REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT NAIROBI

CONSTITUTION AND HUMAN RIGHTS DIVISION

PETITION NO. 218 OF 2013

(CONSOLIDATED WITH PETITION NO. 451 OF 2013)

L N & 21 OTHERS…….. PETITIONERS

VERSUS

THE MINISTRY OF HEALTH……1ST RESPONDENT

KENYATTA NATIONAL HOSPITAL……2ND RESPONDENT

NATIONAL HOSPITAL INSURANCE FUND……3RD RESPONDENT

JUDGMENT

Introduction

1. The consolidated petitions in this matter, Nos. 218 and 451 of 2013, bring to the fore the challenges facing the health sector in Kenya and the difficulties citizens face in accessing adequate health care.

Petition No. 218 of 2013

2. The petitioners in Petition No. 218 of 2013 are **L N, H M,** P N, E B N, J M, J N K, H M, A M, S W, J M, B K, M K, E C, D M, J N N, S K, A N, R K, S M, J M and J G.

3. They filed their petition under certificate of urgency seeking mandatory orders to compel the Ministry of Health to meet the cost of medical dialysis on their behalf at eight private medical facilities namely the Nairobi Hospital, the Nairobi Women's Hospital, The Aga Khan, MP Shah, Mater, Nairobi West and Karen hospitals, and at the Parklands Dialysis Centre, or to subsidise the cost of medical dialysis at the named private medical facilities at the rate at which the petitioners would have accessed treatment at Kenyatta National Hospital.
4. The basis for seeking these orders is that the petitioners, all suffering from renal failure, have been undergoing renal dialysis at the Kenyatta National Hospital which had 20 machines for this purpose but only 6 were available to serve all patients who require renal dialysis, and that the hospital gave preference to in-patients. It is their case that they could not afford healthcare from other service providers and their rights to health had been infringed. They submit that require

dialysis treatment three times a week in order to live, but have been unable to access the treatment at Kenyatta National Hospital due to a lack of adequate machines and/or failure of existing machines; and that they are poor people and cannot afford to pay for dialysis at private medical providers. They seek the following orders in their petition dated 23rd April 2013:

A. A declaration that the actions of the 1st and 2nd respondents of not buying adequate medicine dialysis equipment and/or repairing the existing ones to the point that the petitioners are unable to access mandatory treatment, expressly and singularly violates the provisions of Article 26(1) of the constitution which provides that every person has a right to life and Article 43(1) which provides that every person has the right to health care services.

B. A declaration that the actions of the 3rd respondent of not paying a higher amount (subsidizing a higher amount) for medicine dialysis to be done at private medical institutions (where the machines are easily available) to the point where petitioners are unable to access mandatory treatment due to financial constraints/indigence, expressly and singularly violates the provisions of Article 26 (1) of the constitution which provides that every person has a right to life and article 43(1) which provides that every person has the right to health care services.

C. A declaration that the actions of the respondents of coming up with a deliberate policy for alternative dialysis treatment for patients who cannot access the existing dialysis machines at Kenyatta National Hospital as and when they fail, expressly and singularly violates the provisions of Article 26(1) of the constitution which provides that every person has a right to life and article which provides that every person has the right to health care services.

D. A declaration that for the respondents to deny and/ or fail to provide adequate health care services to the petitioners subjects them to inhuman treatment, and thus expressly and singularly violates the provisions of Article 28 of the Constitution of Kenya which provides that every person has inherent dignity that must be respected and protected.

E. A declaration that the actions of the 2nd respondent to provide dialysis treatment to patients admitted at the institution and deny access to walk-in patient (allegedly due to the unavailability of dialysis machines is an act of discrimination that expressly and singularly violates the provisions of article 27(5) which provides that no person shall discriminate against another.

F. Pending the buying on new dialyses equipment/repair of existing ones, this Honourable Court issues an order compelling the 1st respondent to fully pay for the petitioners to access the compulsory medicine dialysis treatment at the following private medical institutions:-

a) The Nairobi Hospital

b) The Nairobi Women's Hospital

c) The Aga Khan Hospital

d) The MP Shah Hospital

e) The Matter Hospital

f) The Nairobi West Hospital

g) The Karen Hospital And

h) The Parklands Dialysis Centre

5. The petitioners seek, in the alternative to the prayers set out above, but still in relation to the private institutions set out above, a prayer that:

"Pending the buying of new dialyses equipment/repair of existing ones, this Honourable Court issues an order compelling the 1st and 3rd Respondent to subsidize the cost of medicine dialysis to be conducted at the institutions listed below (at the rate at which the petitioners would have accessed treatment at Kenyatta National Hospital- that is to say, if private medical institution charges Ksh10,000 per dialysis visit, the petitioners would pay Kshs2050 only while the 1st and 3rd respondent would pay the balance)".

6. The petitioners also pray for the costs of the petition at prayer H against the respondents jointly and severally, while at prayer G, they seek:

G. An order directing the respondents to come up with a sustainable and actionable administrative, policy, and political mechanism for patients to access uninterrupted medicine dialysis at Kenyatta National Hospital and other public institutions.

