# *REVIEW AND REFORM OF SOUTH AFRICAN HEALTH LEGISLATION*

*by*

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8 LAW

SUMMARY

# REVIEW AND REFORM OF SOUTH AFRICAN HEALTH LEGISLATION

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The transformation of the South African health care system necessitates a comprehensive review and revision of existing legislation pertaining to health. The purpose of this dissertation is to contribute towards the review and reform of South African health legislation, by providing a basis on which to critique and evaluate legislative problems and issues which confront policy-makers and legislators who are responsible for reforming the health system.

The structure of the proposed new KwaZulu-Natal Health Act provides a useful framework through which to examine existing legislation and to investigate legislative problems and issues requiring consideration. Key features of the proposed Act include issues which have traditionally received little or no consideration in South African legislation, such as: provision for community participation and intersectoral collaboration in the provision of health services; recognition of a right to health services and of the rights and duties of health service users; and statutory provision for health promotion programmes. Many other issues identified for inclusion in the proposed Act are subject to existing statutory provisions, but in many instances these laws are either obsolete and inadequate to deal with contemporary problems experienced in the health sector, contradictory, inappropriate in the light of policy articulated by the new government, unenforceable or ineffective, or in some instances even inhumane.

The critical evaluation of legislative options for reform of the health system requires an adequate understanding of past legislative experience, current legislative initiatives, and the constitutional dispensation within which reform is taking place. At the same time, it is necessary for legislators and policy-makers to appreciate the ambit of public health law, its functions, and its importance to the health system.

The relationship between law and health has until now not been fully appreciated in South Africa, resulting in the oversight of significant opportunities for legislative intervention to promote health.

Evidence of the expanding influence of law on health care is found in the fact that health law is no longer merely a national phenomenon, but has an increasingly significant international dimension. The latter half of the twentieth century has seen a proliferation of international legal instruments which impact on a wide range of health-related matters.

Five broad functions of health law may be identified, namely: recognition of health care as a basic human right; specification of the respective rights and duties of people participating in health activities; prohibition or regulation of harmful and unhealthy conduct; regulation of the production and provision of health resources; and the establishment of programmes to promote health.

There are several factors extraneous to legislation which may negate the capacity of legislation to successfully promote and protect health, including: a blanket policy of deregulation; industry pressure; failure of government to articulate policy; inadequate implementation; and perverse effects of laws.

The successful development of health law in South Africa will only be possible if initiatives to introduce health legislation reform go hand in hand with a broader move towards greater integration of the disciplines of health and law, and development of capacity for research and training in health law.

An appreciation of past legislative experience is also of crucial importance in that it facilitates the critical appraisal of contemporary options within an historical context. Historically, the South African health care system has been characterised by fragmentation. This fragmentation has been underpinned and indeed perpetuated by legislation. The development of health care legislation underpinning the health system, since Union in 1910, is described within the context of five principal, though related, manifestations of this fragmentation.

*i. Structural fragmentation.* At the time of Union in 1910, health care in South Africa was characterised by absence of an encompassing control structure, and a split between curative and preventive functions under separate controlling bodies. The opportunity for creating a unified health care system, which arose from a unified political framework, was missed. Furthermore, the subsequent Public Health Act of 1919 (which would remain the basis of health service administration in South Africa for almost six decades) had serious inhibiting consequences for an

attempt to establish a unitary health system and central co-ordination of health care in South Africa.

Growing dissatisfaction with the lack of a comprehensive approach to national health needs culminated in the 1944 National Health Services Commission (Gluckman) Report, which recommended a unitary National Health Service for South Africa. The Service would be co-ordinated by a central health authority with strong regional powers, and would ensure the free provision of adequate medical, dental nursing and hospital services for all sections of the people of the Union of South Africa. Implementation of the Service would be facilitated by the introduction of a new National Health Act to supersede the Public Health Act of 1919. However, despite the formal adoption of the Gluckman Report by the government of the day, it was never implemented.

The 1919 Public Health Act was repealed by the Health Act, 1977. While the Act was successful in certain respects, fragmentation caused by the three tiers of authority and services remained unaddressed, and were in fact perpetuated and reinforced by the Act. This was acknowledged by the report of the (Browne) Commission of Inquiry into Health Services (1986).

Various health plans were introduced in the 1980's and early 1990's in an attempt to resolve these problems and a further attempt at better co-ordination of health services was made by the National Policy for Health Act, 1990. However, these initiatives achieved little to diminish the pervasive fragmentation in the control and rendering of health services at the various tiers of government.

Through the African National Congress (ANC) National Health Plan, and the Reconstruction and Development Programme (RDP), the new South African government has now expressed its intention to create a comprehensive, equitable and integrated National Health System. A single governmental structure will establish national policies, priorities and standards, and will co-ordinate all aspects of public and private health care delivery, while actual management of the delivery of services will be decentralised to provinces, districts and institutions. The intended National Health System will be created through legislation and regulation.

*ii. Professional fragmentation.* Laws regulating health professionals in South Africa are the product of piecemeal development of legislation, which responded

to exigencies which arose from time to time. This has resulted in a system of statutory bodies regulating the various professions which is not conducive to sound human resource management, and is in urgent need of review.

The Medical, Dental and Pharmacy Act of 1928 unified provincial medical bodies and established a single South African Medical Council (representing doctors, dentists, nurses, midwives, masseurs and other auxiliary medical personnel) and a single South African Pharmacy Board.

In 1944, a separate Nursing Act was passed to represent the interests of the nursing profession, despite concerns raised at the time that separation of the Nursing Council from the South African Medical Council would result in counterproductive fragmentation and a lack of co-ordination of the health professions. Subsequent legislative developments further entrenched the autonomy of the Nursing Council.

Fragmentation of control of the health professions continued with the passing of the Dental Mechanicians Act, 1945, apparently to restrict the scope of practice of dental mechanicians in order to protect the domain of dentists.

In 1974, the 1928 Act was replaced by the Medical, Dental and Supplementary Health Service Professions Act and the Pharmacy Act. These Acts respectively provided for the establishment of the South African Medical and Dental Council, and the South African Pharmacy Board (subsequently called the South African Pharmacy Council). The splitting of the legislation was motivated by a desire to enhance the image of the pharmacy profession, even though it was acknowledged by the Minister of Health at the time that the principles of the control measures over pharmacists were the same as those over medical practitioners and dentists.

Further fragmentation of the regulation of health professionals was caused by a consistent refusal of the South African Medical and Dental Council to register any persons practising alternative forms of healing, despite the fact that it was legally entitled to do so. This resulted in the Chiropractors Act, 1971, followed by the Homeopaths, Naturopaths, Osteopaths and Herbalists Act, 1974, and the Associated Health Service Professions Act (which later was renamed the Chiropractors, Homeopaths and Allied Health Service Professions Act).

Legislation was also implemented to racially divide health professions, in line with policies of apartheid. A 1957 amendment to the Nursing Act, for example, statutorily entrenched racial segregation and white control of the nursing profession. Other legislation regulating the health professionals made South African citizenship a prerequisite for membership of the respective Councils, which effectively excluded black people living in the "homelands" from serving on the Councils of the professional bodies. This gave rise to the creation of new statutory bodies to represent health professionals in some of these areas.

The fragmentation of the statutory bodies which has resulted from the homelands policy is currently being addressed by legislative amendments introduced in 1995. However, when considering the improvement of human resource planning and management system in terms of the development of a National Health System, attention needs to be given to further consolidation of the statutory bodies into an umbrella Council for health professionals.

*iii. Racial fragmentation of health services.* The organisational structure of the South African health system in the period since Union was characterised by increased racial fragmentation in health care.

Any hope of implementation of the Gluckman Report's recommendation of a unitary National Health Service for all sections of the people of the Union were crushed by the publication in 1954 of the Tomlinson Report, which recommended the creation of a separate "Bantu Health Service".

The Tomlinson report was followed, in the late 1950s, by the creation of ten national states. The homeland policy grossly increased fragmentation of health services by creating ten separate geographical units, and adding ten additional State departments of health at the first tier of government. The process of reintegration only commenced with the introduction of the Constitution of the Republic of South Africa Act 1993.

Racial fragmentation of health services was also perpetuated by the 1983 Constitution, in terms of which separate Departments of Health were created for white, Indian and coloured people. Together with the existing central Department of Health and the ten homeland departments, the 3 additional "own affairs" health departments brought the total number of health bureaucracies in South Africa to

fourteen. These administrations existed until the end of March 1993, when they were dissolved by Proclamation.

*iv. Administrative fragmentation.* At least one hundred and three statutes of the Republic of South Africa impact on the health of, and the provision of health services to, the inhabitants of South Africa. These statutes are administered by twenty-two government departments. Such extensive administrative fragmentation and divided control of legislation is not conducive to the implementation of uniform health policy.

This problem is perhaps most acute and therefore best illustrated by the division of administrative control of occupational health legislation among several government departments. This resulted from development of different legal instruments for workers' compensation, on the one hand, and regulation of working conditions, on the other. A further distinction was made between regulation of the mining and non-mining sectors.

The report of the (Erasmus) Commission of Inquiry into Industrial Health (1976), found that fragmented control of occupational health was responsible for weaknesses and shortcomings in the control exercised by each individual authority, and resulted in a piecemeal development of legislation which is prone to gaps and to overlapping. A primary recommendation of the Commission was that overall control over all occupational health in the Republic should be assigned to the Department of Health, by means of a single Industrial Health Act. This recommendation was not put into effect. Five years later, the Nieuwenhuizen Commission recommended integration of the dual system of compensation prevailing in South Africa (a system for miners and a system for other industrial workers) under a single Compensation Act.

While occupational health legislation has developed substantially since the Erasmus and Nieuwenhuizen Commissions, these reforms have failed to comply with the Erasmus Commission's recommendations of a single Industrial Health Act administered by the Department of Health, or even the goal of a co-ordinated response to Occupational Health and Safety issues. The Nieuwenhuizen Commission's ideals of a single compensation system have similarly remained illusory. Occupational health legislation remains fragmented between aspects of prevention and compensation. Furthermore, South African occupational health

legislation continues to follow two parallel tracks, one covering the mining industry, and the other dealing with non-mining industry, commerce and services. There remains a disturbing lack of clarity on the interrelationship between the functions of the Departments of Health, Labour and Mineral and Energy Affairs in respect of occupational health.

While acknowledging the continued state of fragmented administration of occupational health legislation, together with the attendant problems which so concerned the Erasmus Commission, the (Leon) Commission of Inquiry into Safety and Health in the Mining Industry reported in 1995 that it would be premature at this stage to consolidate departmental control of occupational health and safety issues. The Commission was, however, of the opinion that when the law in mining is put into a satisfactory state, a move into a larger umbrella health and safety organisation might be appropriate.

There are also other positive signs that greater attention will now be given to a co-ordinated approach to occupational health legislation, including Cabinet approval for a working committee of relevant "role players" to investigate the creation of an exclusive national occupational health and safety council to develop overall national policy on occupational health.

*v. Fragmentation between public and private sectors.* A dual system of health care provision has developed in South Africa between the private and the public sectors, resulting in inequities in levels of service provision. This dichotomy of service provision was actively promoted by former governments. The current ANC-led government has declared its intention to narrow the divide between the private and public health sectors, and to restructure the private sector so as to enhance its important role in improving the health of the nation under the new National Health System.

This new government policy requires a review of the legislation which regulates health service provision in the private sector. This legislation regulates the establishment and running of private hospitals, on the one hand, and health care financing through medical aid schemes, on the other. A review of this legislation demonstrates that it has contributed to the fragmentation that pervades the health system in that it has resulted in inadequate and inappropriate controls on a rapidly expanding private sector.

Clearly, the introduction of appropriate health legislation will be crucial in welding the fragmented pieces of the South African health system into the National Health System envisaged by the new Government.

It is also important to consider the constitutional dispensation within which the development of South African health legislation must take place. The Interim Constitution, which came into effect on 27 April 1994, had profound implications for health.

The Interim Constitution established a new political framework by the creation of nine new provinces. This has significant implications for public sector health services, which need to be reorganised according to the new boundaries, with resultant transfers of staff, facilities and budgets to the new provincial administrations. Health services are made a provincial legislative and executive competence. In effect, provinces may develop their own health systems within national guidelines and norms. Further, while both provincial legislatures and the national Parliament may legislate on health services, to the extent that there is conflict, the provincial laws will prevail, subject to limited exceptions. Local government is also a provincial legislative competence. This has important health implications because local government will continue to play a pivotal role in health service provision.

From a legislative perspective, ten separate Health Acts may develop in South Africa - one national and nine provincial. Unless this process is carefully managed and properly co-ordinated, administrative chaos and increased fragmentation of the health system may ensue.

Also of critical importance to the formulation of health policy and its implementation through legislation, is Chapter Three of the Interim Constitution which contains the Bill of Fundamental Rights. Although there is no specific mention of a general right to health, some of the rights do have *direct* relevance to health. These include: the right to a healthy environment; the right of every child to basic health and social services; the right of detainees to medical treatment at state expense; and the right to protection of dignity. Many of the other rights in the chapter may also have *indirect* impact on health. These include: the right to equality; the right to life; the right to property; the right of access to information held by the State; and the right to personal privacy.

In the light of current initiatives to draft a new and final Constitution, two recommendations are made for the final Constitution based on the need for a broader approach to health promotion that includes legislative action. First, it is recommended that an additional right of every person to "health services" be included in the new Constitution. Secondly, it is recommended that a provision should be introduced into the Constitution which addresses the concern that the implementation of legitimate government policies to advance the common good may be jeopardised by competing individual rights.

In considering the ongoing reform of South African health legislation, it is also useful to assess processes for legislative reform which have been initiated at national and provincial levels since the elections of 27 April 1994, in order that further legislative development should take place with the benefit of hindsight, aware of strengths and weaknesses of what has already been done.

Initiatives to develop a new national Health Act began in early 1994, when the ANC initiated a process of drafting provisions of new health legislation, in order to facilitate the smooth transition of the health system after the elections. The initiative appears to have met with opposition from bureaucrats of the old Department, and it fell through.

This was followed in early June 1994, when two draft Health Bills of uncertain origin were circulated for discussion within the Department of Health. Both drafts were in many respects a clumsy attempt to rework the old 1977 Health Act to accommodate the concept of a district health system, and did little to bring the Act into line with current policy and with modern international trends and concepts of health. The Bills were destined to fail because they purported to deal with contentious policy issues on which there was no clarity, and they appeared to give little consideration to the dictates of the Interim Constitution. A potential crisis was avoided, as the Bills were withdrawn.

The Minister of Health subsequently appointed the National Health Legislation Review Committee to review all national health legislation and to assist in writing a new Public Health Act. The progress of the Committee was initially hampered by insufficient provincial representation, and by inadequate integration of policy and legislative development. The teething problems of the Committee were gradually addressed, and by mid-1995, the Committee had made notable progress.

At a provincial level, the formulation of new health legislation after the April 1994 elections became the responsibility of Strategic Management Teams (SMTs) which were created in each provincial ministry to advise the Members of the Executive Councils and to manage the transition. The KwaZulu-Natal SMT adopted the most comprehensive approach to legislative reform, and this experience is related in detail. The approach adopted by the Western Cape SMT is briefly described as a point of comparison.

The Western Cape SMT undertook an extensive task of drafting a detailed provincial health implementation plan for the province, with the widest possible participation of all relevant role-players in the province. It was anticipated that a framework document crystallised from this draft Provincial Health Plan would be developed as a White Paper, on which draft legislation would be developed for health services in the province.

The KwaZulu-Natal SMT, on the other hand, appointed a health legislation task-force in September 1994 to: identify legislation which should be incorporated into the new KwaZulu-Natal Health Act; develop a framework for a provincial health Act; and commence drafting the new legislation.

The first task which the committee undertook was to develop a set of principles which would underpin the formulation of the new Act. One of the principles accepted was that it would be preferable to develop a new Health Act, rather than merely attempting to revise existing laws in an *ad hoc* manner. A relatively comprehensive framework for the new Act was developed, based on a review of international health laws. The development of a legislative framework was followed by a review of existing legislation which impacted on health. The laws were then categorised in relation to the relative directness of their application to health and health services.

To guide the process further, an Action Plan was framed at the beginning of November 1994, which incorporated the intended activities of the committee for the next 8 months. In accordance with the Action Plan, a process of widespread public consultation was initiated, inviting comments on the proposed framework for the new Act. Submissions were received from a wide spectrum of interest groups, demonstrating significant public interest in the development of the Health Act. Comments were incorporated into the framework wherever appropriate.

Legislative drafters were selected from organisations representing predominantly black lawyers. This was a significant opportunity for capacity development as black lawyers have traditionally been excluded from legislative drafting in South Africa. While drafting, principles of plain language drafting were adhered to, in order to make the law as accessible as possible to its intended audience. Sources which were used while drafting included: existing South African legislation (pertaining to health and otherwise); international legislative precedent; legislative proposals made by various interest groups; and articulated policy.

The Health Legislation Committee of the KwaZulu-Natal SMT has now formally disbanded, and will be re-established under the new Department. The new Committee will have the responsibility of completing the process.

Several important lessons can be learnt from national and provincial legislative processes thus far, including: the danger of legislating where outstanding policy issues remain unaddressed; the desirability of integrating policy-making and legislative processes; the need to involve all major role-players from as early in the legislative process as possible; the importance of maintaining sufficient co-ordination and ongoing collaboration between legislative initiatives at national and provincial levels; the advantages of community participation in the legislative process; and the critical need in South Africa for comprehensive reform of health legislation, and not merely cosmetic changes to existing laws.

Finally, it is noted that while the formulation of appropriate health legislation is crucial, adequate enforcement and implementation are also vitally important to the success of health law initiatives. Innovative methods need to be investigated for proper enforcement of public health laws, and for generating public awareness on the content of the laws that affect them.

If comprehensive reform of South African legislation takes place, this will be a major contribution to the implementation of the Reconstruction and Development Programme, and the experience gained will have potential to serve as a useful model for other countries in the process of political and health system transition.

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# CONTENTS

# PREFACE

The 27 April 1994 saw the dawning of a new era in which all South Africans became entitled to a common South African citizenship in a sovereign and democratic state. Political transition brought with it the promise of a better life for all citizens of South Africa as apartheid policies and racist legislation were relegated to the annals of history, and as the process of reconstructing a society torn by discrimination, prejudice and inter-racial strife commenced.

The South African health care system was not immune to the destructive policies of the past, and has developed in a fragmented and often poorly co-ordinated manner. This has adversely affected the equitability, affordability, accessibility, effectiveness, efficiency and appropriateness of the South African health care system.

The new South African government has identified the improvement of health care as a fundamental component of its Reconstruction and Development Programme. In July 1995, the government also unveiled plans to implement a National Health Insurance System, in terms of which all permanent residents of South Africa would be guaranteed access, on equal terms, to all services provided by a publicly funded Primary Health Care System.[1]

The transformation of the health care system in accordance with articulated policy necessitates a comprehensive review and revision of existing legislation pertaining to health, particularly in light of the fact that existing legislation has in large measure underpinned and supported the distortion of the South African health care system. Unless this legislative change is carefully managed and properly co-ordinated, there is a danger that the transition of the South African health system will degenerate into administrative chaos and that increased fragmentation will ensue.

The purpose of this dissertation is to contribute towards the review and reform of South African health legislation, by providing a basis on which to critique and evaluate contemporary legislative problems and issues which confront policy-makers and legislators who are responsible for reforming the health system.

A central component of the dissertation is therefore a description of existing health legislation and of some of the critical legal and policy issues which require consideration in the comprehensive reform of South African health legislation, together with recommendations for legislative change.

This aspect of the dissertation is dealt with most extensively in Chapter Five, which is a broad overview of existing health legislation which requires consideration when reviewing health legislation with a view to its reform. It is intended that the Chapter will problematise some of the issues involved, generate discussion on them, and provide possible solutions to some of them. A number of the issues are considered in the light of international precedent or articulated policy options. The discussion is based on the framework for the new KwaZulu-Natal Health Act, which was released for public comment in January 1995. This framework has been selected as the point of departure because it is the most comprehensive framework to have been considered in legislative processes thus far, and therefore encompasses a wide range of issues which require consideration in the review and rationalisation of health legislation in South Africa.

While this dissertation is essentially forward-looking, in that it is primarily aimed at contributing to the further reform of South African health legislation, it is acknowledged that proper management of legislative development requires an adequate understanding of past legislative experience, current legislative initiatives, and the constitutional dispensation within which these initiatives are taking place.

An appreciation of past legislative experience is of crucial importance to policy-makers and legislators in that it facilitates the critical appraisal of contemporary options within an historical context. Through historical analysis, it is possible to avoid the mistakes and build on the successes of the past. For this reason, Chapter Two traces the development of South African health care legislation since Union, in 1910. The point of departure for this analysis is the fragmentation which has pervaded the rendering of health care services in this century. Five principal, though related, manifestations of this fragmentation are investigated with a view to determining the extent to which health legislation in South Africa has contributed to this fragmentation.

Having considered the historical background to South African health legislation, the focus of the dissertation shifts to a discussion of the constitutional dispensation within which current development of health legislation is taking place. Chapter Three of the dissertation considers the implications of the Constitution of the Republic of South Africa, 1993 (Act No. 200 of 1993) for the development of new health legislation. Perhaps the most important of these implications is the creation of a dichotomy of legislative powers between national and provincial levels.

The first tentative steps towards the exercise of these powers at national and provincial levels between the time of the April 1994 elections and June 1995 are described in Chapter Four. Although the legislative processes are in many respects only in their nascent phases, it is considered important that the early developments are not lost in the evolving process. Even at this early stage, an analysis of the success of some initiatives and the failure of others provides useful lessons which, if applied, can facilitate the success of further initiatives.

The overview of South African legislative development - past, present and future - is couched within a broad theoretical framework of what public health law is, its importance to a health system, and why it is necessary to develop academic and research capacity for it in South Africa. The thesis therefore begins with a discussion of the relationship between law and public health.

This dissertation is written in the hope that it may in some modest way contribute to the successful and smooth transformation of the South African health system through legislative change. Most importantly, it is intended as a contribution to knowledge in an area of law which has until now been largely neglected in academic debate and in the training of lawyers and health personnel, and thereby to provide a resource which may be constructively used by persons and bodies who are charged with reviewing existing health legislation and formulating new legislation.

# CHAPTER ONE

# THE INTERFACE BETWEEN HEALTH AND LAW

## 1.1 INTRODUCTION

The relationship between law and health is not fully appreciated in South Africa. This results in the oversight of significant opportunities for legislative intervention to promote health. One of the leading United States experts in health law, Frank Grad of Columbia University, has noted that:

> *The reach of public health law is as broad as the reach of public health itself. Public health and public health law expand to meet the needs of our society.*[2]

The significance of this statement can be perceived only with an appreciation of the ambit of public health itself. One of the founding fathers of the discipline, C.E.A. Winslow, provided the following definition:

> *Public Health is the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual a standard of living adequate for the maintenance of health; organising these benefits in such a fashion as to enable every citizen to realise his birthright of health and longevity.*[3]

Health law is that part of the law that concerns medical science and health care - curative, preventive and promotive - and the position of the individual in that regard. It is based on the basic rights of individuals and society, with rights of the patient and the right to health care being central. Health law relates to the consequences of health care and medical treatment in a social context.[4]

Apart from the legal position of the patient with respect to that of the health professional, health law also concerns regulation of the structure and functioning of the health system. The medical, nursing and allied health professions, which comprise the human resources of the health system, may be regulated in relation to: training; qualifications; professional ethics; scope of practice; and control over the quality of care rendered. Financing of health services through user fees, medical aid schemes and health insurance may be subject to special controls. Physical resources of the health system, such as hospitals, drugs and medical equipment, may be subject to regulation relating to, for example: geographical distribution; pricing, and safety controls.

The potential of legislative intervention to promote health may be demonstrated by reference to certain specific examples.

Legislation regarding alcohol, tobacco and drug abuse is a case in point. A recent World Health Organisation (WHO) document states that the introduction of appropriate legislation is necessary for the success of national efforts in the treatment of substance abuse in persons.[5] Legislation regarding substance abuse is typically directed at the source of the product, its distribution, promotional advertising, the age groups who may buy it, the places at which and the means by which it is sold and the manner and quantity in which it may be used.[6] At the same time, effective national legislation helps to achieve treatment programmes for drugs, tobacco and alcohol dependence. Ruth Roemer, Professor of Health Law at the University of California and head of WHO's Tobacco Control Legislation Committee commented that:

> *Legislation is one of the strongest weapons to combat the world's smoking epidemic. Laws establish government policy on the use of tobacco, enlist the resources of government departments, strengthen activities of voluntary agencies, energise citizen groups, and contribute to the development of a smoke free environment.*[7]

Significant protection may be provided for the health of consumers by the introduction of appropriate food laws. Opportunities exist to contain the spread of disease and to prevent contamination by setting hygiene requirements governing buildings, rooms where food is prepared, treated, stored or processed; transport; equipment; personal hygiene; food waste and water supply.

Occupational health legislation is another area which holds enormous potential for health promotion strategies. The traditional approach to occupational health legislation has been to limit its application to specific sectors of the economy, in particular to industrial undertakings, and only protect workers from industrial injuries and occupational diseases. Recent approaches in the European Economic Community indicate a more comprehensive approach to the goals and scope of occupational health legislation.[8] Some of the new laws cover not only employees but all persons present in the place of work or in its immediate neighbourhood as well as the self-employed.

The involvement of the law and the legal system in the planning, financing, delivering and monitoring of health care is not a recent innovation. On the contrary, legal involvement in health care is a matter of long and respected standing, demonstrable at least as far back as Plato's time. It is undeniable, however, that the influence of law upon the delivery of health care is greater today than ever before.[9]

## 1.2 INTERNATIONAL HEALTH LAW

Evidence of the expanding influence of law on health care is found in the fact that health law is no longer merely a national phenomenon, but has an increasingly significant international dimension. The latter half of the twentieth century has seen a proliferation of international legal instruments, such as treaties and conventions, which impact on a wide range of health-related matters.[10]

Many international human rights instruments contain provisions designed to ensure the general protection of public health. Some examples are reproduced below.[11]

Paragraph 1 of Article 25 of the Universal Declaration of Human Rights (1948) provides:

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*

Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) states that:

> *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 realisation of this right shall include those necessary for:*
> *(a) the provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;*
> *(b) the improvement of all aspects of environmental and industrial hygiene;*
> *(c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
> *(d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.*

Article 16 of the African Charter on Human and Peoples' Rights (1981) provides:

> *1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.*
> *2. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.*

Many specific health-related issues have also become subject to regulation by international law in the past few decades. Examples of such issues are: health research and technology[12]; nuclear energy[13]; chemical safety[14]; patients' rights[15]; control of communicable diseases[16]; HIV/AIDS[17]; pharmaceuticals, medical devices and cosmetics[18]; blood and blood products[19]; food safety[20]; infant feeding and nutrition[21]; organ transplantation[22]; control of narcotics and psychotropic substances[23]; occupational health[24]; reproductive health[25]; health of detainees[26]; and mental health[27].

International health law is becoming increasingly important for South Africa in the light of its normalised relations with various international agencies and the resultant obligations under international conventions. The South African legislature and the

Department of Health must now take these obligations seriously, by implementing the relevant international and regional instruments through legislation and other measures appropriate to the national context.

## 1.3 FUNCTIONS OF HEALTH LEGISLATION

While the ambit of health law is exceptionally broad, five broad functions of health law may be identified which are generalisable. These functions are discussed below, and are illustrated by examples of legislative provisions which have been adopted in the legislation of various jurisdictions.

### 1.3.1 Recognition of health care as a basic human right

Section 29 of the Constitution of the Republic of South Africa Act 1993 (Act No. 200 of 1993), guarantees every person "the right to an environment which is not detrimental to his or her health or well-being", while section 30(1)(c) guarantees that "[e]very child shall have the right to security, basic nutrition and basic health and social services".

Many countries have more explicitly enshrined the right to health or health protection in their constitutions.[28] Other countries have given statutory recognition to the right to health in their general health laws. Section 1 of the 1991 Health Code of Honduras, for example, makes health (which is defined as a state of complete biological, psychological, social, and ecological well-being) an inalienable human right. It states further that it is the duty of the State, as well as of all natural and legal persons, to promote its protection, restoration and rehabilitation.[29] Greater specificity in defining the right in legislation may assist parties wishing to have recourse to this right. Section 2 of Mexico's General Law on Health, for example, lists seven objectives of the right to health protection, including: the prolongation of human life and the improvement of its quality; and the protection and enhancement of values that contribute to the establishment, conservation, and enjoyment of health conditions that in turn enhance social development.[30]

Additional effect can be given to the right to health by defining the content of the right in practical terms. Section 5 of Bolivia's Health Code lists eight specific rights encompassed within the general right to health. These include: the right to obtain care from any public or private medical service in cases of emergency, irrespective of economic considerations or the medical system to which the patient belongs; the right of children, disabled persons, and the elderly to obtain special health services; the right of women to obtain antenatal and postnatal medical examinations; and the right to information from the Health Authority on matters relating to the preservation, restoration and improvement of health. The advantage of such specificity is that it empowers, and indeed places an obligation on, authorities responsible for implementing the law to take the necessary steps to give effect to these rights.

### 1.3.2 Specification of the respective rights and duties of people participating in health activities

An interesting application of this function is the inclusion in general national health codes and laws of sections stipulating the rights and duties of users of health services in relation to health personnel and health administrations. Such sections have become a standard feature of many national health laws which have been promulgated over the past decade. Some examples of rights which have been protected in these laws are included below.[31]

Principle XIV of Portugal's 1990 Law Establishing Basic Principles with respect to Health establishes a "Users' Charter", embodying nine specific rights.[32] These include the following rights: to expect rigorous respect of confidentiality in regard to any personal data disclosed; to establish bodies responsible for representing and defending their interests; and to establish bodies responsible for collaborating with the health system, particularly in the form of associations for the promotion and protection of health, or "health establishment associations".

