is symptomatic. This broad general statement is borne out, inter alia, by the Guidelines of the Medical Association of South Africa on the Management of HIV patients. Dr Robin Wood, who deposed to an affidavit which was filed on behalf of respondents, has a problem with the broad general statement. Upon analysis of his affidavit, however, he appears to [*16] say no more than that there are patients who fall within the stated category for whom he would - for various reasons - not prescribe anti-viral therapy on medical grounds. Otherwise stated, in Dr Wood's view there are patients who are exceptions to the general rule.

[14]First applicant is the only applicant who provides details of his medical condition. It appears that he was diagnosed HIV positive in February 1992. During 1992 and while he was incarcerated in the Pretoria Central Prison, he brought an application in the Transvaal Provincial Division that the prison authorities be directed to supply him with certain medication, including the anti-viral drug AZT. At that time first applicant's CD4 count was 376/ml and AZT was prescribed for him by a medical specialist, Dr Miller, who classified his HIV infection as CDC stage 3.

[15]On 23 December 1992 first applicant and the respondents in that matter - being the Minister of Correctional Services and the Commanding Officer of Pretoria Central Prison - reached an agreement in terms whereof he was to be supplied with the prescribed medication. The application was postponed until 26 January 1993 for argument on the issue at whose [*17] expense the AZT should be supplied. On 17 January 1993, prior to the postponed hearing of the matter, first applicant was, however, released on parole and the outstanding issue relating to the costs of the AZT was thus not argued. Between 23 December 1992 and 17 January 1993, first applicant was supplied with AZT. While on parole, AZT was prescribed for and supplied to him at his own expense by the HIV clinic of the Johannesburg General Hospital. At that time, first applicant states, he was employed and thus able to afford the cost of the medication.

[16]In May 1993, first applicant was arrested on a charge of motor vehicle theft. Bail was refused and he remained in custody until he was convicted on this charge and sentenced to effectively six years imprisonment. From the time of his detention, first applicant did not receive any anti-viral medication. On 21 April 1994 he again launched an application in the Transvaal Provincial Division. The matter was set down for hearing on 24 May 1994.

[17]On 4 May 1994 AZT was, however, again prescribed for first applicant by the prison doctor and provided for him at State expense from that date until 16 December 1994 and his application was, [*18] therefore, again not argued. In early 1995 he escaped from prison. In August 1995 he was arrested in Cape Town on a charge of fraud. Since then he has been detained in Pollsmoor Prison. Prior to his incarceration in Pollsmoor Prison and while first applicant was at large, he did not receive anti-viral therapy. He avers that this was due to lack of funds.

[18]In Pollsmoor Prison he did not receive any specific treatment for his HIV positive condition either. In September 1995 his attorney arranged for him to see a general practitioner in private practice, Dr Van der Westhuizen. At that stage, first applicant's CD4 count was 298/ml. Dr Van der Westhuizen diagnosed him as still being CDC stage 3 and recommended that he receive anti-viral therapy in the form of AZT in combination with ddC or 3TC. Despite this recommendation, first applicant still did not receive anti-viral therapy.

[19]During 1996 arrangements were made for HIV positive prisoners to be treated at the HIV clinic of the Woodstock Hospital. At this clinic, first applicant consulted with an HIV specialist, Dr Ashraf Grimwood, who prescribed a combination of AZT and ddI for him. These anti-viral drugs were, however, not [*19] provided by the prison authorities.

[20]In August 1996 first applicant was referred to the HIV clinic at the Somerset Hospital where he was examined by Dr Robin Wood. Dr Wood is a specialist physician and acting head of the Department of Medicine at Somerset Hospital. He is also the head of the HIV clinic at that hospital.

According to Dr Wood, the relevant laboratory results showed that first applicant's CD count was 321/ml. In his report, Dr Wood also states that "definitive clinical staging has been made difficult by the lack of co-operation of this patient. This is exemplified by his refusal to be examined at our surgical outpatient clinic, his unwillingness to have an ultra-

sound abdominal examination, his refusal to be examined at review in the HIV clinic and his stealing the hospital notes from his medical folder". As to the prescription of AZT, Dr Wood stated that "the use of this drug is limited in state hospitals. Our policy is to prescribe this drug for HIV encephalopathy, symptomatic thrombocytopaenia and HIV related wasting syndrome. Mr B (ie first applicant) does not, therefore, qualify for prescription of this drug in our institution".