Petition No. 451 of 2013

7. The petitioner in this petition is **Mr. F N**. He filed his petition under certificate of urgency on 16th September 2013 in which he makes allegations of violation of his right to health similar to those made in Petition No. 218 of 2013 in respect of treatment for kidney dialysis, but directed primarily at the 3rd respondent. He describes himself as an elderly citizen of the Republic of Kenya, 83 years of age, and a contributor to the National Hospital Insurance Fund **(NHIF)** under membership number 0782289. In his petition, he seeks the following orders:

a. ***A declaration that the respondent has by restricting the payments made under the National Hospital Insurance Fund to only a portion of the cost of bed breached the petitioner's fundamental right to receive the best available medical treatment under Article 43 of the Constitution, Article 16 of the African Charter on Human and People's Rights and Article 12 of the International Convention on Economic, Social and Cultural Rights.***

b. ***A declaration that the respondent by failing to include the cost of dialysis treatment as well as treatment for terminal conditions has in effect discriminated against the petitioner as well as others in his condition which discrimination is contrary to his right of equality under Article 27 of the Constitution.***

c. ***A mandatory injunction compelling the respondent to include the cost of dialysis and treatment for diabetes and hypertension as part of its cover to the petitioner and other members of the National Hospital Insurance Fund in his condition.***

d. ***A mandatory injunction compelling the respondent to advice the national government of Kenya to include as part of the medical cover under the National Hospital Insurance Fund cover for treatment of terminal illness including diabetes, hypertension and the cost of dialysis treatment.***

e. *The cost of this Petition*.

8. By an application dated 29th November 2013, the petitioner sought consolidation of his petition with Petition No. 218 of 2013, which orders were issued on 25th February 2014. Consequently, the petitioners in Petition No. 218 of 2013 would be the 1st - 21st petitioners while the petitioner in 451 of 2013 would be the 22nd petitioner in the consolidated petitions.

9. The petitioners shall, in this judgment, be referred to together as the petitioners. They are all adult citizens of Kenya who require renal dialysis treatment as a result of kidney failure.

10. The respondents are the Ministry of Health, the Kenyatta National Hospital and the National Hospital Insurance Fund (NHIF) as the 1st, 2nd and 3rd respondents respectively. The 1st respondent is described as the arm of government responsible for policy making on health care and management of national referral health institutions in Kenya, while the 2nd respondent is a public hospital and is responsible for the provision of health care services to Kenyans. The 3rd respondent is a statutory corporation that provides medical insurance schemes to Kenyans who are its members.

Background

11. The facts giving rise to this petition are largely not in dispute. The petitioners are all adult Kenyans who describe themselves as suffering from renal failure, a medical condition in which the kidneys fail to adequately filter waste products from the blood. They state that they have been undergoing medical treatment at Kenyatta National Hospital for the past five years. Dialysis is a process for removing waste and excess water from the blood and is used primarily as an artificial replacement for lost kidney function in people with renal failure.

12. Kenyatta National Hospital is the main public referral hospital in the country. It had some 20 haemodialysis machines, but most of them are out of order, and only about 6 were functioning at the time this petition was filed. This situation has caused a strain on the existing machines and has resulted in long queues and waiting for patients who need dialysis.

13. Further, the hospital has prioritized access to the dialysis machines on the basis of the urgency and seriousness of each patient. It is this prioritization that the petitioners are aggrieved by, terming it discrimination and violation of their constitutional rights.

14. Like the other petitioners, the 22nd petitioner suffers from renal failure and requires dialysis at least three times a week. His claim is directed primarily at the 3rd respondent, NHIF. He avers that sometime in 2009, he was diagnosed with kidney failure due to terminal diabetes and hypertension. The cost of the dialysis that he requires thrice weekly is Kshs 108,000/= per month at the Nairobi Hospital. He agrees with the other petitioners that the treatment is also available at the Kenyatta National Hospital at a subsidized cost of Ksh 5,000/= per session but the waiting queue for patients is so long that he would only receive the treatment once every two months which would be detrimental to his health. He states that he also pays related doctors' fees and drugs for his condition amounting to Ksh 50,000/= per month.

15. The 3rd respondent, NHIF, is a state corporation under the Ministry of Health established and governed by the NHIF Act, No. 9 of 1998. Its core mandate is expressed to be to provide medical insurance cover to all its members, their spouses, children and their declared dependants. Its membership is open to all Kenyans who have attained the age of 18 years and have a monthly

income of more than Kshs1000/.

The Case for the Petitioners

16. The petitioners' case is set out in the two petitions and the affidavits in support, the first sworn by the 1st petitioner, Mr. L N on behalf of the 1st- 21st petitioner, and the second sworn by the 22nd petitioner, Mr. F N. Their respective cases and submissions were presented by their Counsel, Mr. Tanui and Mr. Kabaru.

17. The petitioners' aver that they are all suffering from renal failure, and therefore require dialysis at least three times a week. Without dialysis, a person suffering from renal failure often dies. They state further that there are presently over 300 patients who rely on the dialysis machines at Kenyatta National Hospital which previously had 20 dialysis machines. However, only 6 are currently fully functioning as the rest have broken down and so the hospital is ill-equipped to cater for patients who need dialysis. As a result, few patients access the working dialysis machines as the hospital gives preference to in-patients. Walk-in patients, who include the petitioners, are often unable to access treatment at the hospital.

18. Aside from the unavailability of renal dialysis machines, the petitioners are also aggrieved by the cost of dialysis treatment which they term as prohibitive. They aver that Kenyatta National Hospital charges **Kshs 5,050/=** per visit, with NHIF meeting only **Kshs 2,400.00** of this amount. They state therefore that as many of them are low income earners while others are unemployed, when they are unable to access the facilities at Kenyatta National Hospital, they must raise money to pay private medical service providers who charge **Kshs 10,000.00** per session, which NHIF has declined to pay for them. It is their case that they cannot afford to pay the said amount at the private hospitals.
19. The petitioners contend that the 1st respondent has the primary obligation to protect and promote their right to health for such obligations are defined and guaranteed by international customary law, international human rights treaties, and the Constitution of Kenya. They contend further that the 1st respondent has the obligation to adopt appropriate legislative, administrative, budgetary, promotional and other measures to fully realize their right to health. They submit that it must, for instance, adopt a national health policy or a national health plan covering the public and private sectors that will ensure access to dialysis.