Title II (sections 4 to 52) of Quebec's 1991 Health Act is entitled "Rights of users".[33] Some of the rights included in this Title are broadly stated, such as the right "to receive, with continuity and in a professional manner, health services and social services which are scientifically, humanly and socially appropriate" (section 5), or "the right to participate in any decision affecting his state of health or welfare" (section 10). Other rights are more specific, such as the stipulation that

"English-speaking persons are entitled to receive health services and social services in the English language" (section 15). Other categories of rights include rights to: information; choice of professional and institution; emergency care from every institution; consent; representation in exercising rights; hospitalisation until the user's condition allows for discharge; legal remedy against providers of care who have culpably caused harm, which remedy cannot be waived; confidentiality; and user access to medical records.

When rights are conferred by legislation on users of health services, clauses are often included in the legislation which impose corresponding duties on users. Principle XIV of Portugal's 1990 law, for instance, stipulates various duties of users, including duties to: respect the right of other users; observe the rules concerning the organisation and operation of services and establishments; and pay the required costs. Section 11 of Spain's 1986 General Law on Health stipulates various obligations of citizens in regard to institutions and agencies of the health system, including duties to: assume responsibility for the proper use of the benefits provided by the health system; and to sign a voluntary discharge in cases of non-acceptance of treatment.[34]

### 1.3.3 Prohibition or regulation of harmful conduct

The generality of this function permits many examples. Legislation may, for instance, restrict the use of tobacco, alcohol, or other dependence-inducing substances. It may also set minimum hygiene standards for the conducting of businesses dealing with food or the disposal of waste. Medicaments which have not been tested or approved may be prohibited from use. Occupational safety standards may be imposed on industrial concerns. Health care which is being dispensed in a way which is harmful to the health of patients may fall foul of legislative standards for the provision of good quality care.

An interesting application of this function is the control of harmful advertising. This is an important mechanism to empower people to make informed choices about their own health and about potential risks to their health, and thereby to contribute actively to the creation and maintenance of their health. Title 13 of Mexico's 1983 General Law on Health[35] regulates advertising of the existence, quality, and characteristics, and for promoting the use, sale or consumption, whether direct or indirect, of articles for health-related purposes, alcoholic

beverages, and tobacco. It further regulates advertising that refers to health, the treatment of diseases, the practice of the health professions, and health products and services. Authorization is required from the Secretariat of Health for advertising which is restricted by the Law. Further, sections 306 and 307 lay down requirements with which affected advertising must comply. These include: the information contained in the message must be verifiable and not deceive the public as regards the quality, origin, purity, preservation, and properties in use of the products; the message must have an educational content; the message must not induce behaviour, practices, or habits that are harmful to physical or mental health that imply a risk or jeopardise the safety, physical integrity, or dignity of persons, in particular women; and advertising must not induce harmful eating habits, or attribute to industrially processed foods a value that is greater or different from that which they actually possess.

### 1.3.4 Regulation of the production and provision of health resources

Health laws typically stipulate licensing or other authorization requirements for the organisation, establishment, operation, staffing, equipment, construction, modification or siting of health facilities. Conditions for the issuance of such authorization are often laid down in regulations. Legislation may also determine basic educational requirements for health professionals to practise. Provision of private health care is often subject to extra regulation, the content of which is a matter of policy. Nova Scotia's Medical Services Act of 1989,[36] for example, was enacted to "prohibit the privatisation of the provision of certain medical services in order to maintain a single high-quality health-care delivery system for all Nova Scotians". Other countries have established laws imposing stringent licensing requirements on private health establishments,[37] while in certain jurisdictions private practitioners are specifically precluded from undertaking particular procedures or activities. Section 10 of Bulgaria's 1991 Order on the conditions and rules governing the private practice of medicine, for example, lists a number of activities which private practitioners may not perform.[38] These include: applying diagnostic and therapeutic methods entailing a temporary change in the individual's state of consciousness, subject to certain exceptions; treatment of patients suffering from certain communicable diseases; abortions; compulsory immunisations; and certain forms of advertising.

### 1.3.5 Establishment of programmes to promote health

This function provides further illustration of the empowering capacity of legislation, and it should dispel any notions of law as merely an instrument to prohibit or regulate undesirable conduct. A good example of this function is provided by Title 11 of Mexico's 1983 General Law on Health.[39] Chapters I, II and III respectively establish the Programme against Alcoholism and the Abuse of Alcoholic Beverages; the Programme against Smoking; and the Programme against Drug Dependence. The chapters authorise education, other preventive measures, treatment, and rehabilitative measures. They also authorise research into various aspects of the addictions mentioned.

## 1.4 THREATS TO LEGISLATIVE INTERVENTION FOR HEALTH

While legislation has significant potential to promote health there are several factors extraneous to legislation which may negate the capacity of legislation to realise these objectives successfully.

### 1.4.1 A policy of deregulation

The first such factor is an approach by government to the effect that regulation of economic activity is an evil which, though necessary to some extent, should be minimised wherever possible. Such a policy of deregulation informed a fundamental change in direction of the South African government's role in the economy in the 1980s. This policy was manifested for example, in the 1987 White Paper on Privatisation and Deregulation in the Republic of South Africa,[40] and the Temporary Removal of Restrictions on Economic Activities Act, 1986 (Act No. 87 of 1986), the purpose of which was ostensibly to promote the unfettered development of free enterprise in all areas by removing restrictive legislation. The White Paper was based on the premise that the approach to regulation was to emphasise the promotion of economic activities and be less directed towards control because regulation may have a restrictive effect on the development of private entrepreneurship, the promotion of competition and the creation of employment opportunities.

There are two major problems that arise in relation to this policy of deregulation. The first problem is that while deregulation is sometimes an appropriate means to achieve objectives of a more dynamic competitive business environment, seeing deregulation as an end in itself is dangerous. Minimising regulation is not always the key to healthy competition, but may in fact encourage the formation of monopolies. This is particularly pertinent in South Africa.

The second major problem of a policy of deregulation is that it tends to emphasise the state's role in promoting corporate freedom at the expense of the protection of the rights of the individual. Even former Minister of Transport, Minister E van der Merwe Louw, said that there is a thin line between freedom of action and abuse and that it will always be necessary to protect the public, employers and others to the extent that they are not in a position to protect themselves against abuse.[41] This statement was emphasised in the 1988 report of the Competition Board concerning health regulation of the production and distribution of milk. The report states that such regulation can only be directed towards the protection of the health of consumers and workers and should not have to further any other objective. The cost of regulation should, according to this report, always be weighed up against absence of regulation.

Commenting on the process of regulation in the United States, the Editor of the New England Journal of Medicine sums up this concern:

> *Laws and regulations are the inescapable corollary of universal access to health care. When citizen's rights are involved, only government can guarantee them.*[42]

### 1.4.2 Industry pressure

Another factor which may limit legislative intervention to promote health is that in the absence of significant outside pressure, government is unlikely to act where big business interests would be threatened. Pressure from industry may take the form of direct threats of financial withdrawal or other support of government initiatives. However, indirect pressure is also exerted. Financial largesse to educational and research institutions and to the media, enables industry to determine the content and direction of research; influence the publication and distribution of research data and the attitudes of opinion formers who are often

advisors to government; undermine critics; curry favour with the public and develop a favourable relationship with government. For example, a former Director General in the Department of National Health and Population Development commented that the tobacco lobby is the strongest lobby group in Parliament.[43] The influence of the tobacco lobby on government was again shown in 1994 when government scuttled plans to increase the tax on cigarettes to a great extent.

### 1.4.3 Policy must precede legislation

Thirdly, every law is an expression of policy and is a means by which to translate policy into action. Until and unless government adopts and clearly defines policy directed at promoting health, health legislation can not be formulated. New South African health legislation is therefore dependent on the articulation of clear policies on health by the new government. This process will be facilitated by the Reconstruction and Development Programme, which provides broad guidelines which are likely to be turned into policy directives. Among these are policies aimed at reducing substance abuse; promoting the overall nutritional status of the population; and ensuring that safe sex practices are promoted.

### 1.4.4 Inadequate implementation

The fourth such limitation is that in the absence of adequate implementation, laws purporting to effect social change will be ineffective. Implementation requires adequate and appropriate enforcement machinery. Serious questions arise whether the normal enforcement agencies such as the South African Police Services are appropriate to enforce public health laws. There are also severe constraints on the effectiveness of the environmental health officers such as a shortage of staff, a limited budget and dangers of corruption reported from other countries . Rather, innovative methods of ensuring proper enforcement need to be investigated such as contracting out certain enforcement functions to non-governmental organisations (as is the case in France), or the encouragement of local authorities to enforce health laws at a local level by linking enforcement to the provision of funds for certain health related programmes at local authority level.

### 1.4.5 Perverse effects

Finally, experience has shown that the purpose of the law and its actual effects do not always correspond. Polsby argues that the United States experience of gun control laws has been that not only do they not work, but they act perversely.[44] Legitimate users of firearms encounter intense regulation, scrutiny and bureaucratic control, illicit makers easily adapt to the new conditions and criminals have become better armed in comparison to non-criminals as a consequence of these laws. Similarly, Bakalar and Grinspoon argue that after 10 years of escalation, the US government's assault on illicit drugs has proved to be a costly failure and has resulted in misdirected resources, social tension, violent crime, ill health, compromised civil liberties and international conflict.[45] Thus, the perverse effects of legislation need to be carefully considered prior to implementing new forms of legislation.

## 1.5 RECOMMENDATIONS

On 15 May 1984, the Thirty-seventh World Health Assembly adopted resolution WHA37.17, of which operating paragraph 1(8) urges Member States to "consider the desirability of enacting health legislation incorporating the basic principles of health for all". This expectation is being met by the South African Department of Health, which has established a special task-force to formulate a new comprehensive, development-oriented Health Act.

While this initiative is both laudable and necessary, it is imperative that it go hand in hand with a broader move towards greater integration of the disciplines of health and law, and development of capacity for research and training in health law. Unless practitioners and scholars of the respective disciplines appreciate their capacity to complement each other, not only will health law fail to develop to its true potential in South Africa, but there is also a danger of growing conflict between the medical and legal professions. In the United States, medical practitioners are reported to be fearful of the legal system and antagonistic towards attorneys, whom they see as using the system to challenge doctors in their professional domain. While this may be attributed partly to increasing numbers of medical malpractice suits, analysts say that the relationship between doctors and lawyers suffers more fundamentally as the result of a mutual misunderstanding of

basic professional objectives and differing methods of problem-solving and reasoning.[46]

Two practical approaches may be adopted to facilitate the integration of the health and legal disciplines in South Africa.

i. *A Division of Health Law*

The first such approach would be to develop the legal advisory services of the Department of Health into a separate division with the specific task of monitoring all laws which might impact on health and of advising on legal issues and proposed reforms. All policy options of the Department would be scrutinised by such a division with a view to determining whether legislation could be effectively utilised to implement the policy. The Division would have the further task of monitoring legislation proposed by all other State Departments, with a view to identifying legal technicalities which might have negative impact on health, and possible modifications to the proposed law which would have substantial health benefit. Legislative precedent for such a division is found in Peru's 1981 Legislative Decree promulgating the law on the organisation of the health sector. This Decree stipulates that the General Legal Advisory Bureau is to form part of the organisational structure of the Ministry of Health, with the task of advising and reporting on technical and legal matters and providing such consultations as are requested by agencies of the Ministry.[47]

ii. *The introduction of health law as a discipline in academic institutions*

Secondly, health law should be introduced as a discipline in the educational curriculums of both health professionals and lawyers. Efforts to improve interprofessional relations must necessarily focus on eliminating the mutual distrust with which the professions view each other. Empirical studies have shown that a most effective method for reducing interprofessional misunderstanding is to increase the exposure each of the professions has to the roles, methods, and knowledge base of the other, preferably at a time when the members of the professions are forming the basic concepts of their own professional roles, that is, during law school and medical school. It has been observed that the failure of medical students to learn about law and law students to learn about medicine is one of the primary reasons that they are both so prone to interprofessional

prejudices.[48] A basic course in forensic medicine is insufficient to develop capacity for health law in South Africa, as the focus of forensic medicine is too narrow, and aspects of the law are taught without being contextualised within the broader structure and functioning of the legal system and its application to health care as a whole.

The integration of health and law, and the recognition of public health law as a discipline in academic institutions, is likely to be a long-term process. It is, however, essential that every opportunity is taken now to promote a greater understanding of the relationship between health and law, especially because such an understanding will greatly benefit the process of health system reform currently under way. It is hoped that this dissertation will to some extent contribute towards this goal, by generating a greater understanding of health law generally, and of South African health law in particular.

Chapter One has provided a broad theoretical introduction to health law in general. The focus now turns to the South African context, beginning with an analysis of the development of South African health care legislation, since Union in 1910. Lessons which may be derived from such an historical analysis provide a useful basis upon which to further develop South African health legislation.

# CHAPTER TWO

# SOUTH AFRICAN HEALTH CARE LEGISLATION SINCE UNION

## 2.1 INTRODUCTION

*With such a complex legislative and administrative background, with the distribution of responsibility between several layers of public authorities - central, provincial and local - and the dependence of curative services upon voluntary agencies, it is little wonder that the pattern of health services in the Union is confusion - (a "crazy patchwork").*

[Report of the National Health Services Commission 1944, p 12]

*There is an excessive fragmentation of control over the health services and a lack of central policy direction. This has led to misallocation of resources and to wasteful duplication of services. Largely as a result of this lack of central policy direction, there has been an underemphasis on preventive and primary health care and an over-emphasis on expensive secondary and tertiary health services, which is inappropriate to the needs of the South African community.*

[Final Report of the Commission of Inquiry into Health Services 1986, p 18]

*Health services are fragmented, inefficient and ineffective, and resources are grossly mismanaged and poorly distributed.*

[Reconstruction and Development Programme 1994, p 42]

The above three statements suggest that while pervasive fragmentation of health services has long been recognised as a fundamental flaw of the South African health system, the problem is as real today as it was fifty years ago. The development of legislation underpinning the health system, since Union in 1910, will be described within the context of five principal, though related, manifestations of this fragmentation. These manifestations are:

i. structural fragmentation of health service provision between central, provincial and local levels of government, and the concomitant division between the *loci* of curative and preventive services;

ii. fragmentation of professional bodies;

iii. racial fragmentation of health care;

iv. administrative fragmentation, in the sense that responsibility for control of different types of health services and administration of a variety of laws impacting on health rests with a host of government Departments - the development of occupational health services will be investigated as a prime example of administrative fragmentation; and

v. the sharply differentiated supply structure between the public and private sectors.

It will become apparent that health legislation in South Africa has contributed to the fragmentation which pervades the health system, and that significant legislative opportunities to implement a unified and well co-ordinated National Health System have been lost.

## 2.2 STRUCTURAL FRAGMENTATION

### 2.2.1 Union

At the time of the establishment of the Union of South Africa in 1910, health care in the four provinces was characterised by vague archaic policy arrangements, absence of an encompassing control structure, and a split between curative and preventive functions under separate controlling bodies.[49]

Unification did not bring noteworthy consolidation and integration of health care in South Africa, although a unified political framework created the possibility of a unified health care system.[50] The South Africa Act 1909 made only incidental reference to the health of the people of the new Union, and it did not repeal

colonial health legislation. Health care responsibilities of the four colonies were simply transferred to the four provincial administrations, while local authorities continued with the tasks entrusted to them in colonial times.

### 2.2.2 The Public Health Act 1919 (Act No. 36 of 1919)

The gross inadequacy of the legislative machinery for guarding the public health was brought forcibly home to the legislators by the influenza epidemic of 1918, which caused some one hundred and fifty thousand deaths in the Union of South Africa.[51] The following year, the Public Health Act, 1919 (Act No. 36 of 1919) was passed.

Significant developments were effected by the Public Health Act.[52] First, it created the new Ministry of Public Health and a National Health Council. Secondly it coordinated the public health legislation of the four provinces, and repealed previous public health legislation, substituting it with an excellent code for the control of infectious diseases and environmental sanitation. Thirdly, it placed specific *primary* responsibility for the public health of any area on the local authority of that area. Fourthly, it contained provisions for bringing pressure to bear upon provincial and local authorities, when necessary in the interest of public health.

The principal functions of the new Department of Public Health were: to guard against the introduction of infectious diseases into the Union from outside; to promote the public health and the prevention, limitation or suppression of infectious, communicable or preventable diseases within the Union; to advise and assist provincial administrations and local authorities in regard to matters affecting the public health; to promote and carry out research in regard to the prevention and treatment of human diseases; to publish reports and information relating to public health and epidemic diseases; and to assist the National Health Council in collecting information.[53] In addition to these duties, the Department occasionally was assigned, or adopted, wider executive functions in regard to public health.[54]

As before the Act, provincial administrations retained responsibility for the establishment, maintenance and management of general hospitals and charitable institutions, and were therefore associated with curative services. Local authorities, as agents of the Department of Public Health, were made responsible

for the control of contagious diseases and for environmental health in their respective areas of jurisdiction, costs being recoverable from the Department of Public Health.[55]

This division of responsibilities was a compromise between leaving the powers of the provinces and local authorities intact, and the radical solution of investing the new Ministry - as was the case then in Great Britain - with two-fold responsibility for health and local government.[56] In order to avoid conflict, interference with the independence of the provinces and local authorities was minimal.[57]

The Public Health Act was problematic in a number of respects. First, a limited conception of public health determined the provisions of the Act, namely that the proper function of the public health services was simply to ensure a sanitary external environment - which in practice meant non-personal health services and the effective control of infectious persons.[58] Such important matters as maternal and child health and dental services were not mentioned.[59] Secondly, the original purpose of the Act, which was to co-ordinate the supply of health care at a national level[60], was in principle defeated. Even after the demonstration, in 1918, by the great influenza epidemic, of the inadequacy of the health services of the country, the resultant Public Health Act failed to establish a national health authority with powers to deal with every aspect of national health and medical services. The control of general hospitals was left in the hands of four subnational authorities without any mechanism for co-ordination at the national level.[61] Those mechanisms that did exist for the Department to bring pressure upon provincial and local authorities were cumbersome, not very effective in actual application, and were rarely invoked.[62]

Although the Public Health Act was amended twenty-one times, it remained the basis of health service administration in South Africa for almost six decades.[63] The tripartite authority structure created a sharp rift between the *loci* of curative and preventive services, and resulted in each tier of authority wanting its own sectional interests and autonomy from the others, at the expense of the broader spectrum of health services. The 1919 Act thereby had serious inhibiting consequences for an attempt to establish a unitary health system and central coordination of health care in South Africa.[64]

### 2.2.3 The National Health Services Commission and its Gluckman Report

> *For many years, men and women in the forefront of the campaign against dirt, disease, ill-health, under-nourishment, overcrowding of dwellings and schools, badly-planned housing areas, insanitation, inadequate domestic water supply and other enemies of the individual and collective wellbeing, have sought to replace the existing unco-ordinated measures by some nationally-planned health service.*
> [Report of the National Health Services Commission 1944, p 3]

Throughout the period between the two world wars there was growing dissatisfaction, on the part of the general public as well as of the experts, with the lack of a comprehensive approach to national health needs, and an ever-deepening appreciation of the importance to national well-being of such an approach.[65] For example in 1931, Dr F A Napier, in his presidential address to the Medical Association of South Africa, said of a comprehensive State Medical Service:

> *It would meet the needs of the whole population, rich and poor. It would provide for a contented and secure profession, and would relieve the economic pressure on the patient and his doctor. It would give increased facilities for complete co-ordination between preventive and curative medicine under one control. It would be less expensive than the present system.*[66]

Further, during this period the poor health status of the population and the adverse effects on health of a poorly co-ordinated service were reiterated by various government Commissions.[67] Thus, when the National Health Services Commission was appointed in 1942 under the chairpersonship of Dr Gluckman, the concept of a national health service for South Africa was not entirely new.

The Commission was appointed by the Governor-General, following the Minister of Public Health's acceptance in the House of Assembly on 17 February 1942 of a motion to appoint a Commission "to investigate and recommend the best measures to be adopted for ensuring adequate health services for all sections of the population of the Union." The terms of reference and personnel of the Commission were gazetted on 28 August 1942. The Commission was appointed to inquire into, report and advise upon:

(1) the provision of an organised National Health Service, in conformity with the modern conception of "health", which will ensure adequate medical, dental, nursing and hospital services for *all* sections of the people of the Union of South Africa; and

(2) the administrative, legislative and financial measures which would be necessary in order to provide the Union of South Africa with such a National Health Service.[68]

The Commission made certain significant findings with respect to shortcomings in the organisation of South African health care.[69] First, health services lacked co-ordination. The report states that "hospital services, which represent the middle phase of the curative services, are variously administered in splendid isolation by four sets of provincial authorities, whereas the other phases are provided either by private agencies or by authorities other than provincial". Secondly, the provision of health services was grossly inequitable, and are "totally inadequate for the great mass of the people, to whom they are supplied, in the main, not according to their needs but according to their means". This problem was exacerbated by rampant private practice. Thirdly, too much emphasis was placed on curative services and institutional care, and not enough on prevention of disease, rehabilitation and community-based care.

The Gluckman Report recommended a unitary National Health Service for South Africa, which would ensure the free provision of adequate medical, dental nursing and hospital services for *all* sections of the people of the Union of South Africa.[70] The provision of these services would be financed by a national health tax. The health system would be co-ordinated by a central health authority with strong regional powers, which would assume direct control of personal health services, while all other public authorities would be relieved of the financial responsibility in connection with them. All non-personal health services would be devolved to local authorities, under the supervision of provincial authorities acting as ministries of local government. Democratic interests would be protected by representation of community, non-governmental organisations and health personnel at local, regional and national levels. The report included a detailed programme to implement the National Health Service.

One of the cornerstones of the programme for implementation of the Service recommended by Gluckman was the introduction of a new National Health Act to supersede the Public Health Act of 1919. The content of the proposed new Act is detailed in the report:[71]

> *First and foremost, a National Health Act will be required, in which it must be made clear that the State is now assuming responsibility for the provision of personal health services for all sections of the people. The Act must establish administrative machinery adequate for the discharge of this new function of the State. It must also make clear that the Provinces and the local authorities are henceforth relieved of all responsibility for personal health services, but remain responsible for non-personal health services. It must impose upon the Provinces the responsibility to supervise and, when necessary to assist financially the local authorities in the discharge of their obligations relating to non-personal health services; and must confer upon the national health authority powers of inspection and where necessary, the right of bringing pressure to bear upon a defaulting local authority. Finally the Act must make clear that a national health authority is advisory to all Departments in respect of any services carried out by them which have a bearing upon the health of the people.*

The National Health Act would be supplemented by an amendment of the Public Service Act providing for the creation of a separate National Health Service Personnel Commission and for the special method of its appointment, an Act enabling the Union Government to take over from the provinces the control of public general hospitals, and a Health Taxation Act.[72]

Despite the formal adoption of the Gluckman Report by the government of the day, it was never implemented. Van Rensburg *et al* cite several reasons for this.[73] First, the Smuts government was reluctant to implement it, in particular in so far as it involved encroachment on the powers of the provinces and the introduction of a national health tax. Secondly, there was intense resistance by the provinces. Thirdly, the medical profession opposed the report, as they feared losing professional autonomy and private practice and profit. The final reason was the coming to power of the National Party, whose interests were directly opposed to the recommendations of the Gluckman Commission. Once again, a valuable

opportunity was lost for the creation of a centrally co-ordinated, unitary health system in South Africa, supported by a sound legislative basis.

### 2.2.4 Health Act 1977

Until 1977, the 1919 Public Health Act dictated the organisational framework of South African health care. The Health Act 1977 (Act No. 63 of 1977) repealed the 1919 Act, and consolidated health legislation promulgated since 1919.

The 1977 Act was an attempt to address problems of: unco-ordinated division of responsibility and functions among the different health authorities at national, provincial and local levels of govt; an escalating degree of inefficiency and overlapping resulting from this division; a lack of uniform health policy; and a predominant emphasis on curative services at expense of prevention.[74] Several measures were adopted in the Act specifically to alleviate these problems.[75]

First, an attempt was made to rationalise the health system by a clear definition of duties, powers and functions of the respective health authorities. In terms of the Act, the central Department is responsible for overall coordination of services[76]; local authorities for preventive, promotive and rehabilitative services[77], thereby relieving them of all curative services; and provincial administrations for curative care and personal services in areas not served by local authorities.[78] See table 1 below.

Secondly, two bodies - the Health Matters Advisory Committee and the National Health Policy Council - were established to better coordinate health services between the tiers of authority, and to move closer to nationally co-ordinated health policy with a view to optimal use of available resources.

Thirdly, the Health Act attempted to shift emphasis in South African health care away from curative, hospital-based care to prevention of illness and promotion of health.

Fourthly, the Health Act provided special encouragement to the private sector to provide services freely and without unnecessary impediments, as part of a national effort.

Table 1

**FUNCTIONS OF CENTRAL, PROVINCIAL AND LOCAL AUTHORITIES**

**Central Department**

* to coordinate State health services with provincial and local authorities and to provide such additional services as are necessary to establish comprehensive health services for the South African population;
* to establish a national health laboratory service;
* to take steps for the promotion of a safe and healthy environment;
* to promote family planning;
* to provide facilities for, and to undertake, research in connection with any matter falling within the Department's functions; and
* to provide services in connection with the procurement or evaluation of evidence of a medical nature with a view to legal proceedings.

**Provincial administrations**

* to provide hospital facilities and services;
* to provide and co-ordinate ambulance services;
* to provide facilities for the treatment of patients suffering from acute mental illness;
* to provide facilities for the treatment of outpatients;
* to provide and maintain maternity homes and services;
* to provide personal health services, in certain instances in co-operation with local authorities; and
* to co-ordinate with the State, other provinces and local authorities to establish a comprehensive health service in the province concerned.

**Local authorities**

* to maintain their districts in a clean and healthy condition;
* to prevent the occurrence within their respective districts of any nuisance, or any unhygienic, offensive condition or harmful condition;
* to prevent the pollution of any water intended for the use of inhabitants of their districts;
* to render in their districts services for: the prevention of communicable diseases; the promotion of health of persons; the rehabilitation of persons cured of any medical condition; the treatment of diseases and injuries which are normally treated by a general practitioner♪; and the provision of essential medicines♪; and
* to coordinate these services with due regard to similar services rendered by other authorities in the district.

♪ Note that these functions were added by Act No. 118 of 1993

The 1977 Health Act was successful in a number of respects.[79] It achieved greater clarity in respect of the delineation of the three tiers of authority and their respective duties, powers and responsibilities, and it took concrete steps to effect more coordination between the tiers. It also established a basis for a shift in emphasis in South African health care towards prevention of illness and promotion of health.

However, the Act achieved little by way of solutions for the fundamental problems of the health system.[80] Not only did the fragmentation caused by the three tiers of authority and services remain unaddressed, but they were perpetuated and reinforced by the Act. Further, in reality, the Act did little to change from hospital- to community-based care, and the predominant emphasis remained on curative rather than preventive services.

### 2.2.5 Browne Commission Report 1986

The failure of the 1977 Act to achieve its objectives is borne out by the findings of the Commission of Inquiry into Health Services, appointed in 1980 under the chairpersonship of Mr G.W.G Browne. The Commission was appointed to inquire

into and make recommendations on the range and cost structure of health services in the public and private sectors in the Republic, with a view to the rationalising of services, the promotion of more effective services and the placing of the costs of the services on a sound and firm basis.[81]

The Commission's report found that the health care system was beset with the same problems which had been identified time and time again since Union. In particular, it found excessive fragmentation of control over health services and a lack of central policy direction, resulting in misallocation of resources and wasteful duplication of services. Further, largely as a result of this lack of central policy direction, it found an under-emphasis on preventive and primary health care, and over-emphasis of expensive secondary and tertiary health services, which is inappropriate to the needs of the South African community.[82]

The Browne Commission never intended to change the existing system radically, but opted for modifications of the present system.[83] It recommended, *inter alia*, that the central direction of health policy be exercised by the Minister of National Health and Population Development, acting on the advice of the National Health Policy Council. Within the framework of this national health policy, as much scope as possible should be given to regional and other authorities to exercise initiative in adapting the health services to the particular needs of the communities they serve. Priority should be given to preventive and primary health services, with special emphasis on health education, environmental and community health, and family planning.[84]

### 2.2.6 The Health Service Facilities Plan 1980 and the National Health Plan 1986

The Browne Commission had been preceded by the publication in 1980 of the National Health Service Facilities Plan, which was intended to co-ordinate health care provision and extend primary health care by introducing a network of community health clinics. The plan was oriented towards primary health care, and identified six levels of health service provision, from provision of basic needs (such as clean water, housing, and adequate food), to access to academic hospitals. The intention was that health priorities would first focus on the provision of basic needs, and once minimum requirements were fulfilled, priority would shift to the level above. The plan was stillborn, mainly because the basic level criteria were

most difficult to fulfil and required fundamental restructuring of existing social and economic systems.[85]

Following the Browne Commission Report, and in an attempt to align the health system organisationally with 1983 constitutional reforms, a new National Health Plan was released in 1986. The primary objectives and principles of the plan were: centralised responsibility for overall planning and policy formulation, with a decentralised, executive responsibility at the second and third tiers of government; the optimal use of available resources by eliminating fragmentation and duplication; the encouragement of private initiative and contributions in the rendering of health care, and the rectification of the division between preventive and curative services.[86]

Again, the rendering of health services would be divided into six levels[87] - see table 2 below. Responsibility for the rendering of services differed according to whether the service was designated an "own affair" or a "general affair" (see discussion below at page 50).