[21]On 12 September 1996, [*20] first applicant launched the present application in which the remaining three applicants subsequently joined.

[22]The remaining three applicants do not give any details of their medical history. Second applicant merely states that he was sentenced to ten years imprisonment in 1994; that he is HIV positive; that his CD4 count is 148/ml; that he is seriously ill and his condition is deteriorating; that he has had a combination of AZT and ddI prescribed for him which he had to buy at his own expense, but that he has no more money and, therefore, cannot afford further medication. All that is known about third applicant is that he is HIV positive; that he is serving an indeterminate sentence and that his CD4 count has declined from 393/ml in November 1995 to 289/ml in August 1996. The only available information about fourth applicant is that he is serving a twelve year prison sentence; that he is HIV positive and that his CD4 count had declined from 417/ml in February 1996 to 347/ml in October 1996.

[23]From the answering affidavits filed on behalf of respondents, it is apparent that the increasing number of HIV infected prisoners has led to investigations and reports by several working [*21] groups. On the basis of these reports, the Department of Correctional Services has formulated management strategy documents for the handling of prisoners who are HIV positive. From these management strategy documents which are annexed to respondents' papers, it appears, however, that they are predominantly concerned with the prevention of prison officials and other prisoners contracting AIDS, rather than with the medical treatment of HIV prisoners.

[24]What eventually transpires from respondents' papers is that the Department of Correctional Services itself has no firm guidelines relating to anti-viral treatment of HIV prisoners. The principle adhered to by the Department is that prisoners should have access to health services and treatment equal to that provided to persons attending health facilities of provincial hospitals. What can be provided for HIV positive prisoners at State expense is, therefore, determined by the policy of provincial hospitals in this regard.

[25]From the affidavit of Dr Wood, it appears that the policy of provincial hospitals regarding the prescription of anti-viral drugs at State expense is, firstly, that only AZT monotherapy is provided; secondly, [*22] that the only HIV patients who can be considered for AZT treatment are essentially those with a CD4 count of less than 200 and whose condition - as I understand the policy - has developed to full-blown AIDS; and thirdly, that in order to qualify for AZT treatment at State expense, the patient must still have a CD4 count of more than 50/ml.

[26]It is pertinently stated by Dr Wood that this policy in provincial hospital is dictated by budgetary constraints. In this regard, Dr Wood paints a grim picture of the financial situation in the HIV clinic at the Somerset Hospital for which he is responsible. At present, he states, more than 700 HIV patients are being treated by the clinic. In his experience the cost of AZT monotherapy amounts to R14 000 per annum per patient. If AZT monotherapy were to be prescribed to all existing eligible patients, he states, the total drug budget of the Somerset Hospital would be grossly insufficient. The cost of combination therapy for all these patients - which apparently amounts to between R18 000 and R24 000 per patient per annum - would utilise between 25% and 60% of the total hospital budget.

[27]In the final instance, Dr Wood says, the difficult [*23] decision - with moral implications - whether to administer expensive medication at State expense, is dictated by a cost benefit analysis. Because of the limited resources available, the treatment has to be administered where the best results will be obtained. In the case of HIV patients, the best results can, for example, be obtained by treating pregnant women to prevent their babies from being infected with the HIV virus. According to Dr Wood, there are, however, no funds available at present to treat pregnant mothers with even short courses of AZT in the Province of the Western Cape.

[28]The fact that most HIV positive State patients do not receive anti-viral therapy, Dr Wood explains, does not mean that they receive no treatment at all in provincial hospitals. The HIV patient, he says, ultimately dies of complications arising from opportunistic diseases to which his/her body becomes susceptible. It, therefore, follows that if the physician

manages to prevent or cure the complications, he is treating the HIV positive patient by improving his/her survival and the quality of his/her health.

[29]Applicants' experts - including Dr Grimwood and Prof Bouic of the Tygerberg Hospital [*24] - do not dispute that provincial hospitals are subject to severe budgetary constraints. They also concede that the treatment of opportunistic infections from which HIV positive patients suffer does improve the quality of their health as well as their rate of survival. Their argument is, however, that according to the internationally accepted view, treatment of opportunistic infections only, is both short-sighted and inadequate. According to these experts, the nature of the HIV virus is such that once the HIV patient starts suffering from opportunistic infections, it is a sign that his/her immune system is depleted. Therefore, even if such opportunistic infection is treated and possibly cured, it will have weakened the immune system of such patient which in turn makes him/her more susceptible to yet another opportunistic infection.