20. The petitioners argue that continually denying them dialysis treatment well knowing that the result is death is a blatant violation of Article 26 of the Constitution. They also argue that allowing in-patients at the Kenyatta National Hospital access to dialysis treatment and denying walk in patients such access is open discrimination contrary to Article 27 (5) of the Constitution. They also allege violation of Article 28 on the right to human dignity, contending that denial of dialysis treatment to a kidney failure patient is subjecting the person to inhumane treatment.

21. The petitioners submit that they are entitled to adequate health care services to the highest attainable standards and it is their contention therefore that if the 1st and 2nd respondents do not have adequate resources to buy renal dialysis equipment, they should make appropriate financial arrangements to pay for and/or subsidize payment for treatment at private medical institutions where the dialysis machines are easily available.

22. The petitioners rely on General Comment No. 9 of the United Nations Committee on Economic, Social and Cultural Rights which they submit emphasizes that it is up to states how they give effect to the rights contained in the International Covenant on Economic, Social and Cultural

Rights, including the right to health, but whatever arrangements they choose, they must be effective.

23. The petitioners ask the court to disregard the decision of the South African Constitutional Court in the case of **Soobramoney –vs- Minister of Health Kwa Zulu Natal 1997 (12) BCLR 1696** with regard to the test the court should use in determining the state's obligation on social economic rights. They ask the court to be guided by the decision in **Minister of Health –vs- Treatment Action Campaign (TAC) (2002) 5 SA 721 (CC)** as the reasoning in that case will promote the realization of the right to health in Kenya. They have also cited a decision from Argentine, **Mariela Viceconte –vs- Ministry of Health and Social Welfare Case No 31.777/96**, in which the court set a deadline for the state to meet its obligation to manufacture a vaccine for a haemorrhagic fever, and submit that the court should be guided by the said decision in this matter. The petitioners have also referred the court to the decision from Ecuador in the case of **Mendoza and Ors –vs- Ministry of Public Health Resn No 0749-2003-RA (28 Jan 2004**). They submit that the court in that case held that the Ministry of Health had failed in its obligations to protect the petitioners' right to health, which forms part of the right to life, by suspending a HIV treatment programme.

24. They urge the court to interpret the provisions of Article 43 (1) of the Constitution in accordance with the provisions of Article 259 and submitted that the orders sought in this petition will, among other things, promote the purpose, values and principles in the Constitution.

25. While agreeing with the submissions made on behalf of the 1st- 21st petitioners, the 22nd petitioner specifically alleges discrimination against the elderly in his claim against the 3rd respondent. He was, at the time of filing the petition, 81 years of age.

26. Due to the congestion at Kenyatta Hospital which has subsidized charges for dialysis of Kshs 5,000/= per session, the 22nd petitioner contend that he is compelled to pay kshs 108,000 for the sessions at the Nairobi Hospital, as well as Kshs 50,000 for doctors' charges and drugs. He argues that the 3rd respondent should pay for the dialysis sessions as well as the doctors' fees and drugs but the respondent only pays for bed charges in the hospital in the region of Ksh 1,400/= per night. He argues that he finds it increasingly burdensome and difficult to pay for the medical charges as at 81 years old, he is now old and effectively out of the job market.

27. The 22nd petitioner submits that the 3rd respondent's failure to pay for his life threatening dialysis treatment is a breach of his right to health care services and constitutes a denial of emergency medical treatment which is a violation of Article 43 of the Constitution. It is his case further that the 3rd respondent's systematic exclusion of elderly persons like himself from medical cover arising from terminal diseases is to discriminate against the elderly and marginalized people contrary to Articles 10 (2) (b), 21 (3) and 27 (4) of the Constitution.

28. He argues that NHIF, in carrying out its statutory mandate, is bound by the Constitution and, in particular, by Articles 10 (2) (b), 20 (5) (b), 21 (3), 27 (4), 28, 43 (2) and 47 of the Constitution. It is also his contention that the failure by NHIF to cover the cost of his dialysis and related treatment has in effect breached his dignity contrary to Article 28 of the Constitution.

29. The petitioner submits that the 3rd respondent is tasked under Section 5 of the National Hospital Insurance Fund Act with the broad mandate of regulating the payment of benefits under the Act. It therefore has the statutory power to cover the payment of dialysis treatment which it has failed to do, and that such failure amounts to contravention of Articles 43 (2) and 47 of the Constitution.

It is also his claim that NHIF has the mandate, under the said section 5, to advice the National Government on a National Policy with regard to the National Hospital Insurance Fund and in particular advice the Government to formulate and implement such policy so as to accord with Articles 10, 27 and 43 of the Constitution, but that it has failed to do so, to his detriment and the detriment of other elderly and terminally ill persons in his position.

30. The petitioner submits that in accordance with Article 2 (6) of the Constitution, Kenya is bound by the treaties and international conventions to which it is a party and, at the minimum, to comply with its treaty obligations under these conventions. It is his contention that apart from stating in an affidavit that they still lack the funds to provide the dialysis cover the petitioners seek, the respondents have not shown the court a statement of their assets, their expenses and what part of those expenses could adequately cover the treatment the petitioners seek.