In terms of the plan, the National Health Policy Council was retained as the final policy determiner and coordinator of all health services, and the Health Matters Advisory Committee was retained in an advisory capacity to the Council. The composition of these bodies was, however, restructured to accommodate the three "own affairs" Departments of Health Services and Welfare. Actual management of hospital services and of preventive services was transferred to the Co-ordinating Board of Provincial Administrators, later renamed the Administrators' Health Council.[88]

The 1986 plan had potential for reform, but again perpetuated fragmentation. The plan left the relationship between provinces and local authorities fundamentally unaltered,[89] and hospital staff were confronted with the possibility of being administered by any one of five different authorities each with its own rules and conditions of service.[90] Implementation of the plan was hampered by the same problems which affected the 1980 plan, but which were aggravated by the attempt to accommodate the 1983 constitutional arrangements.[91] Consequently, the 1986 plan shared the fate of the 1980 plan and was never implemented in earnest.[92]

Table 2
**NATIONAL HEALTH PLAN: DIVISION OF SERVICES**

| |
|---|
| **Level 1 - Provision of basic subsistence needs** |
| * Safe drinking water and wider environmental health<br>* Sewage and waste disposal<br>* Food supplementation<br>* Infrastructure and basic housing |
| **Level II - Health education** |
| * Minimum educational level<br>* Training and education<br>* Guidance |
| **Level III - Primary health care** |
| * Self-care<br>* Community nursing services<br>* Community health centres |
| **Levels IV to VI - Hospitalisation** |
| * Level IV - Community hospital<br>* Level V - Regional hospital<br>* Level VI - Academic hospital |

### 2.2.7 The early 1990's: The National Policy for Health Act 1990 and the National Health Service Delivery Plan 1991

A further attempt at better co-ordination of health services was made by the National Policy for Health Act 1990 (Act No. 116 of 1990), which replaced sections 2 to 13 of the Health Act of 1977. It was intended that greater co-ordination would result from centralising national policy formulation in the hands of the Minister of National Health and Population Development, and by diminishing the role of provincial authorities.[93] The Act consists of three Parts.

The first Part deals with the determination of national health policy. Section 2 provides that the Minister of National Health and Population Development may determine the national policy to be applied to promote the health of the inhabitants of the Republic, provided that such policy is determined within the framework of specified guidelines, and is made according to stipulated procedures. The Minister is also given the responsibilities of: obtaining and processing of statistical returns; determination of targets and priorities relating to health services provided by the State and local authorities; determination of norms and standards for the provision or financing of health services; the making available of persons for the health professions; and the efficient coordination of health services provided by the State and local authorities. The second Part deals with the establishment of the Health Matters Committee, the Administrators Health Council[94] and the Health Policy Council, which respectively replaced the Health Matters Advisory Committee, the Co-ordinating Board of Provincial Administrators, and the National Health Policy Council. Van Rensburg *et al* note that while the names of the three bodies changed, neither the composition of the bodies nor their functions altered significantly.[95] The final Part deals with general matters.

The effectiveness of the Act was constrained by continued provincial control of, and resources committed to, capital stock, which limited the flexibility and implementability of policy changes, and the fact that the areas of greatest need, namely the homelands, remained outside the immediate control of central government.[96]

The early 1990's also saw the publication of the National Health Service Delivery Plan of 1991, which set out a five-year plan to establish a comprehensive health service, which would adhere to the principles of accessibility, effectiveness, affordability, equity, and acceptability. Again the National Health Services Facilities Plan was adopted as the framework, in so far as services were divided into six levels, and primary health care was emphasised.

These developments in the early 1990's show a positive trend towards increasing State emphasis on primary health care, both in the formulation of health policy, and also in the organisation and rendering of health services. However, they achieved little to diminish the pervasive fragmentation in the control and rendering of health services at the various tiers of government.

### 2.2.8 The Steinmetz Report 1993

The most recent development of State policy on rationalisation of health services, prior to the change of government in April 1994, was the publication of the Report of the National Committee to Investigate the Rationalisation of Health Services in the Republic of South Africa and the Self-Governing Territories. This report, published on 17 March 1993, was the culmination of the work of the Committee which was appointed in September 1992 under the chairpersonship of Mr G Steinmetz.

Again, health services would be administered within the framework of a 3-tiered system of government with central, regional and local government levels[97] - see table 3.

If this recommendation of the Steinmetz Report had been implemented, it would have begun to break down the entrenched division between the *loci* of curative and preventive services associated with the various tiers of government. However, it would not have resulted in a comprehensive and truly integrated national health system, with appropriate decentralisation of management to regional and local levels. If anything, the power-base was entrenched more firmly at regional level.[98]

Table 3

**STEINMETZ REPORT: DIVISION OF FUNCTIONS**

**Central (national) department**

* Macro-planning for the delivery of health services in South Africa
* Formulation of macro-policy for the delivery of health services
* International liaison
* Research into new health care trends and requirements
* Monitoring the state of health of the population nationally
* Negotiating with the Dept of State Expenditure on behalf of regional authorities and academic hospitals
* Allocating the national health budget

| |
|---|
| **Regional health authorities**<br><br>* Provision of a comprehensive health service in that region, encompassing:<br>- tertiary health institutions in the region, but excluding academic hospitals<br>- secondary and community hospitals<br>- primary health care services<br>- auxiliary health services<br>- ambulance services<br>- infrastructural support services<br>* Control and management of all health services<br>* Procurement and control of pharmaceuticals, medical consumables, foodstuffs, etc.<br>* Management of the finances of the region<br>* Execution of the policy as laid down by the control board of the region |
| **District health authorities**<br><br>* Control and monitoring of all regional hospitals in the district<br>* Control and monitoring of all community and private hospitals in the district<br>* Rendering of all primary health care<br>* Rendering of all auxiliary and special services<br>* Liaison with community leaders in order to render an acceptable service |

### 2.2.9 The ANC National Health Plan and the Reconstruction and Development Programme 1994

Implementation of the recommendations of the Steinmetz Committee was overtaken by political developments. The elections of 27 April 1994 saw the coming to power of the African National Congress (ANC) as the majority political party. Shortly thereafter, the ANC published its National Health Plan.[99] Subsequently, the Reconstruction and Development Programme (RDP) was published,[100] which articulated the policy of the new Government of National Unity. The RDP incorporates the principal tenets of the ANC's National Health Plan.

In response to South Africa's history of structural fragmentation of health services, the ANC intends to create a comprehensive, equitable and integrated National Health System.[101] A single governmental structure would deal with health, based on national guidelines, priorities and standards. It would co-ordinate all aspects of public and private health care delivery. Actual management of the delivery of services would be decentralised to provinces, districts and institutions in order to increase efficiency, local innovation, empowerment and accountability.

In terms of the RDP, a single National Health Authority would: develop national policies, standards, norms and targets; allocate the health budget; co-ordinate the recruitment, training, distribution and conditions of service of health workers; and develop and implement a National Health Information System. Provincial Health Authorities would be responsible for providing support to the District Health Authorities in the provinces, which would include: providing secondary and tertiary referral hospitals; regulating private hospitals; running training facilities and programmes; evaluating and planning services; and providing any other support the districts might request. Provinces would be geographically divided into districts, in which access to and delivery of health services would be the responsibility of district health authorities.[102] Details of the structure and functioning of the District Health System are currently being worked out through a process of consultation and negotiation.

Decentralisation of health service provision would be subject to central co-ordination within the integrated comprehensive National Health System, because of the danger that decentralisation without co-ordination and planning could result in a more fragmented and inequitable system.[103]

New legislation is central to the implementation of the health plans of the new government. This is clearly expressed in the ANC's National Health Plan, which states that the National Health System "*will be created through legislation and regulation* and will be influenced through many other mechanisms, including fiscal and financial policy"(my italics).[104]

## 2.3 PROFESSIONAL FRAGMENTATION

In terms of the Reconstruction and Development Programme, one of the important areas to receive attention in the development of a National Health System is the improvement of human resource planning and management systems.[105] It is submitted that effective planning and management necessarily requires co-ordinated and integrated regulation of all categories of health professionals. It is further submitted that the current system of statutory bodies regulating the various professions, which is the product of a long history of legislative development, urgently needs to be reviewed, as it is obsolete and is not conducive to sound human resource management. In this section, the development since Union of the legislation establishing the current system of statutory bodies is reviewed specifically in the light of fragmentation of control over human resources for health. Legislative entrenchment of racial fragmentation of some of these bodies will also be briefly considered. The historical review is followed by a recommendation that the current system of statutory bodies should be replaced by an umbrella body which encompasses all the health professions, while allowing each profession a degree of autonomy.

### 2.3.1 Medical, Dental and Pharmacy Act, 1928

Prior to the passing of the Medical, Dental and Pharmacy Act of 1928 (Act No. 13 of 1928), each of the provinces, except the Free State, had a Medical Council and a Pharmacy Board. In the Free State, the Medical Council and the Pharmacy Board were combined in one body. The 1928 Act provided for unification of these bodies, resulting in the establishment of a single South African Medical Council (representing doctors, dentists, nurses, midwives, masseurs and other auxiliary medical personnel), and a single South African Pharmacy Board.[106]

The Act (in Bill form) had a long and chequered history. Immediately after Union, conferences were held where representatives of the four Medical Councils and the three pharmacy boards met and discussed consolidation of the medical laws of the country, and drafted a Bill which was the basis of the 1928 Act. Until 1917, nothing was done. In that year, it was brought before Parliament. Between 1917 and 1928, it was introduced, withdrawn from, and reintroduced to Parliament several times.[107]

The reason for the controversy was that supporters of "unorthodox methods of healing", including the practice of osteopaths, naturopaths and cancer curers, objected to a clause in the Bill which provided that no one not duly qualified would be allowed to practise "for gain, hire or reward, direct or indirect, or for the expectation thereof". Before the Bill was finally passed the clause had to be modified so that an unqualified person would only be breaking the law if he or she practised for "gain". Though supporters of alternative healers were still opposed to the clause, their proposed amendments were defeated.[108]

### 2.3.2 The Nursing Acts, 1944 and 1978

Before 1944, control over the nursing profession was exercised by the South African Medical Council in terms of Act 13 of 1928. In terms of this Act, the nursing and midwifery professions were represented on the Medical Council by two members only, out of a total of twenty-five. Progress with respect to addressing the concerns of the nursing profession was inevitably slow, and this prompted the South African Trained Nurses Association to take the initiative to lobby for new legislation to provide for a greater degree of self-determination by the nursing profession.[109] The passing of the Nursing Act, 1944 (Act No. 45 of 1944) was a form of "compensation" by the government to discourage unionisation of nurses.[110]

Perhaps the most important change effected by the Act was the establishment of a Nursing Council to take charge of the affairs of, and to register, practising nurses and midwives, independent of the Medical Council. Some provision was made in section 4(3) for continued interaction between the two Councils, which provided for reciprocal consultation between the Councils in respect of proposed regulations which affected the counterpart profession. The Act also made provision for the reconstitution of the South African Trained Nursing Association, which was established and registered as a company in 1914,[111] as the South African Nursing Association. The Association was charged with looking after the needs of nursing and nurses. Membership of the Association was compulsory for all practising nurses and midwives who were registered with the Council.

One of the concerns with the Bill, which was raised in Parliament, was that separation of the Nursing Council from the South African Medical Council would result in counterproductive fragmentation and a lack of co-ordination of the health

professions. This concern was expressed *inter alia* by Dr K Bremer, Member of Parliament for Stellenbosch. Dr Bremer's remarks are reproduced here at length because they are particularly pertinent to the recommendations which are made at the end of this chapter.

> *[I]nstead of retaining this ideal of controlling all health and curative services within the compass of one central Medical Council, we are unfortunately departing from that. It was quite possible to give all the powers under this Act to the nursing profession under a Nursing Board operating under the South African Medical Council, and with more nursing representation, if necessary, on the Council, where they would have had the same control as they have today, only you would have had that closer contact between the two professions, although I have said one is and must remain auxiliary, it cannot be regarded in any light as a profession which will give orders to the medical profession either today or at any time. That position can never be altered, and for that reason I believe we must look forward to the time when this divorcement is brought to an end, and when we again come asking for an amendment of the Medical, Dental and Pharmacy Act, and when the Nursing Council, that will be constituted under this Act, will become a Nursing Board under the South African Medical Council, in the same way as we expect that the dentists of this country will be controlled by a Dental Board, operating apart from the Medical Council, except that their resolutions and their findings are subject to control by the General Medical Council. In the same way we expect to have a Board of Auxiliary Services which will operate under the Medical Council, which will report to that Council and which will continue with its work in the interests of the section which they represent. If it was felt that that was not enough equality, then we could have a Medical Board under the general Medical Council acting only for the medical profession. I cannot help but envisage for the future some steps in that direction, which will make an end of this divorcement and which will bring together all those who have control of the country rather than driving them apart.*[112]

The future, however, saw no steps in the direction of ending this "divorcement" that so concerned Dr Bremer. The Nursing Act 1978 (Act No. 50 of 1978)

consolidated amendments to the 1944 Act and restructured the Act to bring it into line with the structure of the Pharmacy Act 1974 (Act No. 53 of 1974) and the Medical Dental and Supplementary Health Service Professions Act 1974 (Act No. 56 of 1974). The Nursing Act of 1978 made provision for the South African Nursing Council to have a very similar brief to the South African Medical and Dental Council, within the autonomous sphere of nursing. As the statutory controlling body, the Council had the following tasks: keeping and updating registers and rolls of nurses; controlling and supervising of training in order to ensure acceptable standards; disciplinary control and disciplinary authorization where professional codes of conduct had been breached. The 1978 Act also made the South African Nursing Association an autonomous body which would initiate, manage and protect the professional interests for which the Nursing Council negotiates.

### 2.3.3 The Dental Mechanicians Act, 1945 and the Dental Technicians Act, 1979

Dr Bremer's ideal of an overarching co-ordinating body to regulate the health professions was not only ignored in the development of nursing legislation, but was ignored in the further development of all legislation impacting on health professionals. In the year following Dr Bremer's plea, the Dental Mechanicians Act (Act No. 30 of 1945) was passed, establishing a Central Mechanicians board, independent of the other statutory bodies.

The ostensible motivation for the Act which was advanced by government was to create a body which would confer a special status upon the trade or calling of dental mechanicians, enabling them to regulate their own affairs. Considerable opposition was voiced in respect of the Bill by Members of Parliament who felt that the Bill was in fact a mechanism to restrict the scope of practice of dental mechanicians in order to protect the domain of dentists. Mr Wanless, Member of Parliament for Umbilo voiced this objection particularly strongly:

> *Unquestionably this is not a Dental Mechanicians Bill; it is a Dentists' Bill. It is a Bill promoted by the Dentists themselves, a Bill seeking to entrench their rights and in a criminal manner seeking to deprive dental mechanicians of the right to sell their labour in a free and open market.*[113]

The Dental Technicians Act 1979 (Act No. 19 of 1979) was a revision of the 1945 Act along the same lines as other Acts relating to the health professions. The Dental Technicians Council was vested with legal control on the same basis as the other professions, with a view to the profession becoming more integrated with the family of health professions.[114]

### 2.3.4 The Medical, Dental and Supplementary Health Service Professions Act, 1974, and the Pharmacy Act, 1974

The Medical, Dental and Pharmacy Act, 1928, was revised in 1974, with a view to modernising the legislation, consolidating amendments, and providing for the control of the pharmacy profession in a separate Act. Two separate Acts were passed, namely the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), and the Pharmacy Act, 1974 (Act No. 53 of 1974). The Medical, Dental and Supplementary Health Service Professions Act established the South African Medical and Dental Council to set standards and guidelines for the professional conduct of doctors, dentists and selected categories of paramedics, and to exercise discipline in cases of malpractice. The Pharmacy Act 1974 provided for the establishment of the South African Pharmacy Board (since 1985 called the South African Pharmacy Council) to exercise powers similar to the South African Medical and Dental Council, but in respect of the pharmaceutical profession.

Dr G de V Morrison, Member of Parliament for Cradock, expressed the motivation for the Pharmacy Bill as follows:

> *This Bill is ushering in a new era for the pharmacy profession. It is a very important milestone in the history of the profession. It is now giving this profession a status and an authority structure of its own and is giving substance to the fact that pharmacy is in fact, a professional discipline in its own right, and when we take into consideration that these are highly trained, well-grounded people, who have had four years of training, it cannot be otherwise.*[115]

The splitting of the legislation was thus motivated by a desire to enhance the image of the pharmacy profession, even though it was acknowledged by the Minister of Health at the time that the principles of the control measures over pharmacists were the same as those over medical practitioners and dentists.[116]

### 2.3.5 The Chiropractors Act, 1971; the Homeopaths, Naturopaths, Osteopaths and Herbalists Act, 1974; and the Associated Health Service Professions Act, 1982

Alternative healing, the subject of acrimonious debate in Parliament when the Medical, Dental and Pharmacy Act of 1928 was passed, was revisited in 1971 when the Chiropractors Bill was tabled. After considerable debate as to the merits or demerits of chiropractics, the Bill was passed to protect the public against the worst forms of quackery, rather than a measure to give formal recognition to the profession. The Chiropractors Act (Act No. 76 of 1971) provided that chiropractors could only practise if their name was entered on a list kept by the Department of Health. Such an entry required prior recommendation of the Chiropractic Association of South Africa.

Some three years later, legislation was tabled before Parliament to protect consumers from dubious activities which were being practised in the name of homeopathy, naturopathy, osteopathy and herbalism. The object of the control was to ensure that any person offering his or her service at a charge would have attained a minimum acceptable standard of knowledge so that the person paying for such services would be protected.[117]

In fact, legislative mechanisms already existed to supervise the practice of all these alternative methods of healing. Provision was made in the Medical, Dental and Pharmacy Act of 1928 for the South African Medical Council to register any person practising a health profession and to control such profession. However, the South African Medical and Dental Council consistently refused to register any persons practising these forms of healing because it was feared that the international repute of the Council would be adversely affected. In the light of the stand of the Medical Council, the Department of Health arrived at the conclusion that separate legislation relating to the professions was an absolute necessity.[118]

The Homeopaths, Naturopaths, Osteopaths and Herbalists Act, 1974 (Act No. 52 of 1974) was passed, creating an instrument whereby the persons practising the professions could place these professions on a sound basis. Control was placed in the hands of the South African Homeopathic Association, which was a consolidation of the three largest associations representing these professions.[119] As was the case with the Chiropractors Act, the Act provided that only listed

persons could practise, and that names could only be listed on the recommendation of the Association. However, the Act provided only for registration of practising practitioners, and did not provide for admission of new practitioners, while no criteria were laid down for registration. All training facilities were also to be closed down, though the government agreed to reconsider this if the occupations standardised their training.[120]

The legal powers bestowed on the Chiropractic Association of South Africa and the South African Homeopathic Association were imperfect, and progress achieved by the associations in the 1970's and early 1980's was achieved largely due to voluntary efforts on the part of the professions. During this time the associations encountered difficulties in the performance of their statutory functions of control, because the statutory powers conferred on them were too limited. In the light of this and in the interests of patients, the Ministry of Health tabled a Bill in 1982 which provided for control of the ethical conduct of practitioners on a more extensive basis.[121] The subsequent Associated Health Service Professions Act (Act No. 63 of 1982) established a South African Council for the Associated Health Service Professions, which was entrusted with the following responsibilities: to devise rules for ethical behaviour; to define the different occupations; and to control the situation regarding homeopathic remedies.

While repeated efforts were made to convince the South African Medical and Dental Council (SAMDC) to afford recognition to these professions, and to accept their being related to the practice of the other professions covered by the provisions of the Medical, Dental and Supplementary Health Service Professions Act, 1974, the SAMDC steadfastly refused.

Dr L.A.P.A Munnik, then Minister of Health and Welfare, expressed his frustration at the attitude of the Council as follows:

> *I am still of the opinion that all the professions practising a curative service should be controlled by the council in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974, but in view of the opinion held by the council, I have no alternative but to introduce legislation in order to control the ethical conduct of practitioners of these professions in the interests of patients. I must emphasise that the Director-General has on my behalf done*

*everything possible at council and executive meetings to bring home the desirability of having these associated health professions under the control and jurisdiction of the South African Medical and Dental Council. The decision of the Council is to my mind short-sighted and no blame must ever in the future be laid by the medical profession at the door of the Minister of the department. We have indeed done our best, but to no avail.*[122]

Significant amendments to the 1982 Act followed in 1985 (Act No. 101 of 1985) and in 1993 (Act No. 63 of 1993). The 1993 Act changed the name of the 1982 Act to the Chiropractors, Homeopaths and Allied Health Service Professions Act. These amendments extended the powers of the Council, now known as the Chiropractors, Homeopaths and Allied Health Service Professions Council, in certain significant respects, including *inter alia*: empowering the Council to lay down stipulations for South African qualifications, and to get training facilities at tertiary institutions; providing for the establishment of professional boards for specific allied health service professions under the Council, in order to advance the interests of the particular professions; provision for the reopening of registers of the professions; provision for recognition of new allied health service professions; and creation of more effective disciplinary powers of the Council.

The cumulative effect of these amendments is that the legal position of the Chiropractors, Homeopaths and Allied Health Service Professions Council is now on par with that of the South African Medical and Dental Council. This is an important legitimation of alternative medicine.

### 2.3.6 Racial fragmentation of the professional bodies

Legislation governing the professional bodies representing health professionals did not only create fragmentation between professions, but also within the disciplines, as the health professions were not immune from the effects of apartheid. Apartheid perhaps struck its harshest blow at the nursing profession by means of the Nursing Act, 1957 (Act No. 69 of 1967).

Minister of Health at the time, Dr J H Viljoen, explained why he considered the 1957 amendment to be necessary:

> *When it is realised that ... the non-White nurses in the foreseeable future might outnumber the Whites, the danger inherent in the failure of the existing legislation to provide for the maintenance of the colour bar in the nursing profession can readily be understood. As the Act reads at present, all registered nurses and midwives, irrespective of race, have the right to stand for nomination as members of the Nursing Council and of the Nursing Association and to take part in elections. In addition, they are all members of the Nursing Association. Apart from the serious effect which the election of non-Whites as members of the body responsible for the control of nursing in the Union will have, the mingling of the races at meetings of the association and social gatherings held in connection with such meetings has already led to serious friction within the nursing profession.*[123]

Provision was therefore made in the Act for the South African Nursing Council and the executive of the Nursing Association henceforth to be exclusively white. Further only white persons could elect members of these bodies. The Nursing Council would be advised of matters affecting coloured or "native" nurses or midwives by means of the establishment of advisory committees for these population groups. While all nurses and midwives continued to be subject to compulsory membership of the Nursing Association, separate meetings of the Association would be held in respect of the different population groups. Provision was also made in the Act for: the keeping of separate registers and rolls in respect of whites, coloureds and "natives" respectively; different uniforms, badges and other insignia for the different races; and the prohibition on the control or supervision over registered or enrolled white nurses or midwives in hospitals and similar institutions by persons who were not white. Training facilities for white and non-white nurses were also officially segregated.

Opposition to the Bill on the basis that it opened the way to unfair discrimination, a lowering of standards, and an effective denial of black nurses of their say in the control of the profession, was ignored.[124] It was only in 1978, with the passing of Act No. 50 of 1978, that the racist measures were removed and that representation of black nurses on the South African Nursing Council was reinstituted, though with the condition that a white majority be maintained.[125]

The Acts governing the other categories of health professionals did not establish racial criteria like those of the Nursing Act of 1957. However, the Pharmacy Act of 1974, the Medical, Dental and Supplementary Health Service Professions Act of 1974, the Nursing Act of 1978, the Dental Technicians Act of 1979, and the Associated Health Service Professions Act of 1982, all made South African citizenship a prerequisite for membership of the respective Councils. Concerns were raised in parliament at the time of discussion of the Dental Technicians Bill that, in terms of government policy at the time, all the homelands would become independent States and eventually all black people would lose their South African citizenship and assume citizenship of one of the homelands. This would exclude black people from serving on the Councils of the professional bodies.

During discussion of the Dental Technicians Bill, Mr H E J Van Rensburg, Progressive Federal Party Member of Parliament for Bryanston, pointed out that the Bill already excluded citizens of Transkei and Bophuthatswana from becoming members of the Council. He went on to say:

> *Let us say the impossible should happen and all the homelands in South Africa became independent. Then, in terms of the Government's present policy, say by the year 2000, when there will be something like 20 million to 25 million permanently urbanised Black people in so-called White South Africa, not a single Black dental technician, representative of those 20 million to 25 million permanently urbanised Black people in so-called White South Africa, could, in terms of the provisions of this legislation, become a member of the council representing their particular profession, their particular discipline. If that is so I can only conclude that this is the harshest possible form of discrimination, based purely on race and aimed at the Black people of South Africa.*[126]

Mr Van Rensburg's proposed amendment to the effect that the citizenship condition should not disqualify people who have lost their citizenship as a result of the homelands becoming independent, was rejected.[127]

The exclusion of citizens of the so-called independent States from membership of the statutory bodies, gave rise to the creation of new statutory bodies to represent certain health professionals in some of these states. The Transkei Medical Council

and the Ciskeian Medical Council were constituted by the Medical Allied and Supplementary Professions Act, 1976 (Transkei) (Act No. 30 of 1976) and the Health Professions and Related Health Practices Act, 1984 (Ciskei) (Act No. 36 of 1984), which both dealt with pharmaceutical, medical and related professions. Separate Nursing Councils were also established in Bophuthatswana, Transkei and Ciskei.

The fragmentation of the statutory bodies which has resulted from the homelands policy is currently being addressed. The Minister of Health has introduced legislation in 1995 to amend the Medical Dental and Supplementary Health Service Professions Act 1974, (Act No. 56 of 1974), the Nursing Act 1978 (Act No. 50 of 1978), the Pharmacy Act 1974 (Act No. 53 of 1974) and the Chiropractors, Homeopaths and Allied Health Service Professions Act 1982 (Act No. 63 of 1982), and to repeal all corresponding laws in the former "independent homelands". The existing Councils are to be replaced by four interim Councils, namely: the Interim National Medical Council of South Africa; the South African Interim Nursing Council; the Interim Pharmacy Council of South Africa; and the Chiropractors, Homeopaths and Allied Health Service Professions Interim Council. The structure and composition of the interim Councils will vary, but all the interim Councils will maintain significant representation by members of the existing Councils, while including a spectrum of new members appointed by the Minister of Health to ensure greater community involvement and participation.

These Councils will have limited terms of office, during which time one of their functions will be to make recommendations to the Minister regarding the constitution of new representative and democratically elected Councils to replace the interim Councils. Another function of each of these interim Councils will be to handle the transformation of the existing Act under which it is constituted and the regulations published thereunder to support the universal norms and values of the profession, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement. It is intended that the interim Councils and the election of new bodies will give the Councils the legitimacy and acceptance required to enable them to function effectively and meet their new obligations.

### 2.3.7 An umbrella body

The 1995 amendments are vital in that they address the racial fragmentation which has pervaded the system of statutory bodies representing the health professionals. However, when considering the improvement of human resource planning and management system in terms of the development of a National Health System, attention needs to be given to whether further consolidation of the Councils is not in order.

The system of separate Councils for the various categories of health professions has served its intended purposes. The professional status of the disciplines of nurses, dental technicians and pharmacists is now well-established. Even the practice of chiropractors, homeopaths and allied health service professions has now been legitimated, and the legal status of their representative Council is now on par with that of the South African Medical and Dental Council. If the professional status and integrity of these disciplines will continue to be afforded the same recognition under an umbrella Council, and will not be made subservient to the priorities of any other profession, the rationale for the separate Councils falls away.

Further, the South African Medical and Dental Council not only governs the practice of medical practitioners, dentists and psychologists, but also at least forty-seven other supplementary health service professions[128]. It would not be conducive to national management of human resources if every time any one of these professions demanded special recognition, an independent Council be created to represent it. This would only give rise to further fragmentation of laws relating to health personnel, together with increased wastage of resources and unhealthy competition between the respective professions.

Dr Bremer's comments regarding the Nursing Act of 1944 (above, page 37) need revisiting. While he was clearly biased towards the advancement of the medical profession, he proposed a model which could give fair consideration to the needs, aspirations and priorities of all the professions. Dr Bremer envisaged a "General Medical Council" encompassing all health professions, together with a system of Boards to advance the interests of each particular profession. The Boards could function independently, but their resolutions and findings would be subject to control by the General Medical Council.

It is submitted that the creation of an umbrella "Health Professionals Council", based on Dr Bremer's idea of a General Medical Council, would further facilitate co-ordination of human resources in the interests of the implementation of a national plan for human resources for health. A single Act would create an umbrella Health Professionals Council, which would co-ordinate a system of Professional Boards for the various categories of health professionals. Channels of accountability between the umbrella Council and the Professional Boards would be established in much the same way as this accountability is ensured in relation to the professional boards established under the South African Medica and Dental Council in terms of section 15 of Act No. 56 of 1974.[129] The precise degree of autonomy of the Professional Boards allowed for in the Act would be subject to negotiation and consultation. At the same time, attention would need to be given to granting legislative recognition to health workers who have hitherto been excluded from coverage of the statutes regulating health professionals, most notably traditional healers and community health workers.

The words concluding Dr Bremer's remarks are particularly pertinent, and bear repeating:

> *I cannot help but envisage for the future some steps in that direction, which will make an end of this divorcement and which will bring together all those who have control of the country rather than driving them apart.*

## 2.4 RACIAL FRAGMENTATION OF HEALTH SERVICES

Racial fragmentation of statutory bodies representing the health professions has already been discussed. However, the effects of apartheid on the organisation of health care in South Africa were considerably more pervasive than this. The entire development of the organisational structure of the South African health system in the period since Union has been characterised by increased racial fragmentation in health care. Most notably, this took the form of the rejection of the Gluckman Report's pleas for a non-racial, National Health Service in South Africa, and the subsequent creation of homeland health departments and the tricameral parliament.