[30]The further argument advanced by applicants' experts, is that provincial hospital policy is based on false economy. According to these experts, international studies have shown that the administration of anti-viral therapy at an early stage is cost-effective in that the high costs of treating opportunistic infections is significantly reduced. Dr Wood, [*25] on the other hand, disputes that there is acceptable scientific data available which bears out the statement that it would be more cost-effective to treat HIV positive patients by way of anti-viral therapy in preference to treating their opportunistic infections. In his view, the results of the international studies referred to by applicants' experts, are speculative and must be seen against the background that anti-viral therapy does not afford a cure for the HIV disease and that the cost of treating the symptoms will have to be incurred in any event.

Discussion

[31]As stated at the outset, the issue between the parties is whether applicants and other HIV prisoners, who have reached the symptomatic stage of the disease and whose CD4 counts are less than 500/ml, are entitled to have prescribed to them and to receive at State expense, the anti-viral therapy described in paragraph 4 of the notice of motion. As appears from the aforegoing, the determination of this issue requires an answer to two separate questions. The first question is whether applicants and other HIV prisoners who fall within the stated category are entitled to have such anti-viral therapy prescribed for them [*26] on medical grounds. The second question is whether applicants and other prisoners who are entitled to have anti-viral therapy prescribed for them on medical grounds are entitled to receive such therapy at State expense.

[32]Before I deal with the opposing contentions by Mr Seligson, who appeared with Ms McCurdie for applicants, and Mr Scholtz, who appeared with Mr Jamie for respondents, I find it necessary to state my basic approach to the matter. The reason for this is that I have been invited by both Mr Seligson and Mr Scholtz to make general decisions on matters of principle, which decisions may very well have far reaching consequences not only for prisoners and prison authorities, but also for the administration of health services in general. I believe that I must decline this invitation as far as possible. I am mindful of the caution which appears from the following dictum by Lord Simon of Glaisdale in Miliangos v George Frank (Textiles) Ltd n4 :

> n4(1976) AC 443 at 481-482. Referred to by MM Corbett in an article, "Aspects of the Role of Policy in the Evolution of Our Common Law", South African Law Journal, Vol 104, Part 1 (February 1987), 57.

[*27]

". . . the training and qualification of a judge is to elucidate the problem immediately before him, so that its features stand out in stereoscopic clarity. But the beam of light which so illuminates the immediate scene seems to throw surrounding areas into greater obscurity: the whole landscape is distorted to the view. A penumbra can be apprehended, but not much beyond; so that when the searchlight shifts a quite unexpected scene may be disclosed. The very qualifications for the judicial process thus impose limitations on its use.

This is why judicial advance should be gradual. 'I am not trained to see The distant scene: one step is enough for me' should be the motto on the wall opposite the judge's desk. It is, I concede, a less spectacular method of progression than somersaults and cartwheels; but it is the one best suited to the capacity and resources of a judge. We are likely to per-

form better the duties society imposes on us if we recognise our limitations. Within the proper limits there is more than enough to be done which is of value to society."

[33]The question whether applicants and other HIV patients who fall within the stated category are entitled to a prescription [*28] of a particular combination of anti-viral drugs on medical grounds, is a medical question. The answer to this question by applicants' medical experts is that the anti-viral medication contended for by applicants should be prescribed for all prisoners who have reached the symptomatic stage of the HIV virus and whose CD4 counts are less than 500/ml. This view appears to find general support internationally. Dr Wood's answer to the question is, however, somewhat different. In his opinion, there are patients who fall into the stated category for whom the said anti-viral drugs should not be prescribed. As was decided by the American Supreme Court n5 , "the Court is not empowered to delve into the intricacies of modern medicine". Mr Seligson's answer to Dr Wood, namely that he stands alone against an overwhelming majority, involves a head count which I am not prepared to undertake.

n5 See Howley v Evans 716F Supp, 601 at 603.

[34]Moreover, a declarator in the terms sought by applicants would, in my view, dictate to medical [*29] doctors when they must prescribe anti-viral treatment. Mr Seligson submitted that the order sought by applicants would leave the medical practitioner with a discretion as to what anti-viral medication he/she deems appropriate. That may be so. The fact remains, however, that it would compel the doctor to prescribe some form of anti-viral medication. For reasons that are, in my view, obvious, it is not the function of this Court to make an order of that nature.