31. In addition to the case of **Ministry of Health –vs- Treatment Action Campaign (supra)** relied on by the 1st-21st petitioners, the 22nd petitioner has referred the court to the decisions of the Supreme Court of India in **Bandhua Mukhti Morcha and Others –vs- Union of India and Others AIR 1984 SC 802** and **Consumer Education and Research Centre –vs- Union of India (1995) 3 SCC 42** for the proposition that the right to human dignity and to life are inextricably linked to the right to health.

32. Counsel for the 22nd petitioner also referred in his submissions to the decisions in **Parmanand Katara –vs- Union of India AIR 1989 SC 2039, VHAP –vs- Union of India SC 349 of 2003** and **Paschim Banga Khet Mazdoor –vs- State of West Bengal AIR 1996 SC 2426,** the latter of which, he submits, deals with a situation exactly like the one now before the court in which the state, while acknowledging its constitutional obligation towards providing life supporting medical facilities to the petitioners, claims not to have the resources to provide such facilities. It is the petitioner's submission that the respondents have not discharged their responsibility under Article 20(5)(a) to show, with respect to the rights enshrined in Article 43, that it does not have adequate resources. The petitioners therefore pray that the petition be allowed as prayed.

The 1st Respondent's Case

33. The 1st respondent has filed Grounds of Opposition dated 29th May 2013 and submissions dated 25th June 2013. Its objections are that the petition is misconceived and otherwise an abuse of the court process; does not disclose any cause of action against the respondents nor any constitutional violations or breaches by the respondents; and further, that the orders sought are not tenable against the 1st respondent as no sufficient grounds have been advanced to warrant the grant of the orders.

34. The submissions of the 1st respondent through its Learned Counsel, Mr. Mohamed, is that the Constitution provides for economic and social rights, including the right to health, under Article 43. Under Article 21, the said right is subject to progressive realization. The respondent therefore relies on the decision in the case of Court of Republic of South Africa & Others vs Irene **Grootboom and Others (CCTII/OO)[2001]ZACC 19;2001 (1) SA 46;2000(11)BCLR 1169(4 October 2000)** to support its contention that the rights under Article 43 are to be progressively realized.

35. It is its case that over the years, the government has taken policy and legislative steps to achieve the realization of economic and social rights, within its resources. It cites as illustrations, among other things, the fact that the government has built hospitals and health centres to provide health

services to Kenyans who cannot afford to go to private hospitals; taken measures to combat cancer by enacting the Cancer Prevention and Control Act, 2012; and given free access to people living with HIV and AIDS free access to anti-retroviral drugs. With regard to the present case, the 1st respondent submits that the government has bought dialysis machines and subsidized the fee for accessing the services. The 1st respondent refers the court to the decision in **Mathew Okwanda –vs- Minister for Health and Medical Services and Others Petition No 94 of 2012** in which the court found that in the absence of a focused dispute and sufficient material to show a violation of constitutional rights, it could not express itself on the issues in dispute.

36. With regard to the question whether the country had enough resources to meet its obligations under Article 43, the 1st respondent submitted that Kenya is a developing country which continues to encounter many constrains in fulfilling the rights and fundamental guaranteed in the Constitution. It relies on the decision in the **Soobramoney case** (supra) with regard to the considerations that the court should have in mind with regard to the needs that the state has to meet if it were to accede to the demands of the petitioners.

37. The 1st respondent submitted, finally, that the present petition falls within the purview of the political question doctrine and the issues that it raises are issues that the court refuses to deliberate because they properly belong to the decision making authority of elected officials. Counsel relied in support on Article 20 (5) (c) of the Constitution. It was his further submission that the country is in a transition period and under part 2 of the Fourth Schedule, health services are being devolved to the County Governments and this requires time, and that the government was committed to ensuring the realization of the rights set out in Article 43 of the Constitution and is taking legislative, policy and other measures to guarantee these rights to Kenyans.

The Case for the 2nd Respondent

38. Kenyatta National Hospital, the 2nd respondent, has filed an affidavit sworn by Dr. Simon Monda, the Deputy Director of Clinical Services at the hospital, on 4th June 2013 and submissions dated 6th August 2013.

39. According to Dr. Monda, the Kenyatta National Hospital's Renal Unit was opened in 1984. It provides services for treatment of medical kidney disease to the whole hospital and the dialysis at the Renal Treatment Unit is just one of the several treatment specializations that Kenyatta caters for. He states that dialysis is highly resource intensive, particularly on consumables, and requires, inter alia, enormous labour and specially trained human resources with specific expertise in the area to man the unit twenty-four hours every day.

40. According to the 2nd respondent, the cost of a single dialysis machine is about Kshs 1.6 million. The consumables per session for a patient cost about Kshs 4,500/= at the 2nd respondent, compared to Kshs 9,000/= in private hospitals, and the renal unit is therefore not considered a profit centre for Kenyatta National Hospital but instead as a significant cost centre considering the machines run non-stop. It is its case that as a result, the machines get really stretched most of the time; which inevitably leads to occasional mechanical failure that require both time and enormous financial resources to repair.

41. The 2nd respondent states further that the number of functioning haemodialysis machines at its renal unit varies according to the state of repair of the machines and the economic constraints at the hospital. The number has however ranged between 10 and 20 which, is below the ideal

number of 30. The shortage of the machines for chronic dialysis patients is further worsened by the requirement of the same machines for very sick patients admitted at the hospital with acute kidney failure. It is its case that such patients have to take priority in the provision of dialysis.