### 2.4.1 The Tomlinson Report 1954

Any hope of implementation of the Gluckman Report's recommendation of a unitary National Health Service for *all* sections of the people of the Union were finally crushed by the report of the Commission for the Socio-Economic Development of the Bantu Areas within the Union of South Africa (the "Tomlinson Report"), which was initially presented to the government in 1954. The Tomlinson Report recommended the creation of a "Bantu Health Service", which would be responsible for the rendering of health services in "Bantu Areas". The envisaged operation of such a service is explained in the report:

> *This service should be staffed by Bantu as far as possible to attract trained Bantu to these Areas, but should be operated initially under the direction of Europeans until the Bantu can assume full responsibility. Practical considerations indicate that the Union Health Department, and not an independent Bantu health authority, should develop and operate the service. ... In the Bantu Areas, the health responsibilities of all the statutory authorities and also ultimately, with their prior agreement, of the charitable organisations and missionary societies, should be transferred to the Native Affairs Department which should then delegate these responsibilities to the Union Health Department. ... This Bantu health service should be developed on simple lines and financed from a special Bantu Health Services Trust Fund to be established by the Dept of Native Affairs and maintained partly by a health tax imposed on all taxable Bantu in the Bantu areas.*[130]

The Government responded to this recommendation by directing the Departments of Health and Native Affairs to appoint an Interdepartmental Committee to investigate fully, in consultation with other interested authorities, the implications - financial, legal or otherwise - and the feasibility, of implementing in practice the proposed transfer and form of co-operation.[131]

### 2.4.2 Health services in the homelands

The Tomlinson report was followed, in the late 1950s, by the creation of ten national states, of which four (Transkei, Bophuthatswana, Venda and Ciskei - the

so-called TBVC States) obtained independence since 1976 and the remaining six (KwaZulu, Lebowa, Gazankulu, QwaQwa, KaNgwane and KwaNdebele) remained self-governing states.[132]

Originally missionary societies took responsibility for providing health care in the homelands. These societies initially bore all costs, but increasingly received State subsidisation via the provinces. As subsidisation of mission hospitals increased, the South African Department of Health gradually became responsible for the provision, planning and co-ordination of health services in the homelands. In 1964, the situation changed, with the Department of Bantu Administration and Development accepting full responsibility for all capital expenditure of hospitals in homelands, while provinces remained responsible for subsidising the running costs of these hospitals. In 1970, the Department of Bantu Administration and Development took over responsibility for health in these states, and appointed the Department of National Health as its agent for the provision of health services in these areas.[133] In 1973, the South African Department of Health, as agent for the Department of Bantu Administration and Development, took control of mission hospitals. Initially this dispensation continued under the administration of the South African Department of Health, while capital and operating costs were the responsibility of the Department of Bantu Administration and Development. However, control was gradually transferred to the various homelands' own, autonomous health departments.[134]

The homeland policy grossly increased fragmentation of health services. Not only was health care geographically fragmented with the creation of ten separate geographical units, but ten additional State departments of health were also added at the first tier of government.

Legislative opportunities to redress the problem of racial fragmentation of health services caused by the homeland policy were simply ignored. The organisation of health care and the determination of health policy in terms of the Health Act 1977 and the National Policy for Health Act 1990 pertained only to "white South Africa", while the division between the South African and homeland health care services was accepted as the given health care framework. It was only with the publication of the Steinmetz Report that plans were made for the eventual reintegration of the departments of health of the TBVC States and self-governing territories.[135]

The process of reintegration commenced with the introduction of the Constitution of the Republic of South Africa Act 1993 (Act No. 200 of 1993), which created one sovereign State which incorporates the territories of the former TBVC States and the self-governing territories. A process of consolidation of the health departments of these territories and of the former provincial administrations is currently being undertaken by the newly constituted provincial administrations, and will be completed with the harmonisation of the health laws of these former jurisdictions.

### 2.4.3 The Tricameral Constitution

> *The Commission is perturbed at the further fragmentation of health services under the present constitutional dispensation. The Commission's terms of reference require it to make recommendations 'with a view to the rationalising of health services, the promotion of more effective services and the placing of the costs of the services on a sound and firm basis', and it must express the conviction that this further fragmentation will not promote these objectives.*
>
> [Final Report of the Commission of Inquiry into Health Services 1986, p 22] .

These remarks of the Browne Commission were directed at the Republic of South Africa Constitution Act 1983 (Act No. 110 of 1983), in terms of which "health" became an "own affair" as of August 1994. In effect, this meant the establishment of separate Departments of Health and Welfare for the House of Assembly, the House of Delegates, and the House of Representatives to look after the health of white, Indian and coloured people, respectively. These administrations each had its own Minister and organisational structure. The Department of Health and Population Development accepted responsibility for health services to blacks until 1989, after which time the responsibility devolved to the provincial authorities.[136]

Vagueness which existed between "own" and "general affairs" was only clarified with the new health dispensation following on the National Health Plan of 1986. In terms of the plan, the first three levels of health care (provision of basic subsistence needs, health education and primary health care) were given to the three "own affairs" Departments of Health and Welfare, while the Department of National Health and Population Development would manage these services on

behalf of blacks in "white South Africa", but with delegated execution of such service by provincial administrations. Academic hospitals (level VI) were made "general affairs", and levels IV and V (community and regional hospitals) were made either "own affairs" or "general affairs" depending on their inpatient composition. Where more than 95% of patients were members of one racial group, the institution would be an "own affair". Where less than 90% of patients were of one racial group, the hospital would be a "general affair". Where the patient mix contained between 90% and 95% of any one racial group, the hospital would be neither an "own" nor a "general" affair.[137]

Together with the existing central Department of Health and the ten homeland departments, the three additional "own affairs" health departments brought the total number of health bureaucracies in South Africa to fourteen. While the "own affairs" departments in reality played an insignificant part in the health sector, they led to greater inefficiency and cost, and to the threat of deterioration of already inadequate services.[138] These administrations existed until the end of March 1993, when they were dissolved by Proclamation.[139]

## 2.5 ADMINISTRATIVE FRAGMENTATION - A CASE STUDY OF THE HISTORY OF OCCUPATIONAL HEALTH LEGISLATION

### 2.5.1 Introduction

> *The fact that the control of industrial health matters is divided among several departments instead of there being a single and comprehensive code applied by a single body is also responsible for the continued weaknesses and shortcomings in the control exercised by each individual authority. By placing industrial health facilities at the national level under the control of various departments which have to deal with problems that are essentially the same, there is an ever-present danger that the piecemeal or patchwork development of legislation will be just as prone to gaps as to overlapping.*

[Report of the Erasmus Commission of Inquiry into Industrial Health 1976, p 37]

At least one hundred and three statutes of the Republic of South Africa (excluding amending statutes) impact on the health of, and the provision of health services

to, the inhabitants of South Africa. These statutes are administered by twenty-two government departments (see Annexure One). It is submitted that such extensive administrative fragmentation and divided control of legislation creates potential problems of gaps and overlaps which are not conducive to the implementation of uniform health policy.

This problem is perhaps most acute and therefore best illustrated by the division of administrative control of occupational health legislation. The development of occupational health legislation in South Africa will therefore be reviewed within the specific context of this fragmentation. Central to this review will be a discussion of the findings and recommendations of the Erasmus Commission of Enquiry into Industrial Health, appointed on 18 October 1974, and the Nieuwenhuizen Commission of Inquiry into Compensation for Occupational Diseases in the Republic of South Africa, appointed on 22 December 1978.

### 2.5.2 Legislative background to the Erasmus and Nieuwenhuizen Commissions

#### 2.5.2.1 The Commissions of 1902, 1907 and 1911

The first significant occupational health legislation in South Africa followed three Commissions of Inquiry in 1902, 1907 and 1911 into excessive rates of phthisis (a combination of silicosis and tuberculosis) among gold miners.

The Milner Commission of Inquiry into Phthisis of 1902 followed a report in 1901 by the Government Mining Engineer in the Transvaal concerning high mortality rates from miners' phthisis.[140] The 1902 Report showed that the average period for the development of advanced phthisis was less than six months. It was followed by the promulgation in 1905 of regulations to inhibit the creation of dust as far as possible. These regulations were not very effective because they were not sufficiently enforced.[141] The ineffectiveness of these regulations prompted the establishment of the Mining Regulations Commission of 1907, which reported that the mortality of white miners was six times higher than that for other adult males on the Witwatersrand.[142] In 1911, a third Commission, consisting exclusively of medical practitioners, was appointed to inquire into the incidence of miners' phthisis on the mines and to make recommendations on compensation.[143]

### 2.5.2.2 Compensation laws

The report of the 1911 Commission prompted the passing of the Miners Phthisis Act 1912 (Act No. 19 of 1912), which introduced compulsory compensation for phthisis. This compensation was initially only available for whites, but was subsequently made available to black miners too, but at substantially lower rates.[144]

The Pneumoconiosis Act 1956 (Act No. 57 of 1956) provided compensation benefits for pneumoconiosis among White mine workers. After a struggle, Black workers obtained some coverage, though the benefits were invariably racially discriminatory.[145]

The list of occupational diseases for which mineworkers could be compensated was finally consolidated in 1973, with the passing of the Occupational Diseases in Mines and Works Act (Act No. 78 of 1973). This Act provides for: the pre-employment medical screening of persons wanting to do work which exposes them to occupational diseases in mines and works; the regular medical examination of persons performing risk work in mines and works; the certification of compensable occupational diseases for the purposes of compensation; the collection of funds from employers for the purposes of compensation and research; and the award, amount and payment of compensation. The Act ensured that workers would be compensated at fixed rates, but enforced racially discriminatory compensation for whites, Asians, coloureds and Africans.

Compensation among workers in the non-mining sector was initially effected in terms of the Workmen's Compensation Act 1914 (Act No. 25 of 1914), as amended by Act No. 13 of 1917, which provided for compensation for industrial accidents and occupational diseases. To be compensated, diseases had to be present together with disablement, and had to be causally related to work. Posthumous benefits were available only if death was caused by the occupational disease. Cyanide rash, lead and mercury poisoning were the three occupational diseases recognised and they were handled administratively as if they were accidents. They were augmented by ankylostomiasis in 1934, and by 1941, fifteen occupational diseases including silicosis were scheduled as occupational diseases.[146]

In 1941, a new Workmen's Compensation Act (Act No. 30 of 1941) was passed, partly in response to growth of secondary industry. It guaranteed compensation for certain statutorily defined diseases as well as for accidents, while removing from workers the common law right to sue employers for failing to ensure a safe and healthy work place. While workers injured at work were ensured compensation, the amount was related to wages and hence low-paid workers derived limited benefits. Further, payment related to the degree of physical damage rather than to the effects of the damage. The Act originally excluded agricultural workers, though it has since been amended to include them.[147]

#### 2.5.2.3 Laws regulating working conditions

In the same year as the Miners Phthisis Act was passed to provide compensation to miners suffering from phthisis, the Mines and Works Act (Act No. 12 of 1911) was passed. This was the first legislation of the Union providing for strict control over safety and health of persons working in mines[148]. The Act, which consolidated colonial laws which existed prior to Union, sought to control environmental and general working conditions on the mines, and related primarily to the control of machinery[149]. Thus, as early as 1911 health, in the sense of prevention of occupational diseases, was separated from compensation for occupational diseases[150]. Subsequent amendments to the Mines and Works Act were consolidated in the Mines and Works Act 1956 (Act No. 27 of 1956).

The Factories Act 1918 (Act No. 28 of 1918) provided for regulation and control of factories, hours and conditions of work, supervision of the use of machinery, and prevention of accidents. It was passed to undercut competition by small factories which may not have improved conditions in order to undercut their competitors and to avoid labour unrest. The Factories Act had severe limits, including that it did not cover many sections of the workforce such as those working in the agricultural sector.[151]

The Factories Act was replaced by the Factories, Machinery and Building Work Act 1941 (Act No. 22 of 1941). This Act laid down basic conditions such as hours of work and regulations pertaining to control of machinery. For the first time, a factories inspectorate was constituted within the Department of Labour, with duties to inspect workplaces and to investigate reportable accidents.[152] After the 1941 Act was passed, it was estimated that 1.8 million workers were still not covered by the Act, while only 0.2 million were.

Limited coverage was provided for white collar workers in offices in 1939, by the introduction of the Shops and Offices Act (Act No. 41 of 1939). This coverage was improved in 1964 by the Shops and Offices Amendment Act (Act No. 75 of 1964), which introduced new health- and safety-related protective measures relating to hours of work and other conditions of employment for white collar workers in shops and offices.

#### 2.5.2.4 Indications of a need for change

The need for major improvements to the occupational health status of workers featured in the report of the Gluckman Commission of 1944. The report mentioned the failure of businesses to comply with the Factories Act, and the fact that workers in factories with poor working conditions suffered from fatigue and absenteeism.[153]

These concerns received further attention in a 1958 report of a committee appointed by the Department of Labour to investigate conditions in dusty industries[154]. The committee found that personal protective measures were often inadequate. It's recommendations included: compulsory medical examinations of dust-exposed workers; the compilation of a list of hazardous industries; measures to improve factory inspections; and the introduction of specific health and safety regulations to make working conditions safer.

### 2.5.3 The Erasmus Commission

On 18 October 1974, the State President appointed a commission of inquiry into industrial health, under the chairpersonship of Justice Rudolf Erasmus. Its report was published in 1976[155]. The report documented widespread industrial hazards and illnesses, and gross inadequacy of existing health and safety services and standards in South Africa. Statutes dealing with occupational health were found to be deficient in several respects. Further, only just over two million of the 8 million workers in South Africa were directly covered by the legislation[156].

One of the major reasons proffered for deficiencies and inadequate coverage of occupational health legislation was that administration of occupational health laws was extremely fragmented, with some ten government Departments being responsible for laws which impact on occupational health[157]. The fragmented

Departmental responsibility of laws which impacted on occupational health at the time of the Erasmus Commission is reflected in table 4.

The Erasmus Commission found that this administrative fragmentation impacted negatively on the state of occupational health services in the Republic, in a number of ways.

First, fragmented administration resulted in overlapping of the functions of the various departments. Departments introduced legislation and made regulations pertaining to occupational diseases and hazards, notwithstanding the fact that such legislation overlaps the general provisions of existing laws and the powers to make regulations thereunder. Another effect of administration of legislation relating to industrial health by numerous departments was that, although the various departments were confronted by the same problems, different standards and requirements were applied, depending on the different views and priorities of these departments or other bodies involved. This caused confusion among those who have to comply with or apply the legislation. Further, inspectors' powers, duties and functions in respect of occupational health also overlapped. The confusion was made worse because the inspectors and officers concerned were not required to have the same qualifications and attributes.[158]

Secondly, the fragmented administration of laws created the danger that the piecemeal or patchwork development of legislation will be just as prone to gaps as to overlapping[159]. Departments were prone to regarding their legal obligations in connection with occupational health as secondary to their main functions and leaving the matter to other departments. It was thus possible for industrial health to fall between two stools. The Department of Health, for example, placed its main emphasis on public health, of which occupational health was only a subsection. The result was that in pursuance of its policy, its medical practitioners did not devote much time to industrial health and the majority of general practitioners hardly had any knowledge of the subject. Further, no specific provision was made for occupational health in the Public Health Act 1919.[160]

Thirdly, the fact that policy was not clearly laid down in a single Act, or that the number of Acts relating to occupational health was not kept to a minimum, was determined to be a decided handicap to the entire occupational health system. The

State became paralysed by the morass of legislation. If anything was done at all, any step forward was taken at the pace of the slowest department or body.[161]

A primary recommendation of the Erasmus Commission was that *overall control* over occupational health in all occupational activities in the Republic should be assigned to the Department of Health:

> *With a view to the establishment of a comprehensive and effective industrial health system, the elimination of fragmentation and overlapping, and the merging of all attempts at promoting industrial health, the Commission recommends that the Department of Health be made the central controlling organisation in industrial health matters.*[162]

Apart from the application of sanctions, the overall control exercised by the Department of Health would entail laying down the general policy regarding occupational health, co-ordinating such policy and interpreting aspects thereof if and when it deems this necessary or is called upon to do so. For the time being, and out of considerations of practicality, aspects of *direct control* would continue to be vested in various other departments. Direct control would entail day-to-day control through inspections, or by any other means, by the body charged with such control, but would not include the power to draft industrial health legislation or to lay down any policy that is inconsistent with the policy of the Department of Health.[163]

The Commission recommended that a principal Act - the "Industrial Health Act" - be placed on the statute book and that the existing legislation, together with the regulations made thereunder, be brought into line with it. The essential components of the Act would be: its object; the establishment of bodies and the definition of their functions and of the duties of employers and employees; enabling provisions for the Department of Health, as the body with overall control over industrial health, to make regulations; the provision of powers for the promotion of occupational health services, research and training; the provision of powers to deal with defects, offences and fines; and the provision of powers to take measures in connection with existing statutory provisions that are replaced or repealed[164]. Chapter XXIV of the report deals with the provisions of the proposed Act in much greater detail.

Table 4

**DEPARTMENTAL ADMINISTRATION OF LAWS WHICH IMPACTED ON OCCUPATIONAL HEALTH (1976)**

| |
|---|
| **Department of Agricultural Economics and Marketing** |
| * Dairy Industry Act 1961 (Act No. 30 of 1961) |
| **Department of Agricultural Technical Services** |
| * Animal Slaughter, Meat and Animal Products Hygiene Act 1967 (Act No. 87 of 1967)<br>* Fertilisers, Farm Feeds, Agricultural Remedies and Stock Remedies Act 1947 (Act No. 36 of 1947)<br>* Livestock and Meat Industries Act 1934 (Act No. 48 of 1934) |
| **Department of Community Development** |
| * Slums Act 1934 (Act No. 53 of 1934) |
| **Department of Forestry** |
| * Forest Act 1968 (Act No. 72 of 1968) |
| **Department of Health** |
| * Atmospheric Pollution Prevention Act 1965 (Act No. 45 of 1965)<br>* Foodstuffs, Cosmetics and Disinfectants Act 1972 (Act No. 54 of 1972)<br>* Hazardous Substances Act 1973 (Act No. 15 of 1973)<br>* Public Health Act 1919 (Act No. 36 of 1919) |
| **Department of Industries** |
| * Fishing Industry Development Act 1944 (Act No. 44 of 1944)<br>* Sea Fisheries Act 1973 (Act No. 58 of 1973) |

**Department of Labour**

* Factories, Machinery and Building Work Act 1941 (Act No. 22 of 1941)
* Industrial Conciliation Act 1956 (Act No. 28 of 1956)
* Shops and Offices Act 1964 (Act No. 75 of 1964)
* Wage Act 1957 (Act No. 5 of 1957)
* Workman's Compensation Act 1941 (Act No. 30 of 1941)

**Department of Mines**

* Atomic Energy Act 1967 (Act No. 90 of 1967)
* Mines and Works Act 1956 (Act No. 27 of 1956)
* Mining Rights Act 1967 (Act No. 20 of 1967)
* Nuclear Installations (Licensing and Security) Act 1963 (Act No. 43 of 1963)
* Occupational Diseases in Mines and Works Act 1973 (Act No. 78 of 1973)

**Department of Transport**

* Merchant Shipping Act 1951 (Act No. 57 of 1951)
* Prevention and Combatting of Pollution of the Sea by Oil Act 1971 (Act No. 67 of 1971)
* Railways and Harbours Control and Management Act 1957 (Act No. 70 of 1957)
* Railways and Harbours Pensions for Non-Whites Act 1974 (Act No. 43 of 1974)
* Railways and Harbours Service Act 1960 (Act No. 22 of 1960)
* Sea Shore Act 1935 (Act No. 21 of 1935)

**Department of Water Affairs**

* Water Act 1956 (Act No. 54 of 1956)

### 2.5.4 Nieuwenhuizen Commission

Some two years after the report of the Erasmus Commission was published, a commission was appointed to inquire into, and report on, compensation for occupational diseases in the Republic of South Africa.[165] The Commission was appointed under the chairpersonship of Prof P.J. Nieuwenhuizen, and its report was published on 29 June 1981.

The Commission examined the dual system of compensation prevailing in South Africa - a system for miners under the Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973), and a system for other industrial workers, under the Workmen's Compensation Act, 1941 (Act No. 30 of 1941). One of the major differences between the Acts was that the former paid out compensation on a fixed and racially determined basis, while the latter was wage- rather than race-related.[166] After an extensive comparison between the two systems of compensation, the Nieuwenhuizen Commission recommended integration of the two systems under a single compensation Act, which would not be racially discriminatory.[167]

### 2.5.5 Legislative developments after the Erasmus and Nieuwenhuizen Commissions

New health and safety legislation emerged more than seven years after the publication of the Erasmus Commission report. The delay was partly due to continuing conflict between government departments as to whether the Department of Manpower or the Department of Health should control the area of occupational health and safety.[168]

The Basic Conditions of Employment Act, 1983 (Act No. 3 of 1983), and the Machinery and Occupational Safety Act (MOSA), 1983 (Act No. 6 of 1983) were both initiatives of the Department of Manpower. The Machinery and Occupational Safety Act established factory health and safety committees, an advisory Council for occupational safety, and set up controls to reduce hazardous work practices. Enabling provisions in the Act held out the possibility of moving toward increasingly stricter regulation of safety at work and the adoption of various standards relating to the use of hazardous substances.[169] The Basic Conditions of Employment Act also included important health-related protections for certain

categories of employees, such as restrictions on working hours. These two Acts only went part of the way toward meeting the recommendations of the Commissions. While legislation was modernised and deracialised, the objective of having a single Act was not achieved.[170]

The Machinery and Occupational Safety Act was replaced by the Occupational Health and Safety Act, 1993 (Act No. 85 of 1993) which has been hailed as a considerable improvement on the earlier Act, as it is a logical extension beyond a preoccupation with safety and accidents, incorporating health and medicine for the first time in the non-mining industry.[171]

The Workman's Compensation Act was replaced by the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993), which now governs compensation for death or disablement caused by occupational injuries or diseases contracted by employees in the non-mining sector. Among other provisions, section 10 of the Act establishes a Compensation Board to oversee administration of the Act, with representation from labour, industry, the State, and the Medical Association of South Africa.

The Occupational Diseases in Mines and Works Act was also recently amended by Act No. 208 of 1993, which was passed with the principal aims of removing racial differentiation from Occupational Diseases in Mines and Works Act and of bringing the Act into line with international and local compensation legislation.[172] A single system of medical surveillance is created for all miners, and a salary-based compensation system replaces the former racially-based system. In general, a more rational approach to compensation is established.[173]

The Mines and Works Act, 1956, was replaced by the Minerals Act, 1991 (Act No. 50 of 1991). The Minerals Act has recently been severely criticised in the report of the Commission of Inquiry into Safety and Health in the Mining Industry, which was released in May 1995. The Leon Commission was appointed on 6 May 1994, under the chairpersonship of Mr Justice R.L. Leon.[174] The terms of reference of the Commission were: to investigate all aspects of the legal regulation of health and safety in the mining industry as defined in the Minerals Act, 1991 (Act No. 50 of 1991); and to make recommendations to the State President on improvements to the existing regulations and the implementation thereof in the light of circumstances prevailing in the industry, and international standards. After a

In addition, the Department of Mineral and Energy Affairs administers the Minerals Act, and is thus responsible for safeguarding the health of miners, and yet has no health professional on its staff.[179]

The 1995 report of the (Leon) Commission of Inquiry into Safety and Health in the Mining Industry notes the fact that "it is more than eighteen years since the (Erasmus) Commission of Enquiry on Occupational health ... put on record the evidence of witness as to the babel-like confusion about which department or body controlled occupational health matters, the lack of effective action due to overlapping legislation, and the incredible waste of manpower entailed in the provision of administrative structures in three government departments". The report goes on to acknowledge that this situation persists.[180]

While the Leon Commission did consider the suggestion of consolidating departmental control of occupational health and safety issues by placing issues of health and safety in the mining industry under the authority of the Occupational Health and Safety Act, the Commission felt that such a change would be premature while the state of the law in mining is as confused and unsatisfactory as it currently is. The Commission did, however, concede that when the law in mining is put into a satisfactory state, a move into a larger umbrella health and safety organisation might be appropriate.[181]

There are nevertheless positive signs that greater attention will now be given to a co-ordinated approach to occupational health legislation. Business Day recently reported that Cabinet had approved a working committee of relevant "role players" to be established to investigate the creation of an exclusive national occupational health and safety Council to develop overall national policy on occupational health.[182] There is as yet no clarity on which role-players will participate in the working committee. However, it is likely to include a diversity of interests, such as: the Departments of Labour, Mineral and Energy Affairs, and Health; nuclear and radiation safety; trade unions; the business sector; environmental affairs; and agriculture. The functions of the committee which are presently envisaged are primarily of an advisory nature, but they may later be extended to include executive functions.[183] This initiative will hopefully provide the basis for the intersectoral co-operation which would be necessary for the consolidation of occupational health legislation in South Africa, and for the rationalisation of administrative control of that legislation.

## 2.6 THE PUBLIC/PRIVATE DIVIDE

Yet another manifestation of the fragmentation that has made the ideal of a National Health System in South Africa even more elusive, has been the development of a dual system of health care provision in South Africa between the private and the public sectors. Privatisation of health care occurred most extensively in the 1980's, and in the late 1980's private expenditure increased faster than public health expenditure.[184] During this decade, a policy of privatisation of health care was articulated by government in a number of plans and Commission reports, including: the National Health Service Facilities Plan (1980); the Browne Commission and Browne Reports (1984-6); the Report of the Committee for Economic Affairs of the President's Council on measures which have a limiting effect on a free-market-oriented system in South Africa (1984); the White Paper on the Report of the Commission of Enquiry into Health Services (1986); the National Health Plan (1986); and the White Paper on Privatisation and Deregulation in the Republic of South Africa (1987).[185] Section 2(1)(iv) of the National Policy for Health Act 1990 (Act No. 116 of 1990) provided that "the private sector shall be encouraged to provide health services in the Republic, but that the provision of such services shall be in the public interest".

A body of legislation has developed which regulates health service provision in the private sector, and which will need to be reviewed in terms of new government policy. This legislation regulates the establishment and running of private hospitals, on the one hand, and health care financing through medical aid schemes, on the other. The development of these components of the legislation is discussed below in turn.

### 2.6.1 Control of the establishment and running of private hospitals

The Public Health Act 1919 made no attempt to regulate the expanding private health sector, and control of private hospitals fell under the four provincial administrations. The provinces exercised control over these hospitals in terms of their respective Hospital Ordinances. The Ordinances all set down prior approval and registration requirements for the establishment, running or maintaining of private hospitals.[186]

In 1972, the State President appointed the Commission of Inquiry into Private Hospitals and Unattached Operating Theatre Units, under the chairpersonship of D.J. De Villiers.[187] The Commission found, *inter alia*, that different approaches were being taken by the various provincial administrations to control of the establishment and registration of private hospitals. Different standards were applied, and there was a lack of co-ordination in regard to the control of the establishment of private hospitals and provincial hospitals. The Commission recommended that the Department of Health control the establishment and registration of private hospitals and lay down minimum standards, so that: a uniform policy might be determined for the whole country; differences in approach would be eliminated; and all would enjoy the same treatment. The Commission further recommended that the Department of Health continue to control the establishment and registration of unattached operating theatre units, as had been the case prior to the appointment of the Commission.[188]

These recommendations of the De Villiers Commission were implemented by the promulgation of the Regulations on Private Hospitals and Unattached Operating Theatre Units No. R.158 of 1 January 1980, which took effect on 1 April 1980.[189] These regulations prescribed registration requirements for any person wishing to "erect, establish, extend, conduct, maintain, manage, control or render any service in a private hospital or an unattached operating theatre unit or permit or arrange for treatment to be provided therein".[190] Stringent prerequisites for such registration are laid down in the regulations. The regulations further prescribe structural, furniture and equipment requirements in respect of unattached operating theatre units, private hospitals, operating theatres in private hospitals, and private maternity units. Provision is made for inspection of facilities to determine compliance with the regulations.

The Browne Commission, in its eighth interim report (1986), found that although these regulations provided ample control measures in theory, there nevertheless remained a lack of co-ordination and planning in the provision of health facilities. It recommended that a system of hospital accreditation be developed to ensure uniformity of standards, and that the Department of National Health and Population Development be empowered to penalise hospitals, if the industry failed to develop adequate controls of its own accord.[191]

Broomberg reported in 1992 that, despite the recommendations of these commissions and the existence of a potentially adequate regulatory framework, the degree of control exerted in practice over the development of private hospitals during the years since the commissions has been extremely loose and fragmented. Similar problems characterise the system of inspecting the building standards and quality of care in private hospitals, resulting in greatly differing standards in private hospitals. Broomberg's analysis led him to the conclusion that a review and revision of existing policy on private hospitals is an urgent priority. Such a review, he maintained, should examine not only the nature of the legislation, but also the mechanisms for its implementation.[192] Such a revision of the regulation of private health facilities is likely to be undertaken by the new South African government, as the ANC's National Health Plan states that a better regulatory framework will in future be applied to the licensing of private sector facilities.[193]

### 2.6.2 Control of medical schemes

Prior to the passing of the Friendly Societies Act, 1956 (Act No. 25 of 1956), no statutory control was exercised over medical schemes. This had resulted, particularly in the years following World War II, in a proliferation of medical schemes without any planning or administration.[194] The Friendly Societies Act provided for the registration, incorporation, regulation and dissolution of "friendly societies" which included, *inter alia*, "societies established with the object of the provision or payment of contributions towards the cost of medical, nursing, surgical, optical or dental attendance or medicines or other medical requirements or surgical, optical or dental appliances or accommodation in hospitals, nursing homes, infirmaries or homes for aged persons".[195]

On 15 January 1960, Dr Albert Hertzog, then the Minister of Health, appointed a Commission of Inquiry into High Costs of Medical Services and Medicines in the Union, under the chairpersonship of Prof H.W. Snyman.[196] At the same time, Dr Hertzog appointed a Departmental Committee of Inquiry in regard to Medical Aid, Benefit and Insurance Schemes. This Committee was entrusted with the task of investigating and reporting on the high costs of medical services and medicines by means of medical aid and benefit societies, and insurance schemes, and the desirability of the State encouraging and safeguarding such schemes.[197] The reports of the Snyman Commission and the Departmental Inquiry were published together in 1962.