[35]That, however, is not the end of the matter. Second applicant states - and it is not denied on behalf of respondents - that a combination of AZT and ddI was prescribed for him on medical grounds. As far as he is concerned, the second of the above-stated questions, namely, whether he is entitled to be provided with these drugs at State expense, is pertinent.

[36]The same question also arises, in my view, with regard to first applicant. As appears from the aforegoing, anti-viral drugs had been prescribed for him by various medical practitioners, including a prison doctor. According to the latest of these prescriptions by Dr Grimwood, he is to be provided with a combination of AZT and ddI. It is true that Dr Wood refused [*30] to repeat this prescription. It appears, however, that his two reasons for doing so are, firstly, that due to lack of co-operation he was unable to properly examine first applicant, and secondly, that in terms of the hospital policy at Somerset Hospital where Dr Wood is employed, first applicant is not entitled to anti-viral treatment. If I understand Dr Wood correctly, neither of these reasons amounts to a denial of the statement by the various other medical practitioners by whom first applicant was examined, that he is eligible for the prescription of anti-viral therapy on medical grounds.

[37]As to third and fourth applicants, it appears that no medical practitioner has thus far prescribed anti-viral treatment for them. An order to the effect that they are entitled to be provided with the drugs that they claim would, therefore, in my view, again amount to an instruction to a medical doctor as to what he should prescribe. As I have already indicated, I do not believe that this Court is empowered to grant such an order.

[38]This brings me to the question whether first and second applicants are entitled to be provided - at State expense - with the anti-viral therapy which has [*31] been prescribed for them on medical grounds. For the sake of convenience, I will henceforth refer to first and second applicants as "applicants".

[39]With regard to this question, Mr Scholtz referred to two decisions by American Courts that failure by the prison authorities to provide HIV positive prisoners with AZT does not amount to an infringement of the prisoners' constitutional rights n6 . Having regard to the reasons for these judgments, it is, however, apparent that the conclusion arrived at in these two cases is of very limited assistance for at least two reasons. The first reason is that both cases involved the treatment of HIV prisoners in 1989. At that time it was found that the plaintiff-prisoners were asserting a right to an experimental and novel form of treatment. In the present case, the medical consensus is that the anti-viral therapy prescribed for applicants can no longer be regarded as experimental. On the contrary, it is internationally recognised as "state of the art" treatment for HIV patients in applicants' condition.

n6 *Hawley v Evans 716 F. Supp. 01 (ND Ga 1989); Wilson v Francesci 735 F. Supp. 395 (HO Fla 1990).*

[*32]
[40]The second reason why these two American cases are of limited assistance, is that they were dictated by the "deliberate indifference test" which was adopted by the United States Supreme Court in Estelle v Gamble n7 in giving effect to the Eighth Amendment prohibition against cruel and unusual punishment. According to this test, a failure by prison authorities to provide medical treatment will only amount to cruel and unusual punishment - as envisaged by the Eighth Amendment - if the prison authorities are shown to have been deliberately indifferent to the prisoners' medical needs n8 . In short - unlike our Constitution - the American Constitution does not contain a provision in terms whereof a prisoner's right to adequate medical treatment is specifically entrenched. This obvious difference must also be borne in mind in considering other decisions of the American Courts, including those in which it was held that federal and state governments have a constitutional obligation to provide "minimally adequate" medical care or "reasonable medical assistance" to those whom they are punishing by incarceration n9 .

n750 L Ed 2d 251 (1976).

n8 This test was reaffirmed by the United States Supreme Court in *Wilson v Seiter (15 L Ed 2d 271).* See also the cases referred to in "The Evolving Standards in Prison Condition cases: An analysis of Wilson v Seiter and the Cruel and Unusual Punishment Clause", (1993), Vol 13, Boston College Law Journal, p 155.

n9 See eg *Harris v Thigpen 941 F. 2d 1495* (11th Circuit, 1991); Wellman v Faulkner 715*F. 2d 269 (7th Circuit, 1983) and Collins v Schoonfeld 344 F. Supp. 257 (DC Md 1972).*

[*33]
[41]Mr Seligson and Mr Scholtz were in agreement that the answer to the question under consideration turns on what would constitute "adequate medical treatment" as envisaged by section 35(2) of the Constitution. They were also in agreement that in giving a meaning to this expression in the Constitution, regard must be had, inter alia, to the principles of law relating to the rights of prisoners which governed our courts prior to the Constitution. This approach seems to be in accordance with that of the Constitutional Court n10 .

n10 See eg S v Zuma 1995 (2) SA 642 (CC) 652H.