42. It is the 2nd respondent's further submission that the incidence in Kenya of chronic renal failure requiring haemodialysis is 200 per million of the population per year; that with Kenya's population standing at approximately 40 million, the hospital gets 8,000 new patients that require renal replacement therapy every year; that approximately 500 patients receive dialysis treatment due to the related high cost; and that it currently has approximately 300 patients on regular chronic haemodialysis at its Renal Unit, up from approximately 120 patients one year ago; and that it therefore gets on average 5 new patients starting on haemodialysis every week.
43. The 2nd respondent also details other initiatives that it has undertaken with respect to renal disease: that it offers a training programme for renal nursing and serves as the training base for provincial hospitals in Kenya. It contends that kidney transplantation is the best remedy and that there is a kidney transplant programme at the Renal Unit which has been highly successful over the past 3 years that has seen kidney transplants carried out in approximately 80 patients at a cost of about Kshs 300,000/= per person compared to Kshs 2 million per person for the same treatment at some private hospitals or outside the country.

44. It is also its case that it has taken other initiatives with a view to improving the situation at its Renal Unit by, among other things, requesting corporate organizations to donate funds and/or machines to the Renal Unit; training renal nurses and working with the Ministry of Health with a view to spreading dialysis services to the Counties and other public hospitals in Nairobi and across the country so as to help decongest the dialysis services at Kenyatta National Hospital; and working with willing organizations to raise funds for kidney transplants to needy Kenyans as this will in turn reduce the pressure on dialysis machines.

45. It submits that it has also committed itself to buying 3 to 5 new dialysis machines each year, as well as leasing others. It has produced an open tender notice inviting tenders for the leasing of 20 Renal Haemodialysis machines as evidence of the actions it is taking to improve the situation at the Renal Unit.

46. The 2nd respondent therefore submits that it is not true, as alleged by the petitioners, that they have been denied or are unable to access kidney dialysis treatment at Kenyatta hospital. It contends that all patients are attended to without discrimination and given priority depending on the seriousness of their conditions in line with the 2nd respondent's current capacity and universal standards without any discrimination.

47. The 2nd respondent argues that to grant the prayers that the petitioners seek would have dire consequences as it would mean marshaling all of Kenyatta Hospital resources to cater for only those patients in need of renal dialysis to the exclusion of all other patients requiring different types of treatment, a situation which the 2nd respondent terms as not only discriminatory but extremely dangerous.

48. The respondent relies on the decisions in **Soobramoney (supra), John Kabui Mwai and 3 Others –vs- Kenya National Examination Council and 2 Others, Petition No 15 of 2011**, and **Mathews Okwanda –vs- Minister for Health and Medical Services and Others (supra)** to support its arguments and prays that the petition be dismissed.

The Case for the 3rd Respondent

49. NHIF has filed an affidavit sworn by its Chief Executive Officer, Simeon Ole Kirgotty, on 3rd June 2013 as well as submissions dated 17th September 2013. Oral submissions were made on its behalf by its Learned Counsel, Mr. Kashindi. In his affidavit, Mr. Kirgotty avers that the NHIF model is anchored on the social principle of solidarity whereby the rich support the poor, the healthy support the sick and the young support the old; and that in the provision of benefits to contributors, their spouses and dependants, it gives priority to ensuring the widest possible enjoyment of the right to health and healthcare services having regard to prevailing circumstances, including budgetary limitations, increasing cost of healthcare and scarce resources.

50. According to the 3rd respondent, it currently has an active membership of 3.8 million members in formal employment who contribute to the fund on a graduated scale, depending on their monthly salary, starting from Kshs 30/=, with the highest contributing Kshs 320/=. Self employed members contribute Kshs 160/= as provided in Legal Notice No 185 of 2003. It therefore provides health financing based on contributions received from its members.
51. Mr. Kirgotty avers that recent analysis by the International Finance Corporation and Deloitte Consulting indicate that its rates are too low considering medical inflation and consumer price index and in order to provide better benefits and coverage that relates to the current medical costs, they ought to be increased. The 3rd respondent contends that pursuant to Legal Notice No 107 and 108 of 2010, the rates were revised with an intention to enhance collections so as to introduce comprehensive healthcare for members, but that initiatives to implement the new revised rates have been curtailed by unending litigation from stakeholders.

52. Mr Kingotty names some of the pending litigation, against NHIF, about seven cases in all, as including **Industrial Court Cause No 887 of 2010, Central Organization of Trade Unions (K) –vs- NHIF** seeking to restrain the implementation of the new rates; **Misc App No 306 of 2010, Central Organization of Trade Unions –vs- NHIF** in which an order was issued restraining the implementation of the new rates; and **J.R Misc App No 262 of 2010, Samuel Kerosi Ondieki –vs- The Attorney General and NHIF** in which the applicant seeks an order to declare **Legal Notice No 108 of 2010** unconstitutional.

53. It is its submission that having been restrained from implementing the new rates, it continues to do the best it can with limited resources against an ever increasing medical inflation and consumer pricing index, while its current contribution rates have remained unchanged since 1990.

54. The 3rd respondent avers with regard to payment of benefits that section 27 of the NHIF Act requires it, in consultation with the Minister for Health, to make regulations prescribing the amount of benefits and the period within which such benefits shall be payable which are in form of medical packages enjoyed by members, their spouses, children and dependants. It states that the law further requires the benefits to be made to “declared hospitals” only, meaning hospitals that are accredited by it in accordance with its Accreditation Policy and Accreditation Manual for Health Facilities; and further, that the NHIF Act provides that the maximum rate of benefit payable in respect of hospital and medical treatment is to a contributor paying standard, special or voluntary contribution.