The recommendations of the committee included, *inter alia*:

i. new legislation should be introduced which: incorporated the financial and other provisions of the Friendly Societies Act 1956; made provision for the establishment of a Central Council for Medical Aid Societies; empowered the South African Medical Council to inquire into and act on complaints; and established a Central Fund to which all medical aid schemes should pay a levy;

ii. if agreement between the Medical Association of South Africa and the Medical Aid Societies could not be reached, the matter at issue should be submitted to the Central Council;

iii. a medical scheme with compulsory membership for all white employees of central and provincial governments should be established;

iv. medical aid societies should be obliged to make provision for, and contribute 75% of the costs of, the following services: services of general practitioners; specialist services; operations; hospitalisation; medicines administered during hospitalisation and injections by doctors; radiological services; pathological services;

v. additional benefits of a non-medical nature should be prohibited;

vi. medical schemes which do not make provision for dependents should not be registered;

vii. provision should be made for State subsidies; and

viii. no scheme should be permitted to terminate membership of a person on the grounds of high claims.[198]

The Medical Schemes Act, 1967 (Act No. 72 of 1967) was the direct result of the reports of the Snyman Commission and the Departmental Inquiry.[199] The Act was subject to several amendments, the most significant of which was enacted in 1993. Prior to this amendment, the main features of the Act included: the establishment, composition and working procedures of the Central Council for Medical Schemes, which could issue rules, conduct investigations, and dispense discipline; the establishment of a Medical Schemes Fund to which all registered medical schemes are obliged to contribute; the establishment of the Representative Association of Medical Schemes (RAMS) as a forum for discussing tariffs between the State, medical practitioners and medical schemes; matters of registration and general matters of management of medical schemes; provision for determination of a scale of benefits; and certain limitations of the powers of medical schemes.

The Medical Schemes Amendment Act 1993 (Act No. 23 of 1993) brought about extensive deregulation of the private sector. The amendment arose largely from a concern that the existing Medical Schemes Act caused overutilisation of, and over-provision by, medical schemes by setting enforceable minimum benefits, and by the fact that payments for services rendered according to the scale of benefits were direct and guaranteed.[200]

Five major changes were introduced by the Act. First, the Representative Association of Medical Schemes (RAMS) is no longer a statutory, but a voluntary organisation. The issue of tariffs has now been left to individual schemes and to the dictates of the market. Secondly, the requirement that schemes provide a minimum package of benefits to members has been repealed. Thirdly, the system of automatic guaranteed payment to doctors by medical schemes was scrapped. Medical schemes can now reject claims by doctors who have charged more than the tariff set by that scheme. In such a case, the doctor would be able to revert back to the member for the balance of the costs. Fourthly, the Medical Schemes Fund was abolished. Fifthly, and perhaps most significantly, provision is made for "managed health care", in which medical aid schemes and health care providers may team up in a single organisation. The motivation for introducing managed health care is that it would remove the incentive to over- or under-supply services. Managed health care is said to have cut costs by as much as 40% in some countries.[201]

### 2.6.3 Policy of the new government

The ANC-led government, which came into power following the April 1994 elections, has articulated policy which, if implemented, would result in a narrowing of the divide between the private and public health sectors. In terms of the ANC National Health Plan, the private sector will be restructured so as to enhance its important role in improving the health of the nation under the new National Health System. The plan states that active co-operation between private and public sectors will promote a positive climate in which the two sectors can work together, with the common goal of achieving health for all.

Mechanisms suggested to enhance this co-operation include: encouraging private practitioners to work increasingly in the public sector, deriving their income from health authorities, but maintaining their independence; encouraging private

practitioners to work in public clinics, health centres and hospitals on a regular rotational basis; and encouraging all health workers in both the public and private sectors to follow agreed National Health System protocol for the care of common conditions, including appropriate referral of patients.[202]

The most recent articulation of government policy on the interaction between the private and public sectors was the Report of the Committee of Inquiry into a National Health Insurance System, released for public comment on 20 June 1995.

The report acknowledges that substantial improvements to the publicly funded primary health care system will require that it draws on the extensive resources used exclusively in the private sector at present. These resources might include, among others, health care personnel, physical facilities, administrative and management infrastructure and expertise.[203]

In the report, it is envisaged that district health authorities would ultimately act as purchasers of care from varying combinations of public and private providers, thus providing opportunities for private providers to enter into market-related contractual relationships with the public sector. Employers currently providing health services to their employees could also be accredited as primary health care providers within the system.[204]

The report also makes certain other recommendations regarding regulation of the private sector, which are designed to contain escalating costs, and improving equity and efficiency. These recommendations include, *inter alia*[205]:

i) it should be made mandatory for all persons in formal employment to obtain private health insurance coverage for a defined hospital benefit package;
ii) various regulatory mechanisms should be introduced which would apply to packages offered by medical schemes, designed to increase risk pooling and cross subsidisation from the healthy to the sick and from young to old;
iii) all health insurance products, medical schemes, benefit funds, and medical savings accounts should be brought under the ambit of a single Act, in order to streamline the regulation of the health insurance market;
iv) regulations aimed at increasing competition between medical schemes should be investigated;
v) mechanisms should be implemented to increase efficiency of scheme management and to improve monitoring of medical schemes; and

vi) provincial hospital authorities should be responsible for authorising the construction of new hospitals and regulating supply of expensive technology in both the public and private sectors.

These recommendations are still to be subject to public scrutiny and negotiations with relevant role-players, and it is therefore not yet known to what extent they will be accepted and translated into legislation.

## 2.7 CONCLUSION

It is apparent that legislation has played a pivotal role in causing the fragmentation that pervades the health system. It is equally apparent that the introduction of appropriate health legislation will be crucial in welding the fragmented pieces of the South African health system into the National Heath System envisaged by the new Government.

An appropriate legislative framework is required to overcome structural fragmentation by authorising a single governmental structure to establish national health guidelines, priorities and standards, and to enable actual management of services to be decentralised. The need for such legislation is recognised in the ANC's National Health Plan.

Fragmentation of statutory bodies representing the health professionals is already being addressed in the proposed 1995 amendments to the various Acts relating to health professionals. As discussed above, however, attention may well need to be given to further consolidation of legislation which would introduce an umbrella body to co-ordinate regulation of the professions.

The legislative basis for racial fragmentation of health services has already been removed. However, remnants of the homeland system remain on the statute books. Section 229 of the Constitution of the Republic of South Africa Act, 1993 (Act No. 200 of 1993) provides that all laws which existed immediately prior to 27 April 1994 in any area which now forms part of the Republic of South Africa, shall continue in force until they are repealed or amended by a competent authority. The health laws of the former TBVC States and self-governing territories therefore all continue in force in their respective areas for the time being. Harmonisation of these laws with the laws of the former provinces and of the Republic is a priority

for each provincial government, because health services cannot continue to be governed by the conflicting legal regimes of former jurisdictions.

Fragmentation of occupational health laws continues to exist, despite various attempts in the last few decades to achieve greater consolidation of the laws and co-ordination of administrative responsibility for the laws. There are, however, indications that the new Government will take measures to effect greater co-ordination.

The problems which arose from legislative fragmentation of occupational health legislation - including overlapping of functions, discrepancies in standards, gaps, and a proliferation of red tape - should serve as a *caveat* against fragmentation of other laws which impact on health. The fact that over one hundred South African statutes which impact on health currently exist, and that they are administered by twenty-two government departments, is alarming. Fortunately, there are indications that the Department of Health is aware of the dangers inherent in this situation. One of the terms of reference of the Department's National Health Legislation Review Committee, established in 1994, is to rationalise and consolidate all national health legislation into a few laws.

Finally, the new Government has made clear its intention to narrow the divide between the public and private health sectors, by developing mechanisms to partially integrate private sector providers into a new National Health System. Whether this integration will be done by means of *ad hoc* contractual arrangements between public institutions and private sector providers, or by means of a national health insurance system in which private providers would participate, provision for this integration will need to be made through legislation.

Significant progress has been made since the April 1994 elections at national and provincial levels towards formulating new health legislation which will eliminate the fragmentation of the past. Chapter Four below considers the progress of these developments. It is however, first necessary to consider the constitutional dispensation in terms of which the new laws are being made. Chapter Three therefore considers the implications for health legislation of the Interim Constitution. An adequate understanding of the constitutional framework within which health legislative reform is taking place is crucial to the evaluation of legislative options for the reform of the South African health system.

# CHAPTER THREE

# THE INTERIM CONSTITUTION

## 3.1 INTRODUCTION

The Constitution of the Republic of South Africa of 1993 (Act No. 200 of 1993), hereinafter called the "Interim Constitution", came into operation on 27 April 1994. Not only did this event constitute the most fundamental transformation in South African constitutional history, but it also has profound implications for health. On the one hand, the new political dispensation, created by the Interim Constitution, has important consequences for the organisation of health services in the country. On the other hand, Chapter Three of the Interim Constitution contains certain fundamental rights which are of relevance to the formulation of health policy and its implementation through legislation. Both of these aspects of the Constitution are expounded on below.

It is also of importance to take note of the interim nature of the Act. The Interim Constitution provides that a new constitutional text is to be adopted within two years of the date of the first sitting of the National Assembly under the existing Constitution.[206] The new text is required to comply with a scheduled set of thirty-four "Constitutional Principles",[207] which are themselves immutable. Some of the Constitutional Principles which are of particular relevance to health and the organisation of health services are reproduced in Annexure Two.

Participants in the health sector now have a significant opportunity to take part in the formulation of the final Constitution, where the existing Constitution is found inadequately to protect the health interests of the population. In the discussion on fundamental rights which may impact on health, recommendations are made for changes to the Interim Constitution in such a way that the final Constitution would give greater priority to health.

## 3.2 THE NEW POLITICAL FRAMEWORK

### 3.2.1 The creation of nine new provincial administrations

Section 124 of the Interim Constitution establishes a new political framework by the creation of nine new provinces, which replace the former four provinces and ten so-called self-governing territories and independent states. This has significant implications for public sector health services which need to be reorganised according to the new boundaries, with resultant transfers of staff, facilities and budgets to the new provincial administrations. Health services inside the boundaries of the provinces now fall under the political authority of the respective provincial Member of the Executive Council (MEC) for Health. The nine health departments will operate within national policy formulated by the national Department of Health, under the national Minister of Health.

### 3.2.2 Legislative competencies with regard to health services

Section 126(1) of the Interim Constitution provides that provincial legislatures have concurrent competence with the national Parliament to make laws for the province with regard to all matters which fall within the functional areas specified in Schedule 6. In terms of section 126(3), an Act of Parliament which deals with the Schedule 6 functional areas will prevail over laws made by the provincial legislatures, only to the extent that -

*(a) it deals with a matter which cannot be regulated effectively by provincial legislation;*

*(b) it deals with a matter that, to be performed effectively, requires to be regulated or co-ordinated by uniform norms or standards that apply generally throughout the Republic;*

*(c) it is necessary to set minimum standards across the nation for the rendering of public services;*

*(d) it is necessary for the determination of national economic policies, the maintenance of economic unity, the protection of the environment, the promotion of inter-provincial commerce, the protection of the common market in respect of the mobility of goods, services, capital or labour, or the maintenance of national security; or*

*(e) the provincial law materially prejudices the economic, health or security interests of another province or the country as a whole.*

Health services are listed in Schedule 6 as one of the functional areas within the legislative competence of the provinces. The effect of section 126 is therefore that, while both provincial legislatures and the national Parliament may legislate on health services, to the extent that there is conflict, the provincial laws will prevail, subject to the limited exceptions stated above. Section 144 of the Interim Constitution has the further effect of making health services an executive competence of the provinces, as it provides that provinces shall have executive authority over all matters in respect of which such provinces have exercised their legislative competence, or matters assigned or delegated to them under the Interim Constitution or under any other law.

The President, acting within powers conferred on him by section 235(8) of the Interim Constitution, has already reassigned the administration of certain laws of the former provinces, self-governing territories and so-called independent states, including laws which relate to health services, to the new provincial administrations.[208] He has also assigned to the provincial governments the administration of the Health Act 1977 (Act No. 63 of 1977), excluding those provisions which were deemed to fall outside the Constitutional legislative competence of the provinces.[209] Excluded from the assignment were, *inter alia*, provisions relating to functions of the national Department of Health and provisions conferring power to make environmental regulations in the interest of public health.

Health services are therefore now within both the legislative and executive competence of the provincial governments. In terms of the Interim Constitution, amendments to the legislative and executive competencies of the provinces require special procedures involving special majorities.[210]

It is clear that sections 126 and 144 give wide powers to the provinces in respect of the delivery of health services. Certainly, they appear to allow the provinces to develop their own health systems within national guidelines and norms. The Ministry of Health and Social Services in the Western Cape has gone so far as to interpret section 126 to mean that the national Department's functions have been reduced to overall policy-making, interprovincial co-ordination and provision of

services which cannot be efficiently or effectively provided by a province, while provinces are given the power to formulate any health policy provided that it does not fall within the exceptions listed in section 126(3).[211]

From a legislative perspective, ten separate Health Acts may develop in South Africa - one national and nine provincial. Unless this process is carefully managed and properly co-ordinated, administrative chaos and increased fragmentation of the health system may ensue. Of central importance to the co-ordinated development of health legislation at national and provincial levels, is the need for clarity on the definition of the term "health services", as it is used in Schedule 6 of the Interim Constitution. This will determine the precise ambit of the legislative competence of the provinces. Clarity on the "grey areas" may be achieved by a process of continuous challenge to the Constitutional Court. A preferable approach would be to attempt to reach consensus between all the provincial Departments and the national Department of Health. This would be cheaper, faster, and more efficient. For this approach to succeed, however, it is vital that there is a commitment by all the provinces to ensure an integrated and comprehensive national health system for all South Africans.

### 3.2.3 Legislative competence with regard to local government

Given the emphasis in the Reconstruction and Development Programme on decentralisation of health service provision to the lowest level,[212] it is clear that local government will continue to play a pivotal role in health service provision. When considering the development of new health legislation in South Africa, it is therefore also important to know how powers of local government are to be determined in terms of the Interim Constitution.

The Interim Constitution does not specify unqualified powers and functions of local government. Rather, these powers and functions are to be determined by law. In this regard, section 175 of the Interim Constitution provides:

> *(1) The powers, functions and structures of local government shall be determined by law of a competent authority.*
>
> *(2) A local government shall be assigned such powers and functions as may be necessary to provide services for the maintenance and promotion of the well-being of all persons within its area of jurisdiction.*

*(3) A local government shall, to the extent determined in any applicable law, make provision for access by all persons residing within its area of jurisdiction to water, sanitation, transportation facilities, electricity, primary health services, education, housing, and security within a safe and healthy environment, provided that such services and amenities can be rendered in a sustainable manner and are financially and physically practicable.*
(My underlining)

Local government also falls within the Schedule 6 functional areas. The Constitution therefore provides that the national Parliament and provincial legislatures have concurrent competence to enact legislation which stipulates the powers and functions of local government in respect of the provision of health services, but that in the event of inconsistency, the provincial laws will prevail except in the limited circumstances listed in section 126.

Interim measures have been provided for by the Local Government Transition Act, 1993 (Act No. 209 of 1993), which will prevail until the final Constitution has been implemented and Provincial legislatures have provided the final legislative framework for local government. The Act makes provision for three phases of local government reform, namely, the pre-interim, interim and final phases.

The pre-interim phase entails the establishment of local negotiation forums for the purpose of negotiating the establishment of transitional councils, which comprise members appointed from statutory and non-statutory bodies. Transitional council options include a transitional metropolitan council with substructures, a transitional local council and a local government co-ordinating committee. In terms of section 7(1)(b), the powers and duties of transitional metropolitan councils and substructures may be negotiated by the local negotiation forums, but shall be at least the powers and duties listed in Schedule 2, which includes *inter alia* ambulance and hospital services. The powers and duties of local government co-ordinating committees may also be subject to negotiation, but certain minimum powers and duties are stipulated in section 7(1)(c) including, *inter alia,* to ensure access by all persons residing within the areas of jurisdiction of the individual local authorities to health services and emergency services.

The pre-interim phase will be succeeded by the interim phase after the democratic local government elections, currently scheduled to take place on 1 November 1995. During the interim phase, elected members will replace appointed members of the transitional councils, and will serve for an interim period of three to five years. Section 8(1)(b) provides that the powers and duties of transitional metropolitan councils and substructures will be determined by the Administrator in a province (an authority designated by the Premier of that Province), but shall be at least those powers listed in schedule 2, which includes hospital and ambulance services.

The interim phase will end and the final phase will commence with the implementation of final arrangements, to be enacted by the Provincial legislatures. The nature of these final legislative arrangements and their implications for the provision of health services will be determined according to the parameters set out in the final Constitution. Once the final legislative arrangements are in place, a second round of local government elections will be held, which will mark the end of interim government at local level.

## 3.3 FUNDAMENTAL RIGHTS

### 3.3.1 Introduction

Chapter Three of the Interim Constitution contains the Bill of Rights, which is binding on all legislative and executive organs of State at all levels of government.[213] Some of the rights enshrined in this Chapter impact on the formulation of health policy and its implementation through legislation.

### 3.3.2 Fundamental rights which impact *directly* on health

Although there is no specific mention of a general right to health, some of the rights do have *direct* relevance to health.

Section 29 provides that every person shall have the right to an environment which is not detrimental to his or her health or well-being. It has been suggested that section 29 could sustain an argument that the State is bound to provide basic health services for all.[214] While this is an unlikely consequence of section 29,

the inclusion of this third-generation right in the Interim Constitution may well lay the foundation for a more specific right to health services in the final Constitution, as is suggested in paragraph 3.3.4.1, below.

More direct protection of the right to basic health services is provided for in section 30(1)(c), which provides that every child shall have the right to security, basic nutrition and basic health and social services. Du Plessis and Corder make the point that enforcement of this provision may prove to be difficult, because the Interim Constitution does not suggest how second-generation entitlements are to be enforced. Nevertheless, they recognise the importance of the fact that such technical difficulties were not allowed to exclude the implementation of appropriate conduct and care in the area of children's rights, and suggest that courts should honour this sentiment as best they can, particularly during the transition when the position regarding second generation rights will remain unclear.[215]

Recognition of the right to health services is also afforded to persons who are detained. Section 25(1)(b) provides that every person who is detained, including every sentenced prisoner, shall have the right to be detained under conditions consonant with human dignity, which shall include at least the provision of adequate nutrition, reading material and medical treatment at State expense.

Finally, it is also arguable that section 10, which provides that every person shall have the right to respect for and protection of his or her dignity, requires that a person be protected from human suffering flowing from a denial of the right to health.[216]

### 3.3.3 Fundamental rights which impact *indirectly* on health

Many of the other rights in the Chapter may also have *indirect* impact on health.

Section 9, for example, provides that every person shall have the right to life. This provision has clear implications for the death penalty, euthanasia and abortion.[217]

Section 8(1) provides that every person shall have the right to equality before the law and to equal protection of the law. Section 8(2) further provides that "[n]o person shall be unfairly discriminated against, directly or indirectly, and, without derogating from the generality of this provision, on one or more of the following

grounds in particular: race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture or language". These provisions place an obligation on the State to ensure equity in the provision of health services. Existing discrepancies in health service provision between racial groups, and between different provinces and local authority areas urgently need to be redressed in the light of this provision.

The tobacco industry has already objected to regulations requiring health warnings on tobacco packages, on the basis of the protection of the right to property, in section 28 of the Interim Constitution, and it has invoked the right of access to information held by the State (section 23) to gain access to Department of Health documentation on tobacco control.[218] Section 23 may also have implications regarding access of patients to their medical records, which is discussed on page 120 below.

Section 13, which provides that every person shall have the right to his or her personal privacy, may also influence the manner in which data may be collected for research and statistical purposes from patient records and other medical databases which contain personal particulars.

### 3.3.4 Need to give higher priority to health in the new Constitution

In the light of current initiatives to draft a new and final Constitution, two recommendations are made for the new Constitution based on the need for a broader approach to health promotion that includes legislative action.

#### 3.3.4.1. A right to "health services"

First, it is of concern that the right of the public to protection of their health is couched in a statement in section 29 which is vague and negatively phrased: "Every person shall have the right to an environment which is not detrimental to his or her health or well-being". While it is acknowledged that specific protections are afforded to detainees and children, no positive duty is placed on the State to provide essential health care to other disadvantaged groups in society, such as women, the disabled, and the elderly. It is recommended that an additional right of every person to "health services" be included in the new Constitution. In terms of section 33(1) of the Interim Constitution, legislative limitation of the ambit of

this right within the constraints of available resources would be permitted to the extent that is reasonable, and justifiable in an open and democratic society based on freedom and equality, provided that the essential content of the right is not negated.

#### 3.3.4.2 Individual rights and the common good

Secondly, the primacy given in Chapter Three of the Interim Constitution to fundamental rights of persons, both natural and juristic, raises the concern that the implementation of legitimate government policies to advance the common good may be jeopardised by reliance on competing individual rights.

The tobacco industry has already based its challenge to the proposed tobacco health warning regulations of the Department of Health on alleged infringement of its property rights, as established in section 28 of the Constitution. Whether or not the claim of the tobacco industry has merit, their challenge should serve as a caution that health promotion legislation in the future may be threatened by competing individual rights.

While it is true that section 33(1) allows for limitation of rights in the public interest, it should not be necessary for government to bear the onus of proving that its interest in matters such as public health, is a substantial one. The substantiality of such interests should be stipulated as an irrebuttable presumption in the Constitution. Once important matters of common good, such as public health, are at stake, it should remain only for government to prove that the intended measures are rationally tailored to the objective.

Such prioritising of the common good is already effected in relation to the right to freedom of economic activity in section 26. In terms of section 26(2), the right freely to engage in economic activity (as provided for in section 26(1)), "shall not preclude measures designed to promote the protection or the improvement of the quality of life, economic growth, human development, social justice, basic conditions of employment, fair labour practices or equal opportunity for all, provided such measures are justifiable in an open and democratic society based on freedom and equality".

Notable for their absence in section 26(2) are the important considerations of "public health" and the "environment". Should section 26(2) remain in place in the new Constitution, these considerations should be added.

It is recommended, however, that section 26(2) falls away in the new Constitution, in favour of a provision prioritising matters of common good in relation to rights more generally. There is indeed no reason why the common good should only be prioritised in relation to the competing right of freedom of economic activity.

It is therefore recommended that section 33 be supplemented by an expanded form of section 26(2), which itself would fall away. The additional section would approximate the following:

> *The rights entrenched in this Chapter shall not preclude measures designed to promote the protection or improvement of the quality of life, economic growth, human development, public health, environment, social justice, basic conditions of employment, fair labour practices or equal opportunity for all, provided such measures are justifiable in an open and democratic society based on freedom and equality.*

## 3.4 CONCLUSION

The Interim Constitution has established some important guidelines for the development of health policy, the organisation of health services, and the formulation and implementation of health legislation. The development and the content of new health legislation which is proposed at provincial and national levels, and which is described in the following two chapters, needs to be viewed critically in this light. To some extent, although limited by the Constitutional Principles in Schedule 4, the Constitutional parameters are a moving target, as significant changes may result from the drafting of the final Constitution. In that case, new health legislation may have to be reviewed again in the light of the changes.

# CHAPTER FOUR

# LEGISLATIVE PROCESSES AT NATIONAL AND PROVINCIAL LEVELS

## 4.1 INTRODUCTION

By June 1995, more than a year after South Africa's first democratic elections of 27 April 1994, no major reform of South African health legislation had taken place at provincial or national levels. That did not mean that health legislation reform was ignored by the national or provincial health departments - processes for legislative reform were well under way at national and provincial levels.

This Chapter tells the story of the processes of developing new Health Acts at national and provincial levels between the time of the elections and June 1995. It documents the first part of a much longer story that is yet to unfold. Although the legislative processes are in many respects only in their nascent phases, it is considered important that the early developments are not lost in the evolving process.

The story is not written as a saga of political intrigue, but is rather motivated by a concern that the further development of legislation at national and provincial levels should take place with the benefit of hindsight, aware of strengths and weaknesses of what has already been done. It is not intended to be an objective and dispassionate narrative of events, but represents the writer's own subjective interpretation of events.[219]

## 4.2 THE NATIONAL LEGISLATIVE PROCESS

### 4.2.1 An early ANC initiative

In early 1994, prior to the elections of 27 April, the African National Congress (ANC) initiated a process of drafting provisions of new health legislation. Drafting focused on restructuring the existing policy-making structures which had been

established under the National Policy for Health Act 1990 (Act No. 116 of 1990). It appears that the motivation for this initiative was to facilitate the smooth transition of the health system after the elections, based on principles outlined in the ANC National Health Plan. The initiative appears to have met with opposition from bureaucrats of the old Department, and after some disagreement between officials of the old Department and incoming ANC-aligned advisors, the initiative fell through.[220]

### 4.2.2 A Departmental initiative

A curious sequel to the ANC initiative occurred in early June 1994, when a draft Health Bill was circulated within the Department of Health for discussion. Less than two weeks later, a second draft Health Bill discussion document, which was a revised form of the first draft, was circulated for comment to local authorities and to regional branches of the Department of Health. It is unclear precisely where this initiative originated, although it appears that it emanated from director level of the Department of Health, which was then still predominantly comprised of the directors who had held office in the former Department of National Health and Population Development. The actual drafting of these proposals was done by the Law Review Project, a section 21 Company. The motivation for the release of these drafts could not be ascertained.

Both drafts were in many respects a clumsy attempt to rework the old 1977 Health Act to accommodate the concept of a district health system, with little obvious attempt at streamlining the 1977 Act, or at bringing the Act into line with current policy and with modern international trends and concepts of health.

In the first draft, references to local authorities in the 1977 Act were replaced by references to district health councils, without providing clarity on the relationship between district health councils and local authorities, or on the role which local authorities should have in the enforcement of the Act. Further, no mechanisms were established for the transfer of assets to district health councils from the Department, the provincial administrations and local authorities.

Further than that, substantive departures from the 1977 Act included provision for intersectoral development committees at various levels, and the omission of provisions dealing with the appointment by local authorities of medical officers of

health and health inspectors, the removal of such persons from office, and the reduction of their salaries.

The second draft Health Bill reverted to designating local authorities as the service rendering bodies at local level, with an expanded range of functions. While provision was made for the establishment of district health councils, they were rather toothless bodies, their functions being only to "oversee and evaluate the performance by local authorities of their functions in terms of the Act".[221] This revised document did little to resolve the confusion surrounding the intended role of district health councils vis-a-vis local authorities.

Other substantive differences between the second draft and the first draft included: the omission in the second draft of provision for intersectoral development committees, and the reconstitution of the policy-making structures in the National Policy for Health Act under the proposed National Health Bill.

It is submitted that, for two fundamental reasons, the timing of the draft Bills was inappropriate, and the Bills were destined to fail from the start.

First, the Bills purported to deal with issues such as the nature of the district health system when discussion about these policy issues was only beginning to emerge. The complete incongruity between the first and second proposals relating to the relationship between district health councils and local authorities is symptomatic of a poor attempt to formulate legislation without any established policy basis. Both drafts were superficial attempts at restructuring. If either of them had been passed by Parliament, the new law would have become a major impediment to restructuring of the health system, once greater clarity on policy had emerged.

Secondly, no consideration appeared to be given to s 126 and Schedule 6 of the Interim Constitution, in terms of which health services became a provincial legislative competence. Not only did the drafts deal in great detail with the provision of health services, but they failed to make sufficient provision for differing conditions in the respective provinces. This was certainly inappropriate given the constitutional framework.

It is submitted that if the same drafts had to be circulated for comment among provincial departments a year later once the departments and legislatures had had

time to establish themselves and to consider the implications of their legislative competence, they would be perceived as a sinister intrusion on the powers of the provinces, and would cause a storm of controversy that would throw the fledgling Department of Health into crisis.

A major crisis was averted, however, as the Bill was withdrawn shortly after release of the second draft. The Bill was withdrawn on the grounds that policy on some critical issues still required to be defined.[222]

### 4.2.3 The National Health Legislation Review Committee

#### 4.2.3.1 The appointment of the Committee

Between June and October 1994, the Minister of Health, Dr Nkosazana Zuma, appointed nine committees to investigate important aspects of the health care system and to recommend policy options for the reconstruction and development process.[223] The committees were comprised of national and international experts with experience and insight in restructuring health care. The committees were generally expected to complete their tasks and to submit their reports to the Minister by the end of December 1994.

One of the nine committees appointed by the Minister was the National Health Legislation Review Committee.[224] Membership of the Committee included representation from the Department of Health, as well as legal and public health expertise.[225] The Committee was established to review all national health legislation. Its particular terms of reference were:

1. to rationalise and consolidate all national health legislation into a few laws;

2. to amend other laws to be in line with new health policy;

3. to repeal those laws which are not necessary;

4. to ensure that all legislation is consistent with the new Constitution;

5. to suggest new issues needing legislation; and

6. to assist in writing a new Public Health Act.[226]

#### 4.2.3.2 Representation of the provinces

Provincial health departments had a substantial interest in the work of the National Health Legislation Review Committee, particularly because health services are a provincial legislative competence in terms of the Interim Constitution. For this reason, regular reports on the progress of the Committee were made to the Provincial Health Restructuring Committee, on which the national Ministry of Health and the provincial Members of the Executive Councils responsible for health were represented.

On 24 November 1994, a Provincial Health Legislation Seminar was held in Pretoria, hosted by the Medical Research Council's Health Law Research Project. Represented at the seminar were: the health legislation committees of seven of the nine provinces; the National Health Legislation Review Committee; and the Health Standing Committee of the National Assembly. The meeting was significant in that it was the first occasion on which members of the provinces charged with drafting had an opportunity to come together and voice concerns.

At the seminar, provincial representatives stated that provincial health legislative initiatives were being hampered by a lack of co-ordination between provincial and national initiatives, and that regular reports to the Provincial Health Restructuring Committee were insufficient to facilitate this co-ordination. Responding to these concerns, the then Deputy Director-General of the Department of Health, Dr Hans Steyn, asked all the provinces to nominate representatives to sit on the National Health Legislation Review Committee.[227] However, insufficient follow-up appears to have been made on the invitation, and there was little provincial representation on the Committee for the next few months. Further, a provincial legislation workshop which was due to be held by the National Health Legislation Review Committee in January 1995 was postponed indefinitely due to organisational constraints.[228]

The absence of provincial representation on the Committee became increasingly problematic as the work of the Committee progressed. Provincial input was particularly needed in respect of legislative matters concerning the rendering of health services in the provinces, and in respect of legislation which possibly fell within the constitutional legislative competence of the provinces. In 1995, a

concerted effort was made to encourage provincial participation on the Committee, and by June 1995, most of the provinces had nominated representatives to serve on the Committee.