[42]At common law it has been held repeatedly that prisoners retain all basic rights not temporarily taken away or necessarily inconsistent with being prisoners. As long ago as 1912 n11 , Innes J dealt as follows with a contention on behalf of the prison authorities that a prisoner may only claim such rights as the prison regulations confer: "[T]he directly opposite view is surely the correct one. They were entitled to all their personal rights [*34] and personal dignity not taken away by law, or necessarily inconsistent with the circumstances in which they had been placed". This principle was restated by Corbett JA in Goldberg and Others v The Minister of Prisons and Others n12 when he explained that, although there are infringements which incarceration necessarily makes on a prisoner's rights, "there is a substantial residuum of basic rights which cannot be denied" n13 .

n11 In *Whittaker v Roos and Bateman 1912 AD 92.*

n121979 (1) SA 14 (A) 39C-E.

n13 See also eg Mandela v The Minister of Prisons 1983 (1) SA 938 (A) and Minister of Justice v Hofmyer 1993 (3) SA 131 (A) 139I-140B.

[43]On the basis of these common law principles, Mr Scholtz submitted that convicted prisoners are entitled to the same standard of medical treatment as is provided for persons attending State institutions. As appears from the aforegoing,

this premise forms the whole substratum of respondents' case. Otherwise stated, the contention on behalf of respondents, [*35] which forms the basis of their case, is that the standard of what is "adequate medical treatment" for prisoners must be determined according to that which is provided for patients outside prison at State expense which, in the present case, means at Provincial Hospitals.

[44]As also appears from the aforegoing, it is stated by Dr Wood - and not denied by applicants - that patients in provincial hospitals who are in the same condition as applicants, are not provided with the anti-viral medication claimed by applicants at State expense.

[45]Proceeding on the basis that prisoners are not entitled to more than HIV patients outside prison, Mr Scholtz's further submission was that the Court will not embark on an investigation of the policy in provincial hospitals regarding the treatment of HIV positive patients. This policy, Mr Scholtz contended, is dictated by budgetary considerations which is a matter of polycentric nature and, therefore, non-justiciable by this Court. According to the authorities relied upon by Mr Scholtz in support of this contention n14 , the term "polycentric" denotes administrative decisions with multi-faceted side effects where each alternative choice gives rise [*36] to a different permutation of consequences. What is meant by polycentric decisions has also been described as follows with reference to the image of a spider's web n15 :

n14 See eg: Baxter, Administrative Law, 86 and 320 and Erasmus, Superior Court Practice, A2.2.

n15 By Professor Lon Fuller in an article in (1978) 92, Harvard Law Review, 353, referred to by Baxter, op cit., 86.

"A pull on one strand will distribute tensions after a complicated pattern throughout the web as a whole. Doubling the original pull will, in all likelihood, not simply double each of the resulting tensions. This would certainly occur, for example, if the double pull caused one or more of the weaker strands to snap. This is a 'polycentric' situation because it is 'many centred' - each crossing of the strands is a distinct centre for distributing tensions'."

[46]If HIV patients in provincial hospitals are to receive the combination therapy claimed by applicants, Mr Scholtz submitted, it would involve a prioritisation of resources in [*37] their favour. In view of the budget restrictions on hospital services, such prioritisation would necessarily be at the expense of other patients dependent upon the provision of health care by the State. Such patients may include persons suffering from acute heart disease, cancer sufferers, children, the elderly, pregnant women and so on.

[47]Mr Scholtz found further support for this line of argument in the decision of the English Court of Appeal in R v Cambridge Health Authority n16 , in which case the father of a young girl, who was suffering from non-Hodgkins lymphoma, sought a mandamus against the health authority directing it to fund a further bone marrow transplant after an earlier one had failed. Although the application for a mandamus was refused, the Court of first instance ordered the health authority to reconsider its refusal to fund the second transplant, inter alia, on the basis that the authority's explanation of limited resources and funding priorities had not been adequately explained. In dealing with this proposition, Sir Thomas Bingham MR expressed himself as follows:

n16*(1995) 2 All ER 129* (CA).

[*38]
"I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can

make. In my judgment, it is not something that a health authority such as this authority can be fairly criticised for not advancing before court."