55. The 3rd respondent submits further that since it operates as an insurance fund, paying amounts in excess of those already considered and approved by the Board, based on actuarial advice would, in fact, jeopardize and compromise the integrity of the fund and it may ultimately result in NHIIF not being able to meet its mandate. It is also its contention that the petitioners have not

suggested that its decision as captured in various Legal Notices relating to amounts or rebates payable and the accredited facilities are unreasonable. It asks the court not to interfere with decisions on benefits and priorities taken in good faith by statutory agencies and medical authorities whose responsibility it is to deal with such matters.

56. It submits, further, that it would be undesirable for the court to make an order on how scarce medical resources should be applied, or that the resources be used for a particular patient or patients, as doing so may have the effect of denying those resources to other patients. It terms the prayers by the petitioners as discriminatory, irrational, perhaps even selfish for a group of beneficiaries to use the court to lay claim to an enhanced share of the fund without caring about the needs of other users of the fund.

57. NHIF further argued that if the court were to grant the prayers sought by the petitioners, everyone else similarly situated would have to be given similar and equal treatment, which was likely to result in a floodgate of litigation as other beneficiaries will, where certain procedures are not readily available at accredited facilities, seek to attend expensive private facilities, which would lead to a collapse of the carefully tailored rebate programme in place. It therefore prayed that the petition be dismissed.

The Case for the Interested Party

58. By an order made on 14th May 2013, the court directed that the private institutions which had been mentioned in the petition and the affidavit in support be served and enjoined as interested parties. Of these institutions, only the Karen Hospital filed any pleadings in the matter, by way of an affidavit sworn by **Ms. Esther Thambu**, the head of Nursing Services at the Karen Hospital, on 21st June 2013. No submissions were, however, filed in respect of Karen Hospital nor did it participate any further in the hearing of the matter.

59. In her affidavit, Ms. Thambu states that Karen Hospital Limited is a medical institution duly licensed by the Medical Practitioners and Dentists Board to offer high quality medical services to the public, which it has undertaken diligently over the years. She states further that the 3rd respondent has its own legal process and members of the public who wish to seek medical attention in Karen Hospital must obtain clearance and a letter of undertaking from the 3rd respondent.

60. It is therefore her contention that the relationship between Karen Hospital and the 3rd respondent was governed by a contract entered into on 1st April 2012 which has since lapsed, and any member of the public who wishes to access its facilities must make his or her own financial arrangements, either personally or with the 3rd respondent. It was also its contention that the 3rd respondent still owes it a colossal sums of money in unpaid medical bills for NHIF members. It submitted therefore that unless the 3rd respondent settles its indebtedness with the Hospital, it will not be able to accommodate the petitioners at Karen Hospital as the Hospital has to pay its suppliers and financiers or else it closes shop.

61. The Karen Hospital further avers that its current rates for dialysis range between Kshs 8,900 for low flux dialysis and 11,900 for high flux dialysis, and while it agrees that the petitioners have a right to healthcare, that right should be balanced against the availability of resources and the likely prejudice that would befall private medical institutions who may be flooded with litigation or with visits from members of the public seeking medical services at no cost.

Determination

62. The Constitution of Kenya has guaranteed to everyone, among other social economic rights, the right to health. Article 43 provides that:

1. ***Every person has the right –***

a. ***To the highest attainable standard of health, which includes the right to health care services, including reproductive health care;***

2. ***A person shall not be denied emergency medical treatment.***

63. This provision reflects the right guaranteed in international instruments to which Kenya is a party, chief among them Article 12 of the International Covenant on Economic, Social and Cultural Rights, which provides as follows:

1. ***The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.***

2. ***The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:***

(a)…;

(b)…;

(c)…;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

64. At Paragraph 1 of General Comment No. 14, the Committee on Economic and Social Rights states as follows:

"Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity".

65. It cannot be disputed that the right to health is intrinsically connected with the right to life, as the petitioners submit, and violation of the right to health would therefore impact negatively on the right to life. It is recognized, however, that the right to health can only be achieved progressively, and that its realization is subject to the availability of resources. Article 21(2) of the Constitution provides that:

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

66. The Constitution further provides the manner in which the court should approach the question of the state's obligation in meeting its obligations under Article 43. It provides at Article 20 (5) as follows:

"In applying any right under Article 43, if the State claims that it does not have the resources to implement the right, a court, tribunal or other authority shall be guided by the following principles-

a. ***It is the responsibility of the State to show that the resources are not available;***

b. ***In allocating resources, the State shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals; and***

c. ***The court, tribunal or other authority may not interfere with a decision by a State organ concerning the allocation of available resources, solely on the basis that it would have reached a different conclusion.***

67. It is thus undisputed that the state has the primary obligation to ensure that the petitioners and other citizens enjoy the highest attainable standard of health. The state has a duty to make the necessary budgetary allocation, as well as to take the necessary legislative and policy measures, to ensure that the right to health is realized.
68. The petitioners argue that they are not able to realize their right to health as they do not have access to essential haemodialysis at the Kenyatta National Hospital as it is ill-equipped to cater for all the patients who need dialysis. They assert that the failure by the respondents to have sufficient machines in operation or to provide dialysis at a low cost, or in the case of the 3rd respondent, to include the cost of dialysis in the amount it meets in private institutions, have resulted in a violation of their right to health. They want an order to compel the respondents to meet the cost of access to such treatment at private institutions. An order is also sought by the 22nd petitioner to compel the 3rd respondent to meet all his medical costs for dialysis, including doctors' charges, from the health insurance fund. The respondents contend that they have done the best they can with the available resources, and are still doing their best to improve the situation, and have not therefore violated the petitioners' right to health.