#### 4.2.3.3 Input of other policy committees

From the commencement of the work of the Committee, it was acknowledged that legislation could not be drafted until clear policy had been articulated on the issues involved. As legislation was one of the major mechanisms whereby the recommendations of the other policy committees of the Department of Health could be implemented, the reports of these Committees were considered crucial to the deliberations of the National Health Legislation Review Committee. Although it was initially anticipated that the National Health Legislation Review Committee would complete its work within a period of three months,[229] it became apparent that the work of the Committee could only start in earnest once the reports of the other policy committees were finalised.

All the committees were approached by the National Health Legislation Review Committee to provide a legislative framework for the policy which they formulated, as well as to identify issues which urgently required legislation.[230] While some of the committees did consider some legislative issues,[231] on the whole policy recommendations appear to have been made without particular regard to possible legislative mechanisms for implementing the recommendations. Further, representatives of the various policy committees were given the opportunity to participate in meetings of the National Health Legislation Review Committee, but few of the policy committees participated in this way.

The National Health Legislation Review Committee was later represented on a taskgroup, chaired by Dr Harm Pretorius, which had the responsibility of assimilating the recommendations of the reports into a single document. However, by then the recommendations of the various policy committees had been finalised, and it was too late for the National Legislation Review Committee to have any meaningful input on the content of the recommendations.

In retrospect, it is submitted that the implementation of the reports of the various policy committees would have been made considerably easier if more attention had been given by the various policy committees to legislative considerations *when the*

*policy was being developed*, or even if membership of every policy committee had included legal representation. In this way, policy could have been formulated with a specific focus on issues which would need to be addressed in order to redress current inadequacies in legislation, and the development of policy would also have been informed by an understanding of the potential and limitations of legislation as an instrument to implement the policy. While it is theoretically correct for the formulation of policy to precede legislation, in practice there are advantages for the development of policy and legislation to occur in tandem.

#### 4.2.3.4 The work of the committee

The Committee started its work by identifying all South African statutes impacting on health, and then reviewing this legislation in the light of the terms of reference of the Committee. The Committee further identified issues which would need to be considered for possible inclusion in the national Health Act, as well as international conventions which were relevant to South African health legislation. The Committee also received numerous submissions from a variety of interest groups regarding *ad hoc* amendments to existing laws and regulations, and these were referred to the legal services section of the Department of Health. Priority areas for legislation were identified, with a view to determining which subject matters should fall within the new National Health Act.

In January 1995, a proposed framework for a new National Health Act, which had been prepared by the KwaZulu-Natal health legislation committee, was tabled at a National Health Legislation Review Committee meeting. It was adopted as a working document on which the new Health Act could be based. Members of the Committee each assumed responsibility for investigating policy and legislation affecting some of the issues.

Once input concerning some of these issues had been received, responsibility for preparing a draft National Health Act for consideration by the Committee was assigned to two members of the Committee - Prof Paul Benjamin and the writer. Once drafting began, the framework for the new Health Act was considerably refined. The two drafters developed proposals which they presented to the National Health Legislation Review Committee as a discussion document in June 1995.

The discussion document contained: draft provisions of a National Health Act; notes on some of these draft provisions; and various memoranda discussing additional topics for incorporation in the Health Act. The document was prepared with the intention that it be circulated in order to generate discussion on issues where there is as yet no definitive policy, the translation of policy into legislation, and the format and structure of a new Health Act. The Act was proposed as a broad enabling framework for the governance of the health system, rather than a detailed regulatory instrument. The proposals are discussed in greater detail in the next chapter.

On receiving these proposals, the Committee agreed that the document would be released as a public discussion document once members of the Committee and the heads of provincial health departments had had opportunity to review it, and once it had been suitably amended.

Thus by June 1995, concrete proposals for the new National Health Act had been prepared, and the National Health Legislation Review Committee had become broadly representative of the national Department of Health and the various provincial health departments. In many respects, this was only the beginning of a long process of development of a new Health Act which must follow. The process is likely to be protracted and will give rise to much dispute as a variety of role-players is consulted. Controversy and compromise are inevitable components of the legislative process, particularly if there is to be widespread consultation with interested parties. Such consultation should not be avoided, however, as the end result will be legislation which is acceptable to more people, and therefore will enjoy greater voluntary compliance than if interested parties were not consulted.

## 4.3 PROVINCIAL LEGISLATIVE PROCESSES

### 4.3.1 Background

The appointment of members of the Executive Councils responsible for health services in each of the various provinces[232] created new political heads for provincial health services, while previous administrative heads for various components of the health services were still in place. This created a dichotomy of authority within provincial health services with the Member of the Executive

Council (MEC) as a political head and the most senior civil servants as the financially accountable officers. The Interim Constitution anticipated such a dichotomy, and put in place various transitional mechanisms to overcome it.[233]

A Commission on Provincial Government was established in terms of section 163 of the Interim Constitution, the object of which was to facilitate the establishment of provincial government. The Commission established a Change Management Strategy, in terms of which Strategic Management Teams (SMTs) were created in each provincial Ministry. The SMTs were transitional structures, which ceased to function once the new provincial departments of health were properly in place. The task of the SMTs was, essentially, to advise the Member of the Executive Council and to manage the transition in each provincial Ministry. One of the terms of reference of the SMTs was to "facilitate the drafting of legislation pertaining to Schedule 6 functions and identify elements of the 1995/6 budget".[234]

The SMTs of most of the provinces delegated responsibility for investigating legislative measures to taskgroups. The various provincial legislative initiatives of the SMTs achieved varying degrees of success. Those initiatives which were least successful attributed many of the difficulties they had encountered to a lack of technical support, and to poor co-ordination between provincial and national levels.[235]

The KwaZulu-Natal health legislation task-force appears to have adopted the most comprehensive approach to legislative reform, and the legislative process adopted in that province is notable because of the widespread consultative process which was carried out. The process has many positive features which may hold significant advantages for other provinces which are in the early phases of legislative development. For these reasons, the discussion of legislative processes at provincial level is focused on the experience in KwaZulu-Natal. The KwaZulu-Natal experience is related step-by-step and in considerable detail, in order that it can be effectively used as a model for other provinces.

The KwaZulu-Natal model is not without its flaws, and in retrospect it could have been improved in several respects. In order to highlight the strengths and weaknesses of the KwaZulu-Natal approach, the approach adopted by the SMT in the Western Cape is briefly described at the outset as a point of comparison.

### 4.3.3 KwaZulu-Natal

#### 4.3.3.1 The appointment of a health legislation taskforce

In order to perform its function of facilitating the drafting of legislation pertaining to health services, the Strategic Management Team in KwaZulu-Natal appointed a health legislation task-force in September 1994. The functions of this committee were:

i. to identify legislation which should be incorporated into the new KwaZulu-Natal Health Act;
ii. to develop a framework for a provincial Health Act; and
iii. to commence drafting the new legislation.

At the outset, the committee was comprised of representatives from the National Department of Health, the former KwaZulu and Natal Provincial Administration health authorities, and local authorities in KwaZulu-Natal. The writer, who was at the time employed as the research officer of the Medical Research Council's Health Law Project, participated in the taskforce as a consultant. The committee subsequently expanded to include lawyers from Lawyers for Human Rights, the National Association of Democratic Lawyers (NADEL), and the Black Lawyers Association (BLA).

#### 4.3.3.2 Principles for a new Act

The first task which the committee undertook was to agree on an ideological approach which would inform the development of the new legislation. The committee therefore developed a set of principles which would underpin the formulation of the new Act. These principles are listed in Annexure Three. While many of the principles are self-explanatory, the motivation for some of them may be unclear. Some of the principles are therefore briefly discussed below, according to the numbering of the principles in the annexure.

Principles one and six are based on the understanding that every law is an expression of policy, and that health legislation cannot be formulated unless the policy objectives are clearly defined. The absence of articulated policy concerning issues such as the structure and functioning of the district health system has subsequently proved to be a major impediment to the drafting process.

Principle two is motivated by a concern that well over one hundred Acts and ordinances, and many more regulations, have been identified which impact on health. This is not conducive to sound health system management, particularly since many of these laws are administered by government departments other than the health department. The principle that a single Act should cover all aspects of health therefore underpinned a need to rationalise health legislation, although it was acknowledged that in practice it would be impossible to achieve complete codification of all health laws.

The need for an enabling Act rather than a regulatory Act (principle 5) arose because it was felt that regulatory detail is more appropriately left to regulations, which can be frequently and relatively easily amended to accommodate changing needs and priorities. A principle was also accepted that the scope of the enablement provided for in the Act should be wide enough to strengthen the powers of the Member of the Executive Council for Health to intervene in all health matters in KwaZulu-Natal (principle 7). This principle was based on a concern that many factors with significant effect on the health status of the population have traditionally been outside the scope of the Health Ministry's powers, and have rather been controlled by other departments.

Given the entrenchment in section 14(1) of the Interim Constitution of the right to freedom of conscience, religion, thought, belief and opinion, it was considered necessary to state the principle that the Act must take cognisance of cultural and religious practices (principle 12). This principle may be significant to regulation in relation to a variety of beliefs and practices, for example: the slaughtering of animals in built-up areas; the practice of traditional healing; and the demand of the Christian Science community that healing should be allowed to take place by prayer alone.[242]

Principle 13 provides for the co-ordination of private and non-governmental initiatives if they involve public funds or assistance. It was felt that the co-ordination of non-governmental initiatives which did not rely on public funds or assistance may be construed as unjustified encroachment by the State on the private domain. However, it was agreed that the resources of private health service providers should be harnessed in the interests of the equitable delivery of primary health care (principle 14), and that interaction with the public sector of non-governmental and private initiatives should be encouraged through the

appropriate use of subsidies (principle 15) and the contracting out of services (principle 16).

Principle 20 was motivated largely by past experience in malaria control in KwaZulu-Natal, where attempts to introduce joint malaria control programmes with neighbouring Mozambique had been hampered by bureaucratic constraints caused by the need to follow diplomatic channels via the national Department of Foreign Affairs.

Principles 21 and 23 reflected the opinion of the committee at the time concerning the relationship between national and provincial legislation - national legislation should be confined to broad co-ordination and setting of standards on a national level, as well as issues on which there was consensus among all the provinces.

#### 4.3.3.3 A framework for the new Health Act

The legislation taskforce decided that it would be preferable to develop a new Health Act, rather than merely attempting to revise existing laws in an *ad hoc* manner. While this process would probably entail additional work, it was considered necessary because it was felt that the scope of existing laws was inadequate to accommodate the demands of a new provincial health system, and a comprehensive approach to health laws would facilitate efficient health system management better than a piecemeal approach.

A relatively comprehensive framework for the new Act was developed. This framework was based on a review of the general health laws of some 45 jurisdictions, which had been done previously by the writer. This framework was later disseminated for public comment, and was modified accordingly. The framework is attached as Annexure Four. The content of the provincial framework differs in some respects from the approach to health legislation traditionally followed in South Africa, in that it includes an emphasis on health promotion and community participation, and is largely enabling rather than regulatory.

While developing the provincial legislative framework, issues were identified which required to be legislated for at national level. A proposed framework for a national Health Act was forwarded by the Committee to the National Health Legislation Review Committee.

Both the provincial legislative framework and the national legislative framework were submitted to the Strategic Management Team for their approval.

#### 4.3.3.4 Review of existing laws

The development of a legislative framework was followed by a review of existing legislation which impacted on health, and which applied either nationally or specifically to KwaZulu-Natal. Members of the committee identified relevant legislation, and summarised the salient features of the laws. The Acts and Ordinances were then categorised in relation to the relative directness of their application to health and health services.

Thirty-one laws were categorised as "legislation unique to health", meaning that these laws fell under the exclusive jurisdiction of the Health Ministry. Thirty-five laws were categorised as being directly related to health, though falling under the jurisdiction of other departments. Forty-two laws were categorised as being laws which affected health or the carrying out of health services in some way, but which affected other departments equally. Laws in this category included, for example, the Liquor Act 1989 (Act 27 of 1989) and the Local Government Transition Act 1993 (Act No. 209 of 1993).

#### 4.3.3.5 The Action Plan

The basic groundwork had been done, which gave the health legislation committee a reasonably good indication of the complexity of the task awaiting it, and of what action would still be required. To guide the process further, an action plan was framed at the beginning of November 1994, which incorporated the intended activities of the committee for the next 8 months. The action plan included: dissemination of the legislative framework for public comment; negotiations with a variety of other role players; contracting of a legal drafting team; drafting of the Act; and finally submission of the final document to the Portfolio Committee on Health, the Cabinet, and the provincial legislature. A time frame was adopted as a guide, which would be modified according to unforeseen circumstances which might arise.

Constant forward planning and critical attention to procedural details were a hallmark of the activities of the health legislation committee, and contributed to its significant progress in a relatively short period of time.

#### 4.3.3.6 The consultation process

In accordance with the Action Plan, a process of widespread public consultation was initiated in early January 1995. The principles of the Act and the provincial legislative framework were distributed to all KwaZulu-Natal provincial hospitals and to the health departments in Ulundi and Pietermaritzburg. Notice of the availability of these documents and requests for comment were published in both Zulu and English in twenty-three local newspapers in KwaZulu-Natal. Individual notices were also sent to: 37 government departments at national and provincial level; 115 non-governmental organisations; 54 KwaZulu-Natal provincial hospital institutions; and 13 state-subsidised hospitals. The notice specified: where the document could be obtained; requirements for the submission of comments; a forwarding address for comments; and a description of the process to be followed after input had been received. A copy of the English version of this notice is attached as Annexure Five. Three weeks were allowed for comments, but this was subsequently extended by a further two weeks, due to public demand. This process elicited forty-nine written submissions from the public.

In addition, a series of six one-hour radio talk shows was held on Radio Zulu to explain aspects of the Act and to invite comment. In response to the radio talk show, the Department received thirty-seven telephone calls and eighty letters. The overwhelming majority of comments received in response to the radio talk show were in relation to proposals concerning the regulation of traditional healers.

Submissions were received from a wide spectrum of interest groups, including: health service providers; policy-making bodies; local authorities; various government departments; religious groups; non-governmental organisations; and private individuals. The overwhelming public response to the invitation for comments demonstrated significant public interest in the development of the Health Act. The health legislative committee took considerable time analysing all comments received. Individual replies were sent to every person who submitted comments.

The majority of comments received were of practical value, and these comments were incorporated into the framework. There were also comments which could not immediately be incorporated into the framework, because they were considered unacceptable, too controversial, or they related to matters which would require legislation at a national level.

The comments which were considered unacceptable were those comments which reflected viewpoints which the committee felt could not be sustained within the context of current policy and ideology, and they were therefore rejected. An example of such a comment which was received from a private individual is:

> *The introduction of the free treatment to pregnant women should only be implemented and exercised to legalized married couples. This will stop and reduce birth rate encouraged and perpetuated by illegitimate sexual practices. The state must arrest any unmarried youth demanding free treatments, regardless of race or qualifications.* (sic)

In the case of highly contentious issues, the committee put them aside to be discussed at interviews or public hearings, which are to be arranged at a later stage. Examples of controversial issues which were set aside in this way are: the division of responsibility for mortuary services between the South African Police Services, the health department, and local authorities; and the legitimacy or otherwise of parents refusing medical treatment to their children on the basis of religious belief.

Where comments were received which related to legislation at national level, the persons who wrote the comments were referred to the relevant authority. Issues which were regarded as national concerns related, for example, to the statutory bodies representing the nursing and medical profession.

#### 4.3.3.7 Contracting of lawyers

In keeping with the spirit of ensuring a broad, participatory approach to the formulation of the new Health Act, the Strategic Management Team declined to make use of State law advisors in the initial drafting processes. Rather they invited nominations for drafters from organisations representing predominantly black lawyers, namely: the National Association of Democratic Lawyers (NADEL), Lawyers for Human Rights (LHR), and the Black Lawyers Association (BLA).

A total of eleven applicants were interviewed. Selection criteria included: the need for representation of both attorneys and advocates; gender representativity; commonality of legal approach; and perceived ability of applicants to work in a team, under the co-ordination of the writer (who was delegated the responsibility of supervising the drafting process). Three lawyers were selected: one male and one female advocate, and a male attorney. They were each employed on contract for a period of one hundred and fifty hours, to commence drafting in March 1995.

None of the applicants had any experience whatsoever in legislative drafting, because black lawyers in South Africa have traditionally been excluded from positions as legal advisors in the civil service. As a consequence, the work produced was perhaps not as polished a product as if experienced drafters had done it. However, this drawback was outweighed by significant advantages. First, the process successfully developed capacity for legislative drafting among black lawyers. The experience gained can be drawn on in future. Secondly, the process allowed a departure from traditional legislative approaches which were considered undesirable, and it allowed for innovation. Any deficiencies resulting from lack of drafting experience could be rectified at a later stage by submitting the draft to experienced drafters for review.

#### 4.3.3.8 Drafting

a) *Plain language*

There was general agreement before drafting commenced that principles of plain language drafting should be adhered to. Committee members were of the opinion that the distinction between so-called "legislative language" and plain language is in many respects artificial, contrived and unnecessary. It was felt that legal jargon and complex statutory provisions should be avoided wherever possible because it often served only to exclude laypersons from the legal process, and from legitimate reliance on their rights. The committee also noted that the plain language movement had received support from Justice Minister Dullah Omar.[243]

While none of the drafters had schooling in plain language drafting, they relied on Australian plain language manuals for guidance in this regard. In drafting provisions of the Act, a deliberate attempt was made to cut down on sentence length, to avoid the use of unnecessary concepts, and to improve layout and

organisation of material. In essence, the drafters attempted to convey their message simply and effectively, without abandoning strict legal concepts.

b) *Sources*

While drafters were encouraged to use their own initiative in drafting provisions of the Act, they were also referred to various sources to inform the development of the Act.

i. EXISTING HEALTH LEGISLATION

In keeping with the perceived need of the committee to rationalise existing health laws, and to harmonise old national laws and the laws of the former KwaZulu and Natal, much of the drafting entailed incorporating existing legislation into the framework, excluding what is now obsolete and redrafting the old laws in a more accessible form.

ii. USE OF OTHER LEGISLATION NOT IMPACTING ON HEALTH

Use was made of some legislation which was unrelated to health but which contained important concepts which could be adapted to further the aims of a provincial health system. An example of this was the modification of the concept of environmental impact assessments, provided for in the Environmental Conservation Act 1989 (Act No. 73 of 1989), in order to make provision in the new Health Act for so-called "health impact assessments", for which there is international precedent.[244]

iii. INTERNATIONAL LEGISLATION

Many of the concepts incorporated in the legislative framework were new to South African law, and international legislative precedent was used for guidance in these respects. The World Health Organisation publication The International Digest of Health Legislation was consulted, as were a variety of other foreign laws, such as Zimbabwe's Traditional Medical Practitioner's Act 1981 (Act No. 38 of 1981).

iv. LEGISLATIVE PROPOSALS MADE BY VARIOUS INTEREST GROUPS

Public comment elicited by the consultation process undertaken by the Health Legislation Committee was considered while drafting. In addition, other proposals of various interest groups were reviewed. An example of such a proposal was a discussion document regarding regulation of traditional healers, which had been released by the National Association of Traditional Healers (NASCOTH) some years previously.

v. ARTICULATED POLICY

An attempt was made while drafting to conform to articulated policy. The ANC Health Plan, the Reconstruction and Development Programme, and the reports of some of the policy committees appointed by the national Department of Health were therefore reviewed to identify relevant policy constraints.

c) *The drafting process*

The drafting process began with the assignment of basic drafting tasks to the drafters, which was followed by a meeting to discuss problems encountered, and to agree on a common approach to drafting. After that, the drafting co-ordinator assigned tasks to the three lawyers, indicating references which needed to be considered in drawing up the relevant sections. Sections of the framework were selected for drafting assignments if: they were relatively non-contentious; they mainly required incorporation of existing laws; or the matters were highly contentious, but proposals as to possible legislative provisions would help to crystallise issues which would require urgent attention by policy-makers, or would require further consultation.

The three lawyers would then submit their drafts to the drafting co-ordinator, who would review and edit them. Where the drafts concerned matters which the co-ordinator considered to fall outside of his expertise, these matters were referred for comment to specialists in the respective fields. Thereafter, the drafts were submitted to the Health Legislation Committee for review.

By mid-June 1995, the 150 hours of drafting time allotted to each drafter had been used up. Drafting of the majority of non-contentious issues in the framework was

complete. There were, however, still significant areas of the framework which had not been drafted because of lack of clarity on policy issues.

In addition, a Traditional Healers Bill had been written in order to be circulated as a discussion document, and to be the subject of further consultation with bodies representing traditional healers. While traditional healing had initially fallen within the framework for a new Health Act, the section was drafted as a separate Bill because it was considered not to fit comfortably with the Health Bill, which was intended to be a broad enabling document for government.

#### 4.3.3.9 The way forward

On 20 June 1995, the Health Legislation Committee met with the health portfolio committee in the KwaZulu-Natal legislature and with newly appointed office-bearers in the KwaZulu-Natal Department of Health Services. This meeting was intended to inform them of progress in the legislative process, and to forge closer links between the various sectors. At that meeting, the Health Legislation Committee was formally disbanded, as it had been a subcommittee of the Strategic Management Team, which had been dissolved once the new Department of Health Services was in place. It was, however, resolved that the Committee would be re-established under the new Department, possibly with a slightly expanded membership.

The newly formulated Health Legislation Committee will have the responsibility of completing the process. The Committee's primary task will be to investigate which outstanding policy issues will still require clarity before the legislation can be finalised, and to assess work already done to determine whether it conforms to the established framework, principles, policy, and public expectations. Where issues are very controversial, or are highly technical, public hearings or private interviews will be held to achieve clarity on the merits of the issues involved. Where legislative provisions may affect other provinces, there will be consultation with the appropriate departments of the relevant provinces. Negotiation will be carried out with other role-players, where this is considered necessary. If problem areas are incapable of resolution, it may be necessary to omit such issues from the first Bill to be tabled in the provincial legislature, and then to develop the Health Act incrementally.

Once the Bill is drafted, it will be presented to forums such as the portfolio committee and various public interest groups for discussion. It will then be presented to the KwaZulu-Natal cabinet for consideration, published for comment, and tabled in the provincial legislature.

## 4.4 CONCLUSION

It is vital to the further development of South African health legislation that appropriate procedures are adopted when legislative reform initiatives are undertaken. Several important lessons can be learnt from legislative processes thus far.

First, legislation must essentially be seen as an instrument whereby articulated policy can be implemented, although it is acknowledged that legislative drafting inevitably involves some degree of policy-making in the sense that the finer details of broad policies often need to be worked out in writing a law. An attempt by makers of legislation to pre-empt the formulation of policy was a large contributory factor in the failure of the two draft Health Acts which were released by the Department in June 1994.

Two approaches have been adopted at provincial level to overcome the problem that the formulation of legislation requires clarity on policy. In KwaZulu-Natal, a framework for the Act was developed and legislative drafting proceeded on those issues in respect of which policy had already been articulated. Legislative issues on which greater clarity on policy was required were left to be drafted once that policy was articulated. The advantage of commencing drafting on non-contentious issues was that the legislative process was able to advance rapidly. However, the Health Act can only be completed once the outstanding policy issues are addressed. In the Western Cape, an attempt was made first to clarify the contentious policy issues before legislation was considered. The advantage of this approach is that, once drafting commences, it should proceed relatively smoothly as most policy decisions would already have been made.

A synthesis of the KwaZulu-Natal and the Western Cape approaches would perhaps be most advantageous. If the development of policy and legislation were integrated, the effectiveness of the resulting policy would be enhanced because the

policy would have been developed with an understanding of the potential and limitations of legislation as an instrument to implement that policy. It is submitted that such an integrated approach would also have increased the usefulness of the work of the National Health Legislation Review Committee and of the other policy committees appointed by the Minister of Health.

The second important principle which emerges from the narrative of legislative processes is that it is vital that all the major role-players are involved from as early in the legislative process as possible. Failure to involve major stake-holders will inevitably be perceived as an attempt to represent partisan interests and will therefore be regarded with suspicion. The entire process will be jeopardised because the legislative proposals will not be widely acceptable. The early initiative of the African National Congress prior to the April 1994 elections, and the Departmental initiatives in June 1994, both foundered largely due to the fact that they were representative of the interests of a limited constituency.

Thirdly, the current constitutional dispensation makes it essential that there is sufficient co-ordination and ongoing collaboration between legislative initiatives at national and provincial levels. Insufficient co-ordination between these initiatives was identified as an impediment to the progress of provincial legislative initiatives since the April 1994 elections. The National Health Legislation Review Committee, which is now broadly representative of national and provincial levels, is a particularly useful instrument to perform this co-ordinating function. The Committee also provides a forum through which provinces can share ideas and experiences which have arisen in their own initiatives, and which may prove useful to reform of health legislation in other provinces. The legislative experience in KwaZulu-Natal which is related above, for example, may already provide useful guidelines to other provinces concerning how reform initiatives may be initiated.

The fourth lesson which can be learnt from legislative processes thus far, in particular the process in KwaZulu-Natal, is that legislative development can be significantly enriched by community participation. The innovation, transparency and public accountability of the legislative process in KwaZulu-Natal not only holds promise of an Act which enjoys public acceptability rarely achieved, but it has potential to serve as a model for legislative processes in other provinces and indeed in all countries undergoing transition in their health systems and politically.

Fifthly, the drafting of new health legislation holds significant opportunities for capacity development in the legal profession. The contracting out of drafting work to lawyers outside the civil service in KwaZulu-Natal also enhanced the drafting process in other ways, for example, by allowing for innovation and critical reconsideration of the desirability of certain established drafting practices.

Finally, legislative processes since the elections have demonstrated that the fundamental changes to the South African health system which are currently envisaged require comprehensive legislative reform, and not merely cosmetic changes to existing laws. The superficial attempt to restructure the health system through the draft Health Act proposed by elements within the Department of Health in June 1994 was cause for concern and, if implemented, might have become a substantial impediment to the implementation of a National Health System.

An incremental approach will probably need to be taken in the implementation of a comprehensive legislative reform programme, due to the fact that certain policy issues may take time to be resolved. Nevertheless, comprehensive reform rather than *ad hoc* amendments should be the ultimate goal in the revision process. The comprehensive nature of the framework for a new KwaZulu-Natal Health Act is evidence of a recognition on the part of the Strategic Management Team in that province that legislative change must be addressed holistically. In the Chapter to follow, this framework is used as the point of departure for discussion of many issues of health law which require consideration in this period of health system transition.

# CHAPTER FIVE

# COMMENTARY ON THE KWAZULU-NATAL FRAMEWORK FOR A PROVINCIAL HEALTH ACT

## INTRODUCTION

The preceding chapters of this dissertation have included a discussion of the nature of the relationship between law and public health; an historical analysis of the development of South African health care legislation since Union; discussion of the constitutional dispensation within which current development of health legislation is taking place; as well as a description of the first tentative steps towards the exercise of formulation of new Health Acts at national and provincial levels between the time of the April 1994 elections and June 1995.

The obvious issue which remains to be considered is the way forward in respect of the further review and revision of health legislation in South Africa. It would be fruitless to attempt in this dissertation to provide a blueprint for legislative reform in South Africa. Many substantive issues of policy require clarity before legislation can be finalised, and it is inevitable that new health legislation will differ substantially from one province to another, in order to accommodate differing provincial circumstances.

However, it is essential for progress in legislative reform that people involved in reform of the health system are made aware of the range of existing legislation which needs to be reviewed, as well as of some of the legal and policy issues which require clarity before comprehensive health legislative reform can take place. In this way, vital public discussion can be generated around these issues.

This final substantive Chapter of the dissertation is therefore a broad overview of much of the existing health legislation which requires consideration when reviewing health legislation with a view to its reform. It is intended that the Chapter will problematise some of the issues involved, generate discussion on them, and provide possible solutions to some of them.

The discussion follows the framework for the new KwaZulu-Natal Health Act (which appears in Annexure Four). It should be noted that the Parts and Divisions which are discussed below are numbered according to the numbering of the framework, as reflected in this annexure. This framework has been selected as the reference point for this Chapter for two main reasons.

First, it is the only framework for a new general health law which had been released publicly for comment by the time of writing this dissertation (mid-July 1995). Although proposals had already been made to the National Health Legislation Review Committee regarding the content of a new national Health Act (see Chapter Four, above), they had not been released publicly, nor had they been accepted as reflecting the official viewpoint of the Department. It is therefore not feasible to include a discussion of the content of these proposals in the dissertation.

Secondly, the KwaZulu-Natal framework is the most comprehensive framework to have been considered in legislative processes thus far, and therefore encompasses a wide range of issues which require consideration in the review and rationalisation of health legislation in South Africa.

It must be mentioned at the outset, however, that there are two limitations on the application of this discussion to legislative initiatives at national level and in the other provinces, which arise from the use of the KwaZulu-Natal framework (hereinafter called "the Framework") as the reference point for the discussion.

The first such limitation is that the discussion primarily addresses legislative and policy issues which are required to be considered at provincial level. However, national legislative reform initiatives may also benefit from the discussion as many of the principles involved may equally be applied to legislative reform at national level.

The second such limitation is that much of the existing provincial legislation described below applies specifically to KwaZulu-Natal. It was impractical to describe the ordinances of all four former provinces, and the laws of all the former self-governing territories, and therefore the discussion of legislation at this level is confined to the laws of the former province of Natal and the former self-governing territory of KwaZulu. However, most of the other provinces have comparable

legislation which is relatively easy to identify, and the principles discussed should in many instances be equally applicable to this legislation.