[48]Mr Seligson's first contention on the other hand was that, since the right to adequate medical treatment [*39] is guaranteed to prisoners in terms of the Constitution, prison authorities can never be heard to say that they are unable to provide such treatment as a result of budgetary constraints or lack of funds. In support of this contention, he relied, inter alia, on the decision of the United States Court of Appeals n17 in Harris v Thigpen n18 where the Court was not prepared to accept that "financial considerations could ever be used by so-called 'poor states' to deny a prisoner the minimally adequate care to which he or she is entitled" n19 .

n17 Eleventh Circuit.

n18 Supra, note 9 supra at 1509.

n19 See also eg Gates v Collier 501F. 2d 1291 (Fifth Circuit, 1974); Newman v State of Alabama 559F. 2d 283 (Fifth Circuit 1977).

[49]In principle, I agree with Mr Seligson's submission that lack of funds cannot be an answer to a prisoner's constitutional claim to adequate medical treatment. Therefore once it is established that anything less than a particular form of medical treatment would not be adequate, the prisoner [*40] has a constitutional right to that form of medical treatment and it would be no defence for the prison authorities that they cannot afford to provide that form of medical treatment. I do not, however, agree with the proposition that financial conditions or budgetary constraints are irrelevant in the present context. What is "adequate medical treatment" cannot be determined in vacuo. In determining what is "adequate", regard must be had to, inter alia, what the State can afford. If the prison authorities should, therefore, make out a case that as a result of budgetary constraints, they cannot afford a particular form of medical treatment or that the provision of such medical treatment would place an unwarranted burden on the State n20 , the Court may very well decide that the less effective medical treatment which is affordable to the State must in the circumstances be accepted as "sufficient" or "adequate medical treatment". After all, as was pointed out by Mr Scholtz, section 35(2)(e) of the Constitution does not provide for "optimal medical treatment" or "the best available medical treatment", but only for "adequate medical treatment".

n20 Cf May, Thomas Cains and Frogmore v Reserve Bank of Zimbabwe 1986 (3) SA 107 (ZS) 119G-H where Dumbutshena CJ said the following about the meaning of expression "adequate compensation" in the Constitution of Zimbabwe: "It was the respondent's contention that an absolute value cannot be placed on what constitutes 'adequate' compensation. I agree. The compensation, to be 'adequate', must be sufficient to compensate the owner for the loss of his property, without imposing an unwarranted penalty on the public . . ."

[*41]
[50]This brings me to Mr Seligson's further contention, namely that respondents did not make out a proper case that the medical treatment claimed by applicants is unaffordable to the Department of Correctional Services. In support of this contention, Mr Seligson argued that it is the Department of Correctional Services and not provincial hospitals that is responsible for providing health services to prisoners. The question whether provincial hospitals can afford to provide all their eligible HIV positive patients with anti-viral treatment, Mr Seligson submitted, is, therefore, not relevant. Moreover, Mr Seligson argued, respondents' case is fundamentally flawed in that it is based on the incorrect premise that the State owes no higher duty to prisoners than to citizens in general and that the standard of "adequate medical treatment", as envisaged by section 35(2)(e) of the Constitution, is determined by what the State can provide for patients outside prisons.

[51]This premise is incorrect, Mr Seligson contended, because the State indeed owes a higher duty of care to HIV positive prisoners than to citizens in general who suffer from the same infection. It is clear, in my view, that [*42] this contention goes to the heart of respondents' case and I wish to state at the outset that, for the reasons that appear from what follows, I am in agreement with Mr Seligson's argument in support thereof.

[52]With reference to, inter alia, accommodation, nutrition and medical care, the Constitution itself draws a distinction between prisoners and people outside prison. In terms of section 35(2)(e), prisoners have a fundamental right to adequate accommodation, nutrition and medical care, whereas no such guarantee is given to people outside prison n21 . Mr Scholtz submitted that as far as medical care is concerned, this is a distinction without any real difference. What is guaranteed to prisoners, he argued, is "adequate medical care" and not "optimal medical care" or "the best available medical care". What is good enough for people outside prison, Mr Scholtz submitted, must be good enough for prisoners. According to Mr Scholtz's argument, such medical treatment as is afforded outside prison must, therefore, per se be regarded as "adequate medical care". I do not believe that this submission can be accepted as a principle of general application. What is true for medical treatment [*43] must also be true for, eg accommodation. Acceptance of the principle contended for by Mr Scholtz would, therefore, mean that the State is not obliged - in terms of section 35(2)(e) - to provide better accommodation for prisoners than that which is provided for people outside. It is an unfortunate fact of life, however, that there are many people in this country whose accommodation cannot be described as adequate by any standard. What is provided for people outside can, therefore, be no absolute standard for what is adequate for prisoners.

n21 Cf sections 26 and 27 of the Constitution.