69. The question that the court must determine is whether, in the circumstances of this case, there has been a violation of the petitioners' right to health, and whether it can grant the orders that they seek.

70. In explaining the steps that it has taken to meet its obligations with regard to the petitioners' right to health, the state has averred that dialysis is highly resource intensive, particularly on consumables, and that it requires, inter alia, enormous labour and specially trained human resources with specific expertise in the area to man the Renal Unit twenty-four hours every day. It states that the cost of a single dialysis machine is about Kshs 1.6 million while the consumables per patient per session costs about Kshs 4,500/=. The cost of dialysis in private hospitals is Kshs 9,000/=.

71. The respondents submit that the government contributes 30% of the healthcare budget, while the citizen meets the rest. The respondents have also made averments to the effect that they are trying to address the current problems with regard to renal dialysis by, among other things, establishing a kidney transplant programme at the Renal Unit, and committing to buying additional machines for the Renal Unit at the rate of 3 to 5 new dialysis machines each year.

72. The 3rd respondent has submitted that it has made attempts to increase its rates so that it can raise the level of benefits available, but that its attempts to increase the level of contribution by

members has been frustrated by litigation from various stakeholders.

73. So what do we have in the current case? Petitioners with an admittedly serious and debilitating condition, and whose long term prognosis, if they cannot get the renal dialysis that they require, is dire. Against this is an admittedly overburdened health care system that has to balance between the needs of the petitioners on the one hand and other, no less needy or deserving patients, on the other hand, and a public health insurance system that is contribution based and whose contributions have not been raised for the last quarter century.

74. Can it be said, in such circumstances, that the state has failed to meet its obligations to the petitioners with respect to their right to health? Can this court, in the present circumstances, order the state to meet the cost of dialysis for the petitioners in private hospitals, or direct the 3rd respondent to pay all the medical costs for the 22nd petitioner at private institutions out of its funds?

75. The facts of this case echo those that confronted the Constitutional Court of South Africa in the case of **Soobramoney (supra)**, which emerge from the judgment of Chaskalson, P. In that case, the appellant was a 41 year old man with diabetes who also suffered from ischaemic heart disease and cerebro-vascular disease who had a stroke and whose kidneys also failed. At the time he filed his case, his condition was irreversible and he was at the final stages of chronic renal failure where his life could be prolonged by means of regular renal dialysis. He sought renal dialysis from the renal unit of the Addington state hospital in Durban, but the hospital could only provide dialysis treatment to a limited number of patients as the renal unit had 20 dialysis machines available, some of which were in poor condition. Each treatment took four hours, and a further two hours had to be allowed for the cleaning of a machine, before it could be used again for other treatment. As a result, the hospital was on most occasions unable to provide the appellant with the treatment he required.

76. The appellant therefore lodged his claim, alleging a violation of his right to emergency treatment guaranteed under section 27(3) of the South African Constitution, which is similar to our Article 43(2), violation of which is alleged by the 22nd petitioner, who argues that the 3rd respondent's failure to pay for his life threatening dialysis treatment constitutes a denial of emergency medical treatment.

77. With regard to the appellant's situation in that matter, the Court observed as follows:

"*The applicant suffers from chronic renal failure. To be kept alive by dialysis he would require such treatment two to three times a week. This is not an emergency which calls for immediate remedial treatment. It is an ongoing state of affairs resulting from a deterioration of the applicant's renal function which is incurable*.

[22] ***The appellant's demand to receive dialysis treatment at a state hospital must be determined in accordance with the provisions of sections 27(1) and (2) and not section 27(3). These sections entitle everyone to have access to health care services provided by the state "within its available resources"*.**

78. With regard to the question of the availability of resources in that case, the Court stated as follows:

[11] What is apparent from these provisions is that the obligations imposed on the state by

***sections 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources. Given this lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled. This is the context within which section 27(3) must be construed*.”**

79. In the case now before me, the petitioners all suffer from chronic renal failure, and as they aver, need dialysis two or three times a week. They ask the court to intervene and ask that their treatment be subsidized by the state at private institutions. In making this demand, they ask the court to interfere with matters of policy which, as the Constitution enjoins at Article 20(5), should be left to the state, as the court is not suited, and does not have the requisite information, to enable it make a determination as to the best use of scarce resources in the health sector vis a vis other equally critical, sectors. I agree in this regard with the sentiments expressed by the court in **Soobramoney (supra)** when it stated at paragraph 29 that:

“*…A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters. [30] Although the problem of scarce resources is particularly acute in South Africa this is not a peculiarly South African problem. It is a problem which hospital administrators and doctors have had to confront in other parts of the world, and in which they have had to take similar decisions. In his judgment in this case Combrinck J refers to decisions of the English courts in which it has been held to be undesirable for a court to make an order as to how scarce medical resources should be applied, and to the danger of making any order that the resources be used for a particular patient, which might have the effect of denying those resources to other patients to whom they might more advantageously be devoted.”*

80. The Court went on to state as follows:

***“The dilemma confronting health authorities faced with such cases was described by Sir Thomas Bingham MR in a passage cited by Combrinck J from the judgment in R v Cambridge Health Authority, ex parte B: “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 all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research 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*.”**

81. The sentiments expressed above sound eerily familiar, seeming to describe the situation that Kenya’s health system is confronted with, and which gives rise to the petitioners’ claim now before me.