## Part 1 - LONG TITLE

While long titles are sometimes a useful guide to interpretation of statutes, they have traditionally been structured in a manner which is not easily accessible to laypersons. It is submitted that the function of a long title would be better performed by a purpose clause - an informative statement setting out what Parliament intends to achieve by the Act. The purpose clause would be both a conceptual statement, and a guide to interpretation of the Act. It would be clearly stated and drafted in plain language in order that readers can readily understand the significance and intended scope of the new law. The clause would set out the fundamental principles on which the new health system would be based, including principles which have developed from the worldwide experience in the primary health care approach, such as: equity; efficiency; acceptability; community participation; and cost effectiveness.

## Part 2 - FUNDAMENTAL PROVISIONS

Due to the fundamental nature of this Part of the Framework, each of the proposed clauses is discussed in turn.

(a) *The definitions clause*

The careful formulation of definitions is fundamental to the interpretation, and therefore also to the successful operation of the Act. Certain concerns need to be taken into account when drafting the definition section in the Health Act.

First, certain terms have such a long history of usage in various contexts in the health sector, that those terms have become too loaded with diverse connotations to be susceptible to a single adequate definition which will be of any value in interpreting a statute. The term "primary health care" is a poignant example. It is submitted that this term has been so loosely used that it is no longer capable of being defined in any useful sense for legislative purposes. In the Reconstruction

and Development Programme, for example, the term is used twice within close proximity to each other to connote two entirely different concepts.[245] On the one hand, the term "primary health care" is used to connote an approach or philosophy underpinning the National Health System:

> *The whole National Health System must be driven by the Primary Health Care (PHC) approach. This emphasises community participation and empowerment, intersectoral collaboration and cost-effective care, as well as integration of preventive, promotive, curative and rehabilitative services.*

Some two paragraphs above, it is used to connote a level of service provision:

> *Each District Health Authority will be responsible for all primary health care services in its district, including independent general practitioners and community hospitals.*

Even if usage of the term "primary health care" was confined to its sense as a level of service provision, there is no unanimity on which services comprise primary health care, and which do not. It is submitted that the problem of interpretation of this term can be circumvented by avoiding usage of the term in the body of the Act. In each case where the term may have been used, the elements which make up the intended meaning can be spelled out instead.

Secondly, unnecessary inconsistencies in the interpretation of health laws can be avoided by ensuring that definitions in the Health Act correspond as far as possible to definitions in other legislation. This will also facilitate the process of rationalising South Africa's large body of health laws. For example, the definition of "milk" in the new Health Act should correspond to the definition of "milk" in the Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972).

(b) *Policy guidelines*

Provision is made in the framework for "policy guidelines". In drafting this section on policy, there are two options. First, definitive statements of policy may be made in the Act itself. This was the approach taken in the National Policy for Health Act 1990 (Act No. 116 of 1990), where any policy made by the Minister

had to be determined within the framework of the following guidelines set out in the Act:

> *(i) That an inhabitant of the Republic, if he is capable of doing so, shall primarily be responsible for his own and his family's physical, mental and social well-being, but that the State and local authorities shall share responsibility in this regard by providing an efficient and comprehensive health service;*
>
> *(ii) that such inhabitant shall pay the costs incidental to his medical treatment, but that the financial circumstances of a patient shall not take precedence over the necessity for treatment, and that indigent persons shall be accommodated;*
>
> *(iii) that the provision of a comprehensive health service by the State and local authorities shall be directed in a responsible manner at the needs of the individual and those of society, but that the available financial resources, natural resources and manpower of the Republic shall be taken into account;*
>
> *(iv) that the private sector shall be encouraged to provide health services in the Republic, but that the provision of such services shall be in the public interest.*

It is submitted that the stipulation in the Act of such definitive statements of policy is undesirable because it binds the health service to a value-laden ideology, which may prove to be unduly restrictive.

It would be preferable rather to specify in the Act those issues concerning which the political head of the health department may make policy, and then to provide only for procedural limitations on the policy-making powers. Such procedural limitations may, for example, be requirements of consultation, or notice and comment procedures.

(c) *Principles for the application, operation and interpretation of the Act*

The function of the principles envisaged by this provision in the Framework would be adequately performed by the purpose clause, mentioned above. Therefore, if such a purpose clause were to be included in the Act, it is submitted that it would be unnecessary to include these principles.

(d) *Statement of provincial government responsibility for the protection of health*

This clause may impose general duties on the provincial government to: protect, promote and improve the health of the population; determine the policies and measures necessary to do this; and include public health care in the socio-economic development plans and budget of the province.[246]

A provision such as this would indicate that while the provincial government may discharge its responsibility for the protection, promotion and improvement of health by entering into agreements and formulating joint programmes with outside agencies such as private health service providers and non-governmental organisations, it would, in the interests of greater effectiveness and efficiency of the health services, ultimately be held accountable in the event of this responsibility not being discharged.

(e) *Specification of what constitute the health authorities of KwaZulu-Natal*

A provision specifying which health authorities exist in the province, and what their basic functions are, would be useful in assisting readers not acquainted with the structure and functioning of the health system to determine what resources are available to them, and to whom they should have recourse in the event of an issue requiring to be addressed.

**Part 3 - COMMUNITY PARTICIPATION**

Community participation has been accepted as a fundamental premise on which the new South African health system should be based. The Reconstruction and Development Programme, for example, states:

> *Communities must be encouraged to participate actively in the planning, managing, delivery, monitoring and evaluation of the health services in their area.*[247]

The importance of community participation has also been affirmed by the World Health Organisation (WHO). Clause 26 of the WHO's 1979 publication Formulating Strategies for Health for All by the Year 2000 reads as follows:

> *Measures have to be taken to ensure free and enlightened community participation, so that notwithstanding the overall responsibility of governments for the health of their people, individuals, families and communities assume greater responsibility for their own health and welfare, including self-care. This participation is not only desirable, it is a social, economic, and technical necessity. Governments will therefore have to devise appropriate ways of promoting such participation, supporting it, effectively propagating relevant information, and establishing or strengthening the necessary mechanisms. ... As part of community participation, in the process of formulating national health policies, it may help to involve political, social and community leaders, organisations, industry, labour, relevant professions, and those engaged in the mass information media in appropriate local, district and national activities.*

The emphasis on community participation in the Framework is important in that it is in line with current policy and trends both in South Africa, and internationally. Attempts at giving legislative recognition to the promotion of non-governmental bodies and the participation of community forums in the planning, rendering and monitoring of health services are to be lauded. It is, however, important that in drafting and implementing the legislation, certain concerns are taken into account.

First, legislative provisions enabling community participation are not sufficient and must be considered in conjunction with other strategies, such as skills-training and education of the community on how to identify health problems and possible solutions to such problems.

Secondly, legislative provision for community participation should be carefully circumscribed so as not to compromise the accountability that is inherent in sound government administration.

A variety of legislative mechanisms has been used internationally to promote community participation, some of which are illustrated below.

i. Structuring of the Health Ministry and health services to allow for community participation

Paraguay's Health Code stipulates that one of the functions of the Ministry of Health is to promote community participation and to organise communities in order to co-operate in protecting and improving health facilities and services.[248]

Section 5(1) of Spain's 1986 General Law on Health provides that the public health services shall be so organised as to enable the community to participate, through the appropriate territorial corporations, in the formulation of health policy and the control of its application. Section 22 provides that employers and workers, acting through their respective organisations, shall participate in the planning, programming, organisation, and control of managerial activities related to occupational health, at the different territorial levels.[249]

ii. Involvement of community organisations in health promotion measures

The legislation of some countries contains clauses placing a general duty on community organisations to undertake and contribute to health promotion activities. Section 29 of Algeria's 1985 law on health protection and promotion,[250] for example, places organisations and the population under an obligation to apply sanitation, hygiene, and epidemic disease control measures, measures against environmental pollution, and measures to improve conditions in the occupational environment, as part of general prevention.

Section 5 of Viet Nam's 1989 law on the protection of public health lists a number of organisations, including the Viet Nam Fatherland Front, the Ho Chi Minh Communist Youth Union, and the Viet Nam Red Cross, and stipulates that they are under a duty to encourage and motivate their members to comply with this Law and to take an active part in the protection of public health.[251]

Such provisions imposing general duties on social and community organisations are useful in that they set out policy objectives for organisations to aspire to. However, the degree of compliance with these provisions is virtually impossible to

monitor, with the result that these provisions are not readily enforceable. Greater involvement of community organisations can perhaps be achieved by legislation providing for government or Health Ministry support for organisations with the objective of promoting health. Such support may take the form of financial assistance, but it may take other forms as well. A selective subsidy to a non-governmental organisation might do more than pay for itself by enabling the agency to mobilise more resources.[252]

In terms of section 59 of Mexico's 1983 General Law on Health,[253] the agencies and entities in the health sector and the governments of the federative entities are to promote and support the establishment of groups, associations, and other institutions that have as their objective organised participation in programmes for the promotion and improvement of individual or collective health, and in programmes for disease and accident prevention, disability prevention, and the rehabilitation of the disabled.

More broadly, legislation concerning various types of projects may provide for involvement of community organisations. Projects well adapted to community involvement include construction of water and waste disposal facilities, health education in the community, family life education in schools, and community arrangements for food production.[254]

iii. Specification of ways in which the community may participate in health services

Legislation may also play an educative role in stipulating ways in which the community may participate in health services. Section 59 of Mexico's General Law on Health,[255] for example, lists seven ways in which the community may participate in health services in the public, social and private sectors. These include *inter alia*: involvement, as voluntary auxiliaries, in the carrying out of simple medical care and social welfare tasks under the direction and supervision of the corresponding authorities; and provision of information to the competent authorities concerning irregularities or shortcomings detected in health service delivery.

iv. Provision for public accountability of health authorities

Public accountability of health authorities is an important mechanism for promoting community participation in health services. Various legislative mechanisms may be used to encourage public accountability.

Legislation may require general public accountability of health authorities. In terms of section 6 of the 1982 Health Care Services Law of the Netherlands, requirements must be laid down in general administrative regulations for periodic public reporting by health authorities and to ensure the public nature of health authority meetings and documents.

Legislation may also require consultation with the public on specific issues of public concern. Section 5D of Victoria's Health (General Amendment) Act 48 of 1988, for example, provides:

> *(1) If the Chief General Manager decides to institute an inquiry [into any activity or proposed activity which may constitute a danger to human health], the Chief Manager must -*
> *(a) consult widely with members of the public; and*
> *(b) cause a discussion paper to be prepared -*
> *about the activity or proposed activity.*
>
> *(2) The Chief General Manager must ensure that -*
> *(a) the discussion paper canvasses as widely as possible all scientific, medical, sociological, economic, and other relevant perspectives; and*
> *(b) a reasonable time is set for public consultation.*

## Part 4 - THE RIGHT TO HEALTH

Part 4 of the Framework supplements section 29 of the Interim Constitution, which provides that every person shall have the right to an environment which is not detrimental to his or her health or well-being. By including the "right to health" in the Framework, recognition is given to the fact that the protection of health is not only an individual responsibility, but is also, to some extent, a responsibility of the

State. In retrospect, this Part of the Framework should rather have been entitled "the right to health services", as government can only provide services but cannot actually guarantee that people will remain healthy.

The obvious problem in giving statutory recognition to a right to health services is the difficulty of defining the content of the right, in such a way that it would have actual effect, while not creating expectations which would be impossible to fulfil. Deliberations on this issue in KwaZulu-Natal were to some extent rendered moot by the announcement on 19 June 1995 by Minister of Health, Dr Nkosazana Zuma, that the national government was considering giving every person living permanently in South Africa a right of access to the National Health System on equal terms. A basic package of primary health services would be made available to all persons, including the following services: maternal and child health services; family planning services; health education; nutrition; immunisation; screening for common diseases; curative services for acute minor ailments, trauma, endemic diseases, communicable diseases and chronic diseases; primary health care investigative services (radiology and pathology); basic rehabilitation services; basic oral health services; basic optometry services; and mental health services.[256]

If accepted, the system of universal access to primary health care described above would be implemented on a national basis. It is likely, therefore, that it would be provided for in national legislation, and therefore it would be unnecessary for legislative provisions in this regard to be included in provincial Health Acts. It might, however, be desirable for provincial Health Acts to enable the political head of the health department from time to time to give notice in the official provincial gazette that certain *additional* health services or benefits are to be available to all persons in the province, or to certain categories of persons in the province, based on determined provincial priorities.

## Part 5 - RIGHTS OF HEALTH SERVICE USERS

While the Framework does propose a Part on the rights and duties of health service users, it is submitted that this issue would be more appropriately dealt with in a National Act, as the basic rights envisaged in this Part should apply to users of health services across the country. A deprivation of basic rights in some provinces which are provided for in other provinces would be grossly unfair and inequitable.

The issue is currently being considered by the National Health Legislation Review Committee for inclusion in the new National Health Act.

The scope of rights which may potentially be conferred on health service users by a Health Act are very wide. Care must, however, be taken to circumscribe these rights within the framework of available resources so as not to accelerate a crisis of accessibility and demand. It would be better to begin with a more limited package of rights, and then to develop these rights incrementally as health services in the country develop. The discussion below addresses legal issues surrounding three matters which, it is submitted, should receive some form of protection in the new National Health Act, namely: medical confidentiality; informed consent to medical intervention; and user access to medical records.

i. Medical confidentiality

The observation by health workers of the principle of medical confidentiality is essential to protect patient privacy. It also has a public interest function. In X v Y [1988] 2 All ER 648 (QBD), Rose J said at 653:

> *In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients 'will not come forward if doctors are going to squeal on them'. Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self treatment does not provide the best care.*[257]

The duty of a medical practitioner to respect the confidentiality of her or his patient is a legal duty recognised by South African common law.[258] Breach of this duty is likely to give rise to a delictual action on the basis of invasion of privacy.

South Africa, though, has no legislation dealing specifically with issues of protection of medical data, and it is therefore up to individual health care institutions to formulate a strategy for the protection of the privacy of patients within their care.[259]

The South African Medical and Dental Council (SAMDC) has, however, made a rule concerning patient confidentiality in terms of its powers under section 49 of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974) to make rules specifying the acts or omissions in respect of which the Council may take disciplinary steps. Rule 16 of the SAMDC's "Rules Regarding Conduct"[260] provides that the SAMDC may take disciplinary steps if a medical practitioner is found guilty of:

> *Divulging verbally or in writing any information which ought not to be divulged regarding ailments of a patient except with the express consent of the patient or, in the case of a minor, with the consent of his parent or guardian, or in the case of a deceased, with the consent of his next-of-kin or executor of his estate.*

Strauss points out that the duty of professional secrecy is not an absolute one, and that health workers may be entitled to disclose confidential information to others where, for example, disclosure is made by judicial order, or where disclosure is manifestly in the public interest.[261] In respect of disclosure by judicial order, Rule 16 of the SAMDC's "Rules Regarding Conduct" includes a note to the effect that in a court of law, professional secrecy may be contravened only after protest after direction from the presiding judicial officer.

An interesting issue was raised in the Appellate Division in Jansen van Vuuren and another NNO v Kruger 1993 (4) SA 842 (A) concerning whether the public interest entitles a doctor to convey the fact that a patient has been diagnosed as HIV-positive to colleagues of that doctor who are likely to treat the patient. In this case, the Appellate Division found that the communication of the patient's condition had been unlawful. At 856 E-G Harms AJA held:

> *AIDS is a dangerous condition. That on its own does not detract from the right of privacy of the afflicted person, especially if that right is founded in the doctor-patient relationship. A patient has the right to expect due compliance by the practitioner with his professional ethical standards: in this case the expectation was even more pronounced because of the express undertaking by the [medical practitioner]. The [doctor's colleagues] had not, objectively speaking, been at risk and there was no reason to assume that they had to fear*

> *a prospective exposure. ... In consequence I conclude that the communication ... was unreasonable and therefore unjustified and wrongful.*

Another consideration which must be taken into account if an attempt is made to provide for patient confidentiality in statutory form, is the importance of not restricting the collection of statistical data which is vital for the planning and management of the health system. Legislation must ensure that this data can be collected freely, without compromising patient confidentiality. It is therefore submitted that *unidentifiable* aggregated health statistics should be exempted from confidentiality provisions, at least in so far as these statistics are to be used by the National Health Information System. Attention would need to be given to what types of information would constitute identifiers (that is, information which would enable the patient to be identified), and should therefore be omitted from records being used for statistical purposes. Examples of such identifiers may include: names, identity numbers, physical addresses, and so on.

ii. Informed consent to medical intervention

Consideration should also be given in a statutorily entrenched charter of health service user rights to the issue of informed consent to medical intervention, and the right to refuse medical treatment. The right of mentally competent adult patients to refuse medical treatment is well entrenched in South African common law. As a general rule, a doctor is not entitled to treat a patient against her or his will,[262] and if the doctor does in fact operate without consent, this could be regarded as serious assault.[263] Legal justification for medical treatment is therefore based on consent, according to the maxim *volenti non fit iniuria*. There are, however, circumstances in which the requirement of consent for medical treatment may be dispensed with. These include: statutory authority where intervention is required in the interests of public health[264]; and emergency treatment of a patient who has not expressed unwillingness to undergo treatment, but is temporarily unable to give consent on account of shock, unconsciousness or intoxication, in which case the treatment will be justifiable by application of the doctrine of *negotiorum gestio*.[265]

In the case of a minor, consent of a parent or guardian is generally required, except in the circumstances specified in sections 39 and 53 of the Child Care Act, 1983

(Act No. 74 of 1983), and in regulations made under the Correctional Services Act, 1959 (Act No. 8 of 1959).[266] Legislative provision is made in section 60A of the Mental Health Act, 1973 (Act No. 18 of 1973) for substitute consent in the case of patients of mental institutions who on account of mental illness are not capable of consenting to medical treatment or operations on themselves.

An interesting legal issue relating to the right to refuse medical treatment was raised by the Christian Science Church in KwaZulu-Natal in response to this proposed Part of the Framework. The Christian Scientists stated that healing through prayer is fundamental to the theology of Christian Science, and that Christian Scientists rely upon prayer alone for the healing of physical illness as well as for meeting other problems of daily life. The notion of mixing orthodox medical practice with the Christian Science methods of healing was rejected, as it was claimed that mixing the two systems tends to neutralise the effectiveness of both. Their recommendation was that provision be made in the Act for the right to decline medical treatment and rather to rely on spiritual means alone for healing.[267]

It has already been established that South African law recognises the right of adult patients to refuse medical treatment. The demand of the Christian Science community would seem, however, to extend to a right of parents to refuse medical treatment or operations being performed on their minor children in favour of spiritual methods of healing. This right is presently precluded by section 39(1) of the Child Care Act, 1983 (Act No. 74 of 1983), which provides that the Minister may consent to medical treatment in lieu of the parent or guardian of a child, where a medical practitioner is of the opinion that it is necessary to perform an operation on a child or to submit her or him to medical treatment, and the parent or guardian refuses consent to the operation or treatment.

The demand by the Christian Science community for a statutory right to refuse medical treatment even in the case of children appears *prima facie* to enjoy support in section 14(1) of the Interim Constitution, which provides that every person shall have the right to freedom of conscience, religion, thought, belief and opinion. However, it is submitted that a challenge to section 39(1) of the Child Care Act on this basis would fail in the Constitutional Court, for two main reasons. First, it is submitted that the Court would abide by the principle that parental rights extend only in so far as what is good for the child, and it would be unlikely that the Court

would be persuaded that it would be in the interests of a child to deprive that child of medical treatment. It is therefore submitted that the limitation on section 14(1) of the Interim Constitution which is inherent in section 39(1) of the Child Care Act would be found to be reasonable, necessary and justifiable in an open and democratic society based on freedom and equality, and would thus constitute an acceptable limitation on rights in terms of section 33(1) of the Interim Constitution. Secondly, the Court would be influenced in its decision by the competing right of every child to basic health services, in terms of section 30(1)(c) of the Interim Constitution.

iii. User access to medical records

South African law makes no provision for access of health service users to their medical records, unless these records are required in the course of discovery of documents in a court action. Prior to commencement of legal proceedings, patients have no right to their medical records, and a medical practitioner in private practice or a hospital authority is the exclusive owner of these records.[268] The SAMDC has decided, however, that medical practitioners must issue a brief, factual written report to a patient, if the patient, on reasonable grounds, requires information concerning herself or himself.[269]

After a review of legal practice in countries such as England, Germany, Netherlands and some states in the United States, Volschenk (Director: Medical Ethics and Legal Services, Medical Association of South Africa) concluded that South African law relating to access to user records is not in keeping with international trends. He recommends that legislation be introduced which allows health service users access to their medical records, provided that the legislation includes adequate safeguards for patients, doctors and other health care professionals.[270]

Provision may, for example, be made for access to certain parts of a user record to be temporarily denied if communication of those parts of the record would be likely to be seriously prejudicial to the patient's health, or if disclosure of those parts of the record would make it possible to identify a third person who disclosed information concerning the health of the patient to that patient's medical practitioner.

These recommendations require urgent consideration, particularly in the light of section 23 of the Interim Constitution, which provides that every person shall have the right of access to all information held by the State or any of its organs at any level of government in so far as such information is required for the exercise or protection of any of his or her rights.

## Part 6 - HEALTH IN THE CONTEXT OF MACRO-ECONOMIC POLICIES AND THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME

One of the basic principles of the Reconstruction and Development Programme (RDP) is that the programme must be integrated and sustainable.[271] The RDP brings together strategies to harness all South Africa's resources in a coherent and purposeful effort that can be sustained into the future. It is particularly important to view health intervention in the context of an integrated socio-economic development programme because medical intervention cannot provide significant improvement to health status in isolation. Indeed, a 1988 WHO report states that in all countries, and especially in developing countries, the impact on health of sectors outside the formal health system is probably greater than that of the health services.[272]

The impact of the health department can thus be greatly enhanced by developing mechanisms for intersectoral collaboration, and for intervention of the health department outside the formal health sector. A variety of legislative mechanisms has been used for these purposes, some of which are illustrated below. In considering these possible mechanisms for intersectoral collaboration when drafting provisions of health laws, it is important to ensure that the policy objectives behind the provisions are not frustrated by the non-health-related agendas of other departments.

### i. Co-ordinating committees

Legislation may require the establishment of co-ordinating committees or boards at various levels, with representatives from different sectors. This may take the form of a national health council in which all the ministries with a concern in health should be represented, preferably by top officials. The national health council could perform the function of coordinating the formulation of policy, planning,

resource allocation, programme implementation, and other features of health system management among the several sectors. A high level committee such as a cabinet committee would provide a vital power base for collaboration.[273]

Health councils may also be established at lower levels of the health system. Section 21 of Paraguay's 1979 Law establishing the Department of Primary Care,[274] for example, sets up community health councils. The composition of these councils includes representatives from: the health centre concerned; local government units; the local fire department; local private health care establishments; and local public educational establishments. The councils are responsible for regularly monitoring the activities of the health centres and suggesting improvements.

A notable initiative to promote intersectoral collaboration at local level has been the Healthy Cities movement. This movement began in 1986 in Canada and in Europe, through the support of the World Health Organisation Regional Office for Europe, and has subsequently been adopted in a number of cities in the United States.[275] The movement focuses on action for health promotion at the city level by placing health as a priority on the city's political agenda. Through a process of community-wide decision-making, "healthy cities" aim to develop strategies to reorientate public health and to make disease prevention and health promotion highly visible and supported by the community. Cities in Indiana which adopted the healthy cities concept selected committees from leaders representing the informal powers structures of the cities, to coordinate the process. Categories of healthy city committee members included:[276]

* Arts and culture
* Business
* Dentistry
* Education
* Employment
* Environment
* Finance
* Health Department
* Hospital
* Public Health Associations
* Local government
* Mayor's office
* Media
* Medical care
* Other health care
* Parks and recreation
* Planning and housing
* Population groups
* Religion
* Social services
* Transportation
* Utilities and energy.

Intersectoral committees may also be established to deal with a particular health problem. Section 183 of El Salvador's 1988 Health Code, for example, establishes a joint commission, made up of representatives of the Ministry of Health and the Ministries of Labour and Social Security, Defence and Public Safety, and the Interior. The Commission is to coordinate the activities of the Ministries in the field of accident prevention.[277]

ii. Joint performance of a specified function

Legislation may require that a specified function be performed jointly by a variety of sectors. Section 10(a) of the Czech Republic's 1991 Law,[278] for example, lists particular functions which must be performed by the Ministry of Health in cooperation with professional organisations and civic associations, including the drawing up of a tariff with regard to the provision of care, and selection procedures for the appointment of managerial staff in the health field. Section 17 of Afghanistan's 1983 Public Health Law[279] empowers the Ministry and the Central Council of Trade Unions to fix the detailed procedures for the provision of medical services to workers, while section 24 provides that timetables of the medical examination of children in educational establishments are to be determined by the Ministry of Public Health, in collaboration with the Ministry of Education.

Other legislative examples include: joint formulation and implementation of a health education plan;[280] intersectoral collaboration in drawing up health requirements for the prevention and control of accidents and in drawing up technical and administrative regulations governing medicaments;[281] collaboration between the Ministry of Health and the Ministry of Agriculture and Stockbreeding in classifying the characteristics of pesticides and fertilisers based on the extent of their hazard to health;[282] and collaboration between the Ministry of Health and the Ministry of Labour and Social Welfare in the collection and analysis of statistical data on industrial accidents and occupational diseases.[283]

iii. Co-ordination of activities for a common social objective

Section 51 of Paraguay's 1980 Health Code,[284] for example, requires the Ministry of Public Health and Social Welfare and the Ministry of Education and Religious Affairs to coordinate their activities for the protection of the health of sportspersons, gymnasts, and pupils of educational establishments. Section

104(2) of Spain's 1986 General Law on health[285] establishes permanent collaboration between the Department of Health and other relevant Departments, in particular the Department of Education and Science, in order to provide more suitable training of the human resources necessary for the operation of the health system.

iv. Legislative provision for collaborative agreements

Section 36 of Iceland's 1983 Law on the health services,[286] for example, lays down that the Ministry of Health and Social Security, in collaboration with the Ministry of Education, the University of Iceland, and district medical officers, may conclude agreements enabling members of the health professions to enhance, at any time, their knowledge of basic or supplementary subjects.

v. Requirement of Health Ministry approval for the activities of other ministries or departments

Section 454 of Colombia's 1979 law prescribing health measures,[287] for example, prescribes that the Ministry of Development may register a given pharmaceutical product only after a favourable report has been received from the Ministry of Health, and must cancel any registration at the latter's request.

vi. Health Ministry participation in the formulation and implementation of legislation impacting on health

Legislative provision for Health Ministry participation in a broad range of legislation is a particularly effective mechanism for expanding the Ministry's control beyond the narrow ambit of health services. Section 19(2) of Spain's 1986 General Law on health[288] provides:

> *The health authorities shall propose, or participate with other Departments in the formulation and implementation of legislation on:*
> *(a) air quality;*
> *(b) waters;*
> *(c) foods and food industries;*
> *(d) solid and liquid organic wastes;*
> *(e) the soil and subsoil;*

*(f) the various forms of energy;*
*(g) mass transportation;*
*(h) toxic and dangerous substances;*
*(i) housing and urban planning;*
*(j) the school and sports environment;*
*(k) the occupational environment;*
*(l) places, premises, and facilities for public recreation; and*
*(m) any other aspect of the environment related to health.*

The KwaZulu-Natal framework, in point 7.1(a) makes provision for participation of the KwaZulu-Natal health authority in the formulation and implementation of legislation of other Departments impacting on health, following the model set out in point (vi) above.

The Framework further makes provision for so-called "health impact assessments", which are another mechanism whereby the health department can have influence on factors which influence health, yet fall outside the formal health sector. Health impact assessments would be closely modelled on the concept of environmental impact assessments, as provided for in the Environmental Conservation Act 1989 (Act No. 73 of 1989). Provision would be made for identification of activities which may have a substantial detrimental effect on the health of inhabitants of the province. Activities so identified may relate, for example, to: water supply, disposal or use; agricultural processes; industrial processes; transportation; energy generation and distribution; waste and sewage disposal; chemical treatment; or recreation. It would be stipulated in the Act that, prior to any identified activities being undertaken, authorization would be required from the political head of the health department in the province. An application for such authorization would only be considered after submission of a health impact report, which would have to conform to requirements set out in regulations.

## Part 7 - THE PROVINCIAL HEALTH SYSTEM

Provision is made in Division 7.1 of the Framework for legislation designating the functions, powers and jurisdiction of the provincial health department and its committees and officials. The health administrations of the former KwaZulu and Natal have been undergoing restructuring since the elections in April 1994, and the

legislation, when drafted, will reflect the new structure which is being put into place.

A considerably more complex issue on which there is little consensus on policy is the nature of the district health system (Division 7.2 of the Framework). An efficient district health system is of central importance to the delivery of services in the provincial health system and indeed to the introduction of a unitary, integrated and comprehensive health care system. In terms of the RDP, district health authorities must be the main bodies responsible for ensuring access to and delivery of health services.[289] For the restructuring of the health system to take place smoothly and efficiently, it is desirable that legislation be enacted to create a district health system as rapidly as possible.

However, there appear to be at least three major obstacles to the district health system which need to be addressed decisively before the required legislation can be finalised. These obstacles relate to: governance of the district health system; the financing of district health services; and boundaries of health districts.[290]

i. Governance of the district health system

There is currently debate concerning whether local government should be responsible for community and district-level health services, or whether provincial government should initially be responsible for all health services within a province, including community and district-level services. A firm political decision is required on this issue before legislation can be finalised.

Some of the main advantages of local government responsibility for these services include:

a) it allows for greater decentralisation of management autonomy;
b) it ensures accountability of health service providers to elected local government representatives;
c) intersectoral action is facilitated by having a single local authority responsible for primary health care as well as for many other related services, for example: water, sanitation and housing; and
d) contributions from ratepayers towards the cost of district health services can more easily be retained at local level.

Disadvantages of this option include:

a) implementation of the district health system may be hampered by continued uncertainty regarding local government restructuring;
b) it would necessitate large-scale transfer of personnel currently employed by provincial administrations to local authorities - the consequent expense involved in establishing uniform salaries for these personnel would be considerable; and
c) there might be difficulty in promoting equity of service provision, when some local authorities are wealthier than others.