[53]With reference to the position at common law, Mr Scholtz submitted that if the same standard of care and treatment is provided for prisoners attending State institutions, they would be retaining the residuum of rights which survive incarceration. I do not believe that this is so. Unlike persons who are free, prisoners have no access to other resources to assist them in gaining access to medical treatment. It is true that some [*44] HIV positive prisoners will, upon release, be dependent on the State for medical treatment. On the other hand, there are prisoners, like first applicant, who may well be able, upon their release, to earn an income which will enable them to afford anti-viral treatment or who will receive charitable assistance from their employers. As far as the latter category of prisoners is concerned, an inroad would be made upon their personal liberties if they were to be refused access to anti-viral treatment. Since such inroad cannot be described as a necessary consequence of incarceration, I do not believe that the refusal to provide these prisoners with anti-viral medication is consistent with the principles of our common law. In saying that I obviously do not intend to suggest that the standard of medical treatment for any particular prisoner should be determined by what he or she could afford outside prison. What I am saying, is that the standard of medical treatment for prisoners in general cannot be determined by the lowest common denominator of the poorest prisoner on the basis that he or she could afford no better treatment outside.

[54]As far as HIV prisoners are concerned, there is [*45] another factor which should, in my view, be borne in mind, namely that they are more exposed to opportunistic viruses than HIV sufferers who are not in prison. It is applicants' case that tuberculosis and pneumonia are prevalent in prison. Although respondents' deny the prevalence of these particular opportunistic infections, they do admit that the overcrowded conditions in which prisoners are accommodated, exacerbates the vulnerability of HIV prisoners to opportunistic infections. Even if it is, therefore, accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the State for patients outside, this principle can, in my view, not apply to HIV infected prisoners. Since the State is keeping these prisoners in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the State must provide them must be treatment which is better able to improve their immune systems than that which the State provides for HIV patients outside.

[55]The conclusion that the standard of adequate medical treatment for HIV infected prisoners is not per se determined [*46] by what the State provides outside for HIV patients, is in effect a conclusive answer or respondents' contention.

[56]What respondents have shown through the affidavit of Dr Wood, is that provincial hospitals cannot afford to provide all state patients who are HIV infected with the anti-viral treatment claimed by applicants. Dr Wood's motivation for this statement is - at least as far as Somerset Hospital is concerned - not disputed by applicants and, in fact, appears to be unanswerable. It is clear from respondents' papers that the Department of Correctional Services is also subject to budgetary constraints. I agree with the submission by Mr Seligson, however, that respondents have not on the papers made out a case that, as a result of these budgetary constraints, the Department of Correctional Services cannot afford to provide the anti-viral treatment for HIV positive prisoners who are eligible for such treatment.

[57]With regard to possible financial constraints, there is the further consideration of a cost-saving raised by applicants' experts to which respondents have, in my view, not given a satisfactory answer. As appears from the aforegoing, it is contended by applicants' [*47] experts, on the basis of international research, that the administration of anti-viral therapy at an early stage is cost-effective in that the treating of opportunistic infections is significantly reduced. It is true that respondents' medical expert, Dr Wood, does not agree with the results of the international research. It is also true, as was submitted by Mr Scholtz, that this dispute between medical experts cannot be determined on the papers. It does, however, stand to reason that the postponement of the costly treatment for opportunistic infections must result in some cost-saving even if such saving does not exceed the cost of prophylactic anti-viral treatment, as appears to be suggested by the results of international research. From respondents' papers, it appears that they have disregarded the possibility of any cost-saving through anti-viral treatment.

[58]In these circumstances, the polycentric issue referred to by Mr Scholtz n22 , does not arise. If a proper case were to be made out by respondents that, due to the constraints of its own budget, the Department of Correctional Services could not afford the medical treatment claimed by applicants, I might have come to the [*48] same conclusion as the English Court of Appeal in R v Cambridge Health Authorities n23 or I might have found that "adequate medical treatment" for applicants is dictated by such budgetary constraints. From what I have already stated, it is apparent, however, that on the facts of this case it is not necessary for me to make a definite finding on these difficult issues.

n22 See paragraph 42 above.

n23 See paragraph 43 above.