82. I believe the sentiments of the court set out above also respond to the petitioners’ claim of discrimination with regard to the availability of dialysis treatment. They have argued that allowing the admitted patients at the Kenyatta National Hospital access to dialysis treatment and denying

walk-in patients such access is open discrimination contrary to Article 27 (5) of the Constitution, while the 22nd petitioner argues that the 3rd respondent, by systematically excluding elderly persons such as himself from medical cover arising from terminal disease including dialysis treatment has in effect discriminated against the elderly and marginalized people from its medical cover contrary to Articles 10 (2) (b), 21 (3) and 27 (4) of the Constitution.

83. Article 20 (5) (b) imposes a duty on the state to channel its resources in respect of social economic rights while giving priority to ensuring the widest possible enjoyment of the right and having regard to prevailing circumstances, including the vulnerability of particular groups or individuals. In this case, it is the respondents, in the face of limited resources such as functioning haemodialysis machines at Kenyatta National Hospital Renal Unit, who are best placed to make that all important and difficult judgment call with regard to whom, between chronically ill renal patients such as the petitioners and the in-patients with acute renal failure, it should give priority in the provision of dialysis.

84. In addition, one must bear in mind the possible consequences of the orders that the petitioners are seeking in this matter. They ask that they should be provided with life-saving dialysis treatment, and if it is not available at state institutions, the state should subsidize the provision of such services at private institutions. The sad but inescapable truth about our circumstances, however, is that there are countless others facing similarly dire medical situations which compete with those of the petitioners. Who is to say that it is those with renal disease, who require dialysis, rather than those with cancers, for instance, who require radiotherapy, who should be given priority in the provision of resources? If the court orders that those who need renal dialysis should be treated at the state's expense in private institutions, why not also those with equally serious illness for whom access to health care in public institutions is limited? This, in my view, is not the province of the court.

85. The court acknowledges that the petitioners are in a difficult and no doubt life-threatening situation, and that the state could and perhaps can do a lot better than it has done with regard to the provision of health care and ensuring access to citizens, thus realizing its obligation with regard to the right to health. Given, however, that the failure by the petitioners to access dialysis treatment as and when they want it and at a cost that they can afford arises from limited resources as has emerged from the pleadings, I am unable to find a violation of the rights of the petitioners under Articles 26, 27, 28 and 43 of the Constitution, and I am therefore unable to issue any of the orders that they seek.

86. The ideal situation is one in which the petitioners and the many other patients with renal failure access medical dialysis at a frequency that suits their health needs, and at a cost that they can afford, and that they do not have to be subjected to long queues and waiting times. It would also be ideal if the 3rd respondent had the capacity to cover all the medical expenses for its contributors. But we do not live in an ideal world, and the court must allow the policy makers to make appropriate decisions.

87. The petitioners have referred the court to decisions from Argentina and Ecuador in which the court made decisions, some with timelines, within which to take certain medical decisions. I think these decisions can be distinguished from the present circumstances. The Argentinian case of **Mariela Viceconte –vs- Ministry of Health and Social Welfare (supra)** related to the manufacture of a vaccine, while the Ecuadorian case of **Mendoza and Ors –vs- Ministry of Public Health (supra)** related to the re-starting of a HIV programme that had been terminated.

88. It would be to issue orders in vain, in my view, for the court to attempt to tell the state that it must have a certain number of dialysis machines at a certain period in time or that it must ensure access to these machines in private institution when the court cannot determine the availability of resources, or what impact the diversion of resources to meet the petitioners' individual demands would have. I say this while appreciating the dearth of information supplied by the parties, particularly the 1st respondent, in relation to its policies and budgets for health vis a vis other sectors, but bearing in mind also the limitations of the court in making a determination on what is appropriate expenditure in the various sectors for which the state is responsible.

89. The petitioners urged the court to be guided by the decision of the Constitutional Court of South Africa in the case of **Treatment Action Campaign (supra)**. However, in that case, while the court did order the removal of restrictions on the use of Nevirapine to avoid mother to child transmission of HIV in public hospitals and clinics which were not research sites, it did recognize the limitations of the court in such matters. It observed at paragraph 35 and 36 of the judgment that all that can be expected of the state in matters relating to access to socio-economic rights such as the right to health is that it acts reasonably to provide access to the socioeconomic rights guaranteed under section 26 and 27 of the South African Constitution. It further stated, at paragraph 37 and 38, that:

[37] ***It should be borne in mind that in dealing with such matters the courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum-core standards called for by the first and second amici should be, nor for deciding how public revenues should most effectively be spent. There are many pressing demands on the public purse. As was said in Soobramoney: "The State has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society."***

[38] ***Courts are ill-suited to adjudicate upon issues where court orders could have multiple social and economic consequences for the community. The Constitution contemplates rather a restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions achieve appropriate constitutional balance.*****"**

90. In the present case, I am satisfied, on the material before me, that the measures taken by the respondents to ensure access to haemodialysis by the petitioner are reasonable in the circumstances. I am not therefore able to issue the orders that the petitioners seek. Their petition is therefore dismissed, but with no order as to costs.

Dated Delivered and signed at Nairobi this 28th day of January 2015

MUMBI NGUGI

JUDGE

Mr. Tanui instructed by the firm of Manyonge Wanyama & Associates Advocates for the 1st -21st petitioners

Mr. Kabaru instructed by the firm of Kabaru & Co. Advocates for the 22nd petitioner

Mr. Mohamed instructed by the State Law Office for the 1st respondent

Mr. Sifuma the firm of Nyachae & Ashitiba & Co. Advocates for the 2nd respondent

Mr Kashindi instructed by the firm of Munyao Muthama & Kashindi & Co. Advocates for the 3rd respondent