[59]What has been established on the papers in this case is firstly, that, although there is as yet no cure for the HIV virus, the internationally recognised "state of the art" medical treatment for HIV infected patients is anti-viral medication; secondly, that it is also recognised internationally that without medical intervention, the course of the HIV virus is such that it leads inexorably to immune depletion and dysfunction, although at a variable rate; and, thirdly, that the depletion of the immune system renders such HIV positive persons susceptible to opportunistic infections, which [*49] in turn further depletes the immune system, again increasing the risk of opportunistic infections, and leads to the eventual death of the patient.

[60]Applicants have, therefore, established, in my view, that although anti-viral therapy is at present only prophylactic, the benefits of this treatment - in the form of extended life expectancy and enhanced quality of life - are such that this treatment must be provided for the unfortunate sufferers of HIV infection, if at all affordable. As I have already stated, respondents have failed to make out a case that the Department of Correctional Services cannot afford to provide HIV infected prisoners in the stated category with the combination anti-viral therapy claimed by applicants. In these circumstances the medical treatment claimed by applicants is, in my judgment, no more than the "adequate medical treatment" to which they are entitled in terms of section 35(2)(e) of the Constitution. It follows, that the failure to provide applicants with this treatment amounts to an infringement of their constitutional rights.

Form of the order

[61]For reasons that appear from the aforegoing, I have come to the conclusion that first and second [*50] applicants are entitled to some form of relief in terms of paragraph 4 of the notice of motion. As has also been stated, however, this Court is not, in my judgment empowered to grant an order in the wide terms sought in that paragraph in that such an order would amount to a direction to medical doctors as to when they must prescribe anti-viral treatment. What I, therefore, propose to order is that first and second applicants be provided with such anti-viral therapy as has already been prescribed for them on medical grounds and only for as long as such therapy continues to be so prescribed.

[62]For the reasons already stated third and fourth applicants are, in my judgment, not entitled to an order directing respondents to provide them with anti-viral treatment which has not been prescribed for them on medical grounds. I did consider a declarator to the effect that these two applicants have a right to be provided at State expense with such anti-viral treatment as may be prescribed for them on medical grounds. The possibility cannot be excluded, however, that a

medical practitioner may prescribe anti-viral treatment with reference whereto the respondents could make out a case that [*51] it is unaffordable to the State and/or that there is less expensive but equally - or almost equally - effective anti-viral treatment available. These questions, ie what type of medical treatment could possibly be prescribed for them and the cost of such treatment, have not been addressed in the present application. Moreover, it is apparent from the papers that respondents' attitude to HIV infected prisoners has thus far not been unsympathetic. There is therefore no reason to believe that their future decisions regarding the medical treatment of HIV positive prisoners such as third and fourth applicants will not be influenced by the reasoning which - hopefully - transpires from this judgment. Accordingly judicial restraint in my view dictates the somewhat unspectacular method of progression advised by Lord Simon of Glaisdale in Miliangos v George Frank (Textiles) Ltd ie one step at a time n24 .

n24 See the dictum quoted in paragraph 32 above.

[63]The purpose of applicants' alternative prayer for a mandamus, that [*52] they should be released from prison, was obviously intended to provide for the eventuality that the relief sought in paragraph 4 of the notice of motion is refused on the basis that the anti-viral treatment claimed is found to be unaffordable. Since this eventuality did not materialise, the alternative claim became irrelevant.

Costs

[64]What remains to be decided, is the appropriate order of costs. From what I have stated, it is apparent that first and second applicants will be substantially successful and there is no reason why they should not be entitled to their costs.

[65]Third and fourth applicants will not be successful and it could be argued that they should be held liable for respondents' costs. I do not believe, however, that such order would be fair. The indications are that respondents did not incur additional expenses in order to oppose the application by third and fourth applicants, that is apart from the expenses which respondents incurred through their unsuccessful opposition to the application by first and second applicants. Moreover, Mr Scholtz fairly conceded that, although he had no specific instructions in this regard, the application was, in a sense, brought [*53] as one of public interest and that, in these circumstances, he could not motivate a costs order against any unsuccessful applicant.

Conclusion

[66]For these reasons, the order of this Court is as follows:

(a)First, second and third respondents are directed to supply first and second applicants with the anti-viral medication which has been prescribed for them - that is a combination of AZT and ddI - for as long as this medication continues to be prescribed for them on medical grounds.

(b)Third and fourth applicants' claims are dismissed.

(c)First, second and third respondents are ordered, jointly and severally, to pay first and second applicants' costs of suit, such costs to include the costs of two counsel.

(d)Regarding the unsuccessful application of third and fourth applicants, there will be no order as to costs.