The main advantages of initial provincial government responsibility for district health services are said to include:

a) the establishment of a district-based health system would be likely to occur more quickly and more uniformly;
b) the achievement of equity and the redistribution of resources within provinces would be facilitated;
c) transfer of personnel between districts and between different levels of the health service would be possible as all would be employed by a single authority;
d) monitoring, evaluation and corrective actions would be simplified; and
e) fewer personnel would need to be transferred.

Disadvantages of this option include:

a) additional district-level management units will have to be established within provincial health departments, with resultant increase in administrative infrastructure and costs;
b) decentralisation of real decision-making powers to district level might not occur in practice;
c) intersectoral collaboration and actions would be rendered more difficult because responsibility for different sectors related to health would be divided between different authorities; and
d) district management personnel would be ultimately accountable to the provincial administration, rather than to the community they serve.

An additional consideration which must be taken into account is that legislation which provides for provincial government responsibility for district health services may be subject to challenge in the Constitutional Court, on the grounds that section 175(3) of the Interim Constitution provides that a "*local authority* shall, to the extent determined in any applicable law, make provision for access by all persons residing within its area of jurisdiction to ... primary health services" (my italics).

ii. Financing of district health services

If the range of services provided by local government is to be expanded to include comprehensive primary health care services, this expansion of services will have to be matched by additional funding, as local revenue will probably be insufficient in many areas to finance the additional responsibilities and personnel. Appropriate budgetary allocation formulas will therefore have to be formulated to accommodate this expansion of functions.

iii. Boundaries of health districts

Clear criteria for the delimitation of health district boundaries need to be established by the provincial health department before a district health system can be put into place. The possible congruency of health district boundaries with boundaries of local government authorities and of other administrative sectors is an issue which requires particularly urgent consideration.

Yet another issue which requires consideration when determining the powers, functions and responsibilities of local authorities under the Health Act, is the appropriate ambit of powers of local authorities to make bylaws related to health and health services.

While there has been variation between the various provinces, individual local authorities have until now typically been empowered to make bylaws regarding a number of matters impacting on public health. Section 266(1) of the (Natal) Local Authorities Ordinance, 1974 (Ord. No. 25 of 1974), confers powers on local authorities to make bylaws concerning a wide variety of issues impacting on health.[291]

The rationale for allowing for such local variation in legislative requirements regarding such a wide range of issues is not immediately apparent. For example, it makes little sense for different legal requirements regarding the height of the walls of an abattoir to apply depending on whether the abattoir is built on one side of the boundary of a local area or on the other. It is also not clear why different hygiene requirements should apply to a milk purveyor when conveying the milk to different retailers in adjacent local areas. Apart from the apparent lack of logic inherent in such differing requirements, enforcement of health requirements is made more difficult and more costly.

In addition, there is a danger that health interests will be compromised by local legislators under the influence of big business interests in their local areas. Local authorities depend heavily on local business for financial and other support. Local councillors also frequently have business interests in their local areas. They may be reluctant to compromise their own profits by setting restrictive health requirements, or to risk losing the vote of business people in the next local government elections. While big business has influence over provincial legislatures as well, business interests are likely to be felt far more at a local level.

It may therefore be desirable in provincial health legislation to impose reasonable limitations on the powers of local authorities to make bylaws. Any such limitations would have to be made in consultation with local authorities in the provinces, given the fact that section 175(4) of the Interim Constitution recognises the power of local authorities to make bylaws which are not inconsistent with the Interim Constitution, an Act of Parliament or an applicable provincial law.

## Part 8 - PUBLIC SECTOR HEALTH SERVICES

In terms of section 14(1)(a) of the Health Act, 1977 (Act No. 63 of 1977) the national Department of Health was made responsible for co-ordinating public sector health services rendered at national, provincial and local level, and for providing any additional services which were necessary for a comprehensive health service. While it is anticipated that the national Department will continue to play a broad co-ordinating role, primary executive and legislative responsibility for health services now rests with provincial governments, in terms of the provisions of the Interim Constitution.

The Part of the Framework dealing with public sector health services covers a wide variety of health services rendered in the public sector, and is subdivided into several Divisions. It is beyond the constraints of this dissertation to discuss these Divisions in any detail, and only some of the key issues addressed will be elaborated on.

**Division 8.2 - Public Sector Health Establishments**

Various pieces of legislation exist which impact on public sector health establishments, and would need to be taken into account in the drafting of this Division.

Section 16(1)(a) of the 1977 Health Act provides that hospital facilities and services are a function of provincial administrations. The Academic Health Centres Act 1993 (Act No. 86 of 1993) provides for the establishment of academic health centres, which include hospitals for the training of medical personnel, with the concurrence of universities having faculties of medicine. More detailed regulation of public sector health establishments is contained in the Hospitals Ordinances of the four former provinces.

The Provincial Hospitals Ordinance, 1961 (Ord No. 13 of 1961) applies in Natal. Section 2 established a Health Services Branch to perform all work related to the establishment, regulation, control and management of provincial hospitals, services and institutions. In terms of section 3, the Deputy Director-General: Health Services, was appointed as head of this branch. Section 4 empowered the Administrator of Natal to establish and maintain provincial hospitals, nursing and midwifery services, and clinics, as well as related services. Other provisions in the Ordinance relate to: the appointment and powers of a hospital superintendent (s 5); the establishment of Hospital Boards (Chapter II); the admission, treatment and discharge of patients (Chapter III); and various miscellaneous matters (Chapter V). Regulations about the administration, management, and control of provincial hospitals, services, and institutions, were made under the Ordinance.[292]

The Framework makes provision for much of the above legislation to be incorporated into the new Health Act, and in some respects expands the regulatory powers of the political head of the health department in order to allow for greater co-ordination and rationalisation of public sector facilities. For example, regulations

which classify health facilities, determine criteria for their establishment, and designate the functions and responsibilities of the various categories of health facilities, could facilitate rationalisation and careful planning of service provision. It is, however, essential that the enabling provisions are drafted in such a way so as to prevent over-regulation which may threaten the viability or efficiency of health services.

A notable feature of the Framework is its provision for "participatory management" of health facilities, which is in keeping with current policy that communities must be encouraged to participate actively in the planning, managing, delivery, monitoring and evaluation of the health services in their area.[293] In the light of this emphasis on participatory management, the composition and functions of hospital boards, which are established in terms of Chapter II of the (Natal) Provincial Hospitals Ordinance, 1961 (Ord No. 13 of 1961), will need to be reviewed. Consideration needs to be given to the establishment of forums at all health facilities in order to permit participation by staff, health service users, civic organisations, non-governmental organisations and other parties with a defined interest in the provision of health services by the facility concerned. Provided that the forums are able to impact on management and policy decisions of health facilities in a meaningful way, these forums should ensure transparency resulting in greater acceptability of health services provided, and they should have a significant role to play in minimising conflict, labour unrest and disruption of service delivery.

**Division 8.3 - Emergency Services**

Several pieces of legislation refer to ambulance and emergency medical services.

Section 16(1)(b) of the Health Act, 1977 (Act No. 63 of 1977) provides that it is a function of a provincial administration "to provide ambulance services within its province and, with due regard to similar services provided by provincial administrations in adjacent provinces, to co-ordinate such services".

In terms of sections 7(1)(b), 8(2) and 10(3)(h) read with schedule 2 of the Local Government Transition Act, 1993 (Act No. 209 of 1993), the functions of a Transitional Metropolitan Council include the provision of ambulance services.

Section 5 of the National Emergency Telephone Service Act, 1993 (Act No. 143 of 1993) provides that a local authority may apply to be approved as a reporting centre if it is capable of transmitting requests in regard to ambulance and medical and other emergency services.

In addition, various provincial Ordinances provide for the establishment and maintenance of ambulance services. Section 264(6) of the (Natal) Local Authorities Ordinance, 1974 (Ord. No. 25/1974) provides that local authorities may establish ambulances and prescribe charges for their use. In addition, section 4(3) of the (Natal) Provincial Hospitals Ordinance, 1961 (Ord. No. 13 of 1961) empowered the Administrator to establish and maintain ambulance services and to subsidise running such services. Section 26 of that Ordinance empowered the Administrator to make regulations regarding a number of matters, including ambulance services. The Administrator exercised these powers in regulations which were gazetted on 19 October 1961.[294] These regulations provide that the control of ambulances attached to provincial hospitals vest in the superintendent of such hospital, and specify the particulars which may be required of patients using ambulance services, and the fees which they must pay.

This legislation is inadequate in a number of respects, including a failure to regulate private ambulance services or to set minimum standards for the transportation of patients. It is essential that legislation concerning ambulance services be revised as a matter of urgency.

**Divisions 8.4 and 8.5 - Epidemics, emergencies and disasters**

The Framework makes provision for separate Divisions dealing with epidemics, in the one, and emergencies and disasters, in the other. The Divisions provide for special powers and extraordinary measures to enable the immediate and effective participation of health authorities in the event of a severe epidemic or some other emergency or disaster affecting the province, or in the event of a sudden deterioration of the environment constituting an imminent danger to the environment.

It is submitted that these Divisions should be amalgamated because the extraordinary powers which may be granted to combat these exceptional situations are generally very similar. Ordinary measures for the control of communicable

diseases are provided for in Part Seventeen of the Framework (see discussion below).

Several pieces of legislation provide for extraordinary measures in the circumstances outlined above.

Section 2(1) of the Civil Protection Act, 1977 (Act No. 67 of 1977) makes provision for the declaration of a state of disaster if a disaster occurs which is of such a nature and extent that extraordinary measures are necessary to assist and protect the Republic and its inhabitants, and to combat civil disruption. A "disaster" is defined in the Act to include the disruption of essential services, including the provision of health services. Section 3(1) of the Act also authorised provincial councils to make Ordinances in relation to the protection and rendering of assistance to persons in connection with a disaster.

The (Natal) Civil Protection Ordinance, 1978 (Ord. No. 5 of 1978) defines a disaster to mean a natural disaster or the disruption of essential services, including the provision of water, electricity or gas, sewage or refuse removal services, health services, or the transportation of persons or goods. Section 3(1) provided that, for the purposes of protecting and assisting persons and property or the combating of civil disruption in the event of a natural disaster, a local authority may take such steps as the Administrator may direct with respect to, *inter alia*: co-ordinated planning for the medical treatment and care of injured and sick persons; provision of emergency housing, food and clothing; and continuation of public health services.

The remainder of this Ordinance concerns *inter alia*: extraordinary powers of local authorities and the Administrator in the event of a disaster; the appointment of officers and committees; and the training of persons in connection with the carrying out of functions in terms of this Ordinance. These provisions are amplified in the (Natal) Civil Protection regulations.[295]

KwaZulu had its own legislation concerning civil protection. The provisions of the KwaZulu Civil Defence Act, 1984 (Act No. 11 of 1984), however, are almost identical to the provisions of the (Natal) Civil Protection Ordinance.

Although the various laws concerning civil protection are not administered by the Health Ministry, they clearly contain provisions which have direct bearing on the provision of health services. In developing the framework for the new KwaZulu Health Act, it was considered important that the extraordinary powers regarding the provision of health services in crisis situations should fall within the control of the health department, in order to ensure effective planning of the deployment of health services in these situations, and the immediate participation of health services according to priorities determined by health authorities. At the same time, the importance of intersectoral collaboration in the combating of epidemics, disasters and emergencies was recognised, hence the provision for multidisciplinary disaster management committees at various levels.

The proposed KwaZulu-Natal Health Act would greatly strengthen the power of the Health Ministry to intervene in the event of epidemics, disasters and other emergencies. The strongest power which is provided for in the Framework is the power of the political head of the health department, or an officer accountable to that person, to proclaim a state of health emergency. In the event of a health emergency, provision would be made in the Act for health authorities to exercise extraordinary powers which are necessary to avert the crisis.

**Division 8.6 - Mental Health**

Most of the issues addressed in the Framework are currently dealt with in the Mental Health Act, 1973 (Act No. 18 of 1973). This Act provides for the reception, detention and treatment of persons who are mentally ill, in institutions. The KwaZulu legislature passed the KwaZulu Mental Health Amendment Act, 1988 (Act No. 7 of 1988), which made the South African Mental Health Act,1973 (Act No. 18 of 1973), as it stood on 14 March 1986, applicable to KwaZulu, with some minor amendments.

The administration of the South African Mental Health Act had, by the end of June 1995, not yet been assigned to the provinces. However, such assignment is likely to occur in the near future due to the fact that mental health services clearly fall within the legislative competence of the provinces.

Current mental health legislation is oriented towards a mental health care service which is largely curative and is predominantly hospital-based. This legislation will

have to be reviewed in the light of a reorientation of mental health services towards health promotion, the prevention of mental illness, and intervention at community level. This shift in approach is clearly evident in the mental health policy described in the ANC Health Plan, the principle tenets of which include:

i. promoting the development of an adequate, flexible range of mental health services at a community level wherever possible;

ii. ensuring a multisectoral and integrated approach to mental health services;

iii. promoting the empowerment of people and communities, thus enhancing psychological well-being;

iv. emphasis on the promotion of healthy lifestyles and the prevention of mental disorder where possible with priority given to high risk groups;

v. fostering respect for the rights of people with mental illness and mental handicaps;

vi. promoting awareness of mental health and mental health issues; and

vii. promoting mental health in children with priority given to addressing the needs of vulnerable children.[296]

**Division 8.7 - Maternal, Child and Women's Health**

Section 30(1)(c) of the Interim Constitution provides that every child shall have the right to security, basic nutrition and basic health and social services. In addition, the Minister of Health gave notice in the Government Gazette that, as from 1 June 1994, free health services must be rendered to: children under the age of six years; and to pregnant women, for the period commencing from the time the pregnancy is diagnosed to forty-two days after the pregnancy has terminated, or if a complication has developed as a result of the pregnancy, until the woman has been cured or the conditions resulting from the complication have stabilised.[297] Conditions for which free health services are rendered to pregnant women include those conditions that are not related to the pregnancy. Non-citizens of South Africa who fall into the above categories and who incidentally develop a health

problem whilst in South Africa, also benefit from the free health services. Provision of these free health services is subject to certain exceptions. Such services will only be provided at State health care facilities, at State-aided hospitals of which more than half their expenditure is subsidised by the State, or by district surgeons. Further, they are not available to persons and their dependents who are members of a medical scheme, and to non-citizens of South Africa who visit the country specifically for the purpose of obtaining health care.

Several other South African laws also address issues of maternal, child and women's health. These laws are outlined below.

Section 16(1)(e) of the 1977 Health Act states that the functions of provincial administrations include the provision and maintenance of maternity services.

Section 39 of the Child Care Act, 1983 (Act No. 74 of 1983) concerns medical treatment of children. Section 39(4) gives a general right to any person over the age of 18 years to consent independently to the performance of any operation upon herself or himself, and in the case of a child over the age of 14, to consent independently to any (non-invasive) medical treatment of himself or herself, or of his or her child. Section 39(1) provides for substitute consent by the Minister in regard to the performance of necessary medical procedures on a child, where the child's parents or guardian refuses to consent, cannot be found, of for some other reason is unable to consent. Section 39(2) provides for substitute consent by the medical superintendent of a hospital in regard to emergency operations or medical treatment, where this is necessary to preserve the life of a child or to save her or him from serious and lasting physical injury or disability, and the need for the operation or treatment is so urgent that it ought not to be deferred for the purpose of consulting the person who is legally competent to consent.

Special provision is also made in the Child Care Act for consent to medical children in custody. Section 53(3) provides that transfer of custody from the parent or guardian of a child to an institution[298] or to another person does not involve a transfer of the power to consent to the performance upon a child of an operation or medical treatment which entails a serious danger to life. However, section 53(4) provides that if the head of the institution or custodian of the child has reasonable grounds to believe that the medical procedure envisaged is necessary to preserve the life of the child or to prevent serious and lasting physical injury or

disability, and that the need for the procedure is so urgent that it ought not be deferred for the purpose of consulting the parents or guardian of the child or the Minister, the head of the institution or the custodian may authorise it.

Regulations made under the Correctional Services Act, 1959 (Act No. 8 of 1959) provide that an operation may be performed on a minor prisoner without the consent of his or her guardian where, in the opinion of a medical officer, it will be in the interests of the prisoner's health or life, and it is not possible or practicable to obtain the guardian's consent.[299]

Section 42(1) of the Child Care Act also places a legal duty on dentists, medical practitioners, nurses and social workers to notify the Director-General in the event of suspected child abuse or neglect. Failure to comply with this notification requirement is a criminal offence (subsection (4)). Subsection (6) protects health workers against legal proceedings in respect of any notification given in good faith in compliance with section 42.

The obligation to report suspected ill-treatment of children has now been considerably extended by the Prevention of Family Violence Act, 1993 (Act No. 133 of 1993). Section 4 provides that:

> *Any person who examines, treats, attends to, advises, instructs or cares for any child in circumstances which ought to give rise to the reasonable suspicion that such child has been ill-treated, or suffers from any injury the probable cause of which was deliberate, shall immediately report such circumstances -*
>
> *(a) to a police official; or*
>
> *(b) to a commissioner of child welfare or a social worker referred to in section 1 of the Child Care Act, 1983 (Act No. 74 of 1983)*
>
> (my emphasis)

The Prevention of Family Violence Act also makes provision for the granting of interdicts with respect to family violence (section 2), and provides that notwithstanding anything to the contrary contained in any law or in the common law, a husband may be convicted of the rape of his wife (section 6).

The Abortion and Sterilisation Act, 1975 (Act No. 2 of 1975) defines the circumstances in which an abortion may be performed or in which a person who is incapable of consenting or incompetent to consent to sterilisation, may be sterilised. Legal indications for abortion are listed in section 2 to be:

i. where the continued pregnancy endangers the life of the woman concerned or constitutes a serious threat to her physical health;

ii. where the continued pregnancy constitutes a serious threat to the mental health of the woman concerned such that there is a danger of permanent damage to the woman's mental health and abortion is necessary to ensure the mental health of the woman;

iii. where a serious risk exists that the child to be born will suffer from a physical or mental defect of such a nature that he or she will be irreparably seriously handicapped;

iv. where the foetus was conceived in consequence of rape or incest;

v. where the foetus was conceived in consequence of illegitimate carnal intercourse with a woman who is, due to a permanent mental handicap or defect, unable to comprehend the consequential implications of or bear the parental responsibility for the fruit of coitus.

In the case of abortion on psychiatric grounds, three doctors, one of whom must be a State registered psychiatrist, must consent. For rape, the woman must report the offence to the police and testify before a magistrate in the jurisdiction where the crime occurred. The magistrate issues a certificate allowing the abortion if he or she believes the woman's account. In all cases the abortion must be carried out in State registered institutions with the consent of the superintendent and of three doctors. Abortions which are procured otherwise than in accordance with the provisions of this Act are illegal and give rise to criminal penalties.

Similar provisions to those in the South African Abortion and Sterilisation Act are contained in the KwaZulu Abortion and Sterilisation Act, 1986 (Act No 10 of 1986).

Abortion laws in South Africa have been criticised by pro-choice lobbyists on the grounds that they exclude the majority of South African women from access to safe abortions because the legal indications for abortion are very limited, and the implementation of the laws are complex. They argue that the restrictive legislation results in many thousands of backstreet abortions occurring annually, resulting in unnecessary morbidity and mortality. A special parliamentary committee is currently investigating the possibility of liberalising abortion laws in South Africa.

Maternal and child health was identified in the ANC National Health Plan as a priority area for health policy.[300] Annexure Six lists issues which were identified in the report of the Maternal, Child and Women's Health Committee of the Department of Health, released in February 1995, as priorities of the Reconstruction and Development Programme.

It is submitted that existing South African legislation provides an inadequate legislative framework for the implementation of new policy. The proposed KwaZulu-Natal Health Act promises to be the first South African law to provide a comprehensive approach to the promotion and protection of the health of mothers, women and children, in line with international legislative trends.[301]

A rather curious feature of the Framework, however, is its provision for the "protection of the health of unborn persons". While this provision appears to favour the pro-life viewpoint of abortion, the intention behind its inclusion in the Framework was not to address the abortion issue at all, as this was considered to be a matter for determination at national level. Rather, it was intended to make provision for the implementation of special programmes designed to reduce factors which threaten the well-being of foetuses, for example the use of tobacco and alcohol during pregnancy.

**Division 8.8 - Family Planning and Reproductive Health Services**

Several South African laws impact on family planning and reproductive health services.

Section 14(1)(d) of the 1977 Health Act stated that it was a function of the national Department of Health to promote family planning. Note too that in the proclamation of 31 October 1994 assigning the administration of various provisions

of the Health Act to the provinces[302], section 16 of the Health Act was amended to include the promotion of family planning among the functions of provincial administrations.

Section 38A(d) of the Nursing Act, 1978 (Act No. 50 of 1978) provides that nurses in the public service may be authorised to perform services with reference to the promotion of family planning.

Artificial insemination is regulated by the Human Tissue Act, 1983 (Act No. 65 of 1983), and by detailed regulations made thereunder.[303] Artificial insemination is a lawful procedure, provided that it is performed in accordance with the Act and regulations.

The Abortion and Sterilisation Act, 1975 (Act No. 2 of 1975) has already been mentioned. This Act governs only the sterilisation of persons who for any reason are incompetent to consent to sterilisation. The Act prohibits the sterilisation of such a person unless certain stringent requirements have been complied with. Sterilisation in other circumstances is not mentioned, and is therefore still essentially governed by the common law. There is therefore no legal obstacle preventing a mentally competent, consenting adult from choosing sterilisation as a means of contraception.

Several jurisdictions apply greater statutory controls to voluntary surgical sterilisation. Some of these controls are simply an extension of the principle of informed consent. For example, in some jurisdictions, counselling of applicants to sterilisation is required prior to the performance of the procedure.[304] Where the applicant is married, Finland has a requirement that both spouses be counselled regarding whose sterilisation is more appropriate.[305]

However, the population development policies of some jurisdictions have resulted in far more stringent restrictions being placed on the performance of sterilisation procedures on consenting adults. In Honduras, for example, only the following categories of person may undergo voluntary sterilisations: women between the ages of 24 and 35 with three or more children; women above 35 with one child or more, and after exhaustion of nonsurgical remedies; and men of 30 and over who have had three or more children.[306]

An interesting anomaly arises in South African law in relation to the provision of contraceptive measures to children between the ages of 14 and 16 years. In terms of section 39(4) of the Child Care Act, 1983, a minor who is 14 years of age or older can consent independently to medical treatment, which would include the giving of contraceptive advice or the provision of contraceptive measures by a medical practitioner. While a girl over the age of 14 may, therefore, consent independently to contraception, it is illegal under section 14(1)(a) of the Sexual Offences Act, 1957 (Act No. 23 of 1957) to have sexual intercourse with a girl under the age of sixteen years.

A further problem arising from section 39(4) of the Child Care Act, is that children under the age of fourteen who are sexually active, do not have access to contraceptive measures without the consent of their parent or guardian. This gives rise to the problem that medical practitioners cannot legally prescribe contraceptive measures to children under fourteen who do not wish to disclose to their parents or guardian the fact that they are sexually active. It is submitted that the national Department of Health should consider introducing legislation which indemnifies medical practitioners who prescribe contraception to clients who are under 14 years old and request contraception. Provision could also be made for mandatory counselling of minors in such circumstances in respect of problems which accompany sexual activity at a minor age.

**Division 8.9 - School health**

Section 33(1) of the Health Act, 1977, provides that the Minister may make regulations relating to -

> *a) the closing of any teaching institution for the purpose of preventing the spread of communicable disease, and the regulation or restriction of the attendance by any person at any teaching institution; and*
>
> *b) the duties of parents or guardians of scholars and students who are suffering or have suffered from, or who have been exposed to infection with, any communicable disease, and of persons in charge of teaching institutions, in respect of such scholars or students.*

Section 112(1)(fA) of the Education Affairs Act (House of Assembly), 1988 (Act No. 70 of 1988) provides that the Minister of Education may make regulations as to the compulsory medical, psychological or dental examination of pupils and persons employed at schools and hostels, and health inspections of school and hostel premises.

Provision is made in section 266(1) of the (Natal) Local Authorities Ordinance, 1974 (Ord. No. 25 of 1974) for local authorities to make bylaws regarding the safeguarding of the health and physical welfare of children attending schools, nursery schools, creches and play schools. Chapter XIV of the standard bylaws framed by the Administrator of Natal, in terms of this Ordinance, relates to health and hygiene in creches. This Chapter provides for hygiene, cleanliness and structural requirements for creches, and regulates the dispensing of medical care in creches and nursery schools. It also prescribes specific safety measures which must be complied with in order to prevent injury or infection of children, and establishes requirements for the keeping of medical reports in respect of each child.

The legislative provisions outlined above again raise the concern that important health functions, in this case responsibility for the protection of the health of schoolchildren, fall under the jurisdiction of several departments. It is, for example, unsatisfactory that the Education Affairs Act provides that the Minister of Education may, without consulting the Minister of Health, make regulations as to the compulsory medical, psychological or dental examination of pupils and persons employed at schools and hostels, and health inspections of school and hostel premises.

Another concern arising from this legislation is that it is predominantly geared to curative intervention and to the containment of communicable diseases, and makes little provision for programmes to provide children with the skills necessary to make healthy choices in their daily lives.

The proposed KwaZulu-Natal Act seeks to address both these concerns. It brings matters of school health squarely within the jurisdiction of the health department, although provision would undoubtedly be made in the Act for mandatory collaboration with the political head of the education department in KwaZulu-Natal. Further, while addressing issues of curative intervention, the Act would have a marked emphasis on health promotion. For example, provision is made in the

Framework for the establishment of a Commission, which would have representation from all interested sectors, to prepare health education courses for schools. Provision is also made for specific health programmes in schools, which could relate to, for example: communicable and non-communicable diseases; nutrition; habits endangering health, such as tobacco and alcohol use; mental health; and sexuality. Note that the provision in the Framework relating to physical training and sports education refers specifically to minimum safety standards in these activities.

**Division 8.10 - Rehabilitative Services**

While it is not clear from the Division heading whether rehabilitative services refers to physical rehabilitation after illness or rehabilitation from drug addiction, it can be assumed to refer in the main to rehabilitation services for persons dependent on drugs, as rehabilitation from physical and mental conditions is dealt with in Division 8.11. The main pieces of legislation dealing with rehabilitation from drug addiction are considered below.

The Prevention and Treatment of Drug Dependency Act, 1992 (Act No. 20 of 1992), provides for the establishment of services for the rehabilitation of drug addicts. The Act provides for the establishment of a Drug Advisory Board, and for the establishment, maintenance and management of treatment centres for drug abusers. Provision is also made for the observation, treatment, supervision and accommodation of persons who have been released from a treatment centre.

In the territory of KwaZulu, the KwaZulu Abuse of Dependence-Producing Substances and Rehabilitation Centres Act, 1979 (Act No. 12 of 1979) applies. This Act brought the KwaZulu legislation in line with the South African Abuse of Dependence-Producing Substances and Rehabilitation Centres Act 1971 (Act No. 41 of 1971), as amended until 1978. The South African Act was subsequently repealed by Act No. 20 of 1992, but the KwaZulu Act remains in the statute books.

The KwaZulu Act provides, *inter alia*, for the prohibition of dependence-producing drugs as specified in a schedule to the Act. This schedule is divided into three parts: Part I contains a list of prohibited dependence-producing drugs; Part II a list of dangerous dependence-producing drugs; and Part III a list of potentially

dangerous dependence-producing drugs. Dealing in or possession of the drugs specified in Part I of the schedule is absolutely prohibited. Possession of drugs specified in Parts II or III of the schedule is permitted only if sold or supplied on the written prescription of a medical practitioner, dentist or veterinarian.

The Act also provides for the establishment of rehabilitation centres to which certain persons may be committed for treatment, as well as related matters, including: admissions and committals; running and registration of the centres; powers of the police; methods of dealing with absconders; and empowerment of the Minister to make regulations regarding a variety of issues.

Rehabilitation institutions in the former homelands were also subject to particularly draconian legislation, in the form of the Proclamation by the State President on Rehabilitation Institutions in National States.[307] This proclamation was made by a former State President in terms of the powers granted to him by the Black Administration Act, 1927 (Act No. 38 of 1927). This Proclamation was repealed in its entirety within the Republic of South Africa in 1989, but was expressly retained within the self-governing territories[308].

The Proclamation makes provision for the establishment and control of rehabilitation institutions in Black Areas, and for conditions of detention of black persons in institutions. It provides for the transfer, classification, treatment, training, and period of detention of inmates, and various other matters such as procedures for dealing with absconders and deaths of inmates. Provision is made for every inmate, unless prevented by illness, to be compelled to work for the institution, a Black authority or the State, for up to 56 hours per week, excluding time spent in going to and from work, tidying premises, meals, and other approved rest periods, with provision for allowances as a privilege, depending on conduct. Section 18 creates eighteen offences, including attempting suicide, evading work, and feigning illness. Contravention of this provision results in the imposition of penalties such as starvation, increasing working hours, and solitary confinement.

The provisions of this Proclamation are not consonant with the therapeutic objectives of rehabilitation. The Proclamation should be repealed in all areas as a matter of urgency.

While rehabilitation from drug abuse is essentially a function of the Department of Welfare, it has significant implications for the health status of the persons involved. Provision should therefore be made in health legislation for intersectoral collaboration between the Departments of Health and Welfare in the treatment and rehabilitation of drug abusers.

**Division 8.11 - Social welfare, prevention of disability, and care and rehabilitation of the physically and mentally handicapped**

Rehabilitation of people who have suffered illnesses is a vital function of primary health care, and is a function of local authorities in terms of the Health Act, 1977. Section 20(1)(d)(iii) of the Health Act provides that every local authority shall take all lawful, necessary and reasonably practicable measures to render in its district, subject to the provisions of this Act or any other law, primary health care services, including services for the rehabilitation in the community of persons cured of any medical condition. Basic rehabilitation and physical therapy services, to be performed by physiotherapists and occupational therapists, also form part of the proposed basic package of services which are to be available to all permanent residents in South Africa, in terms of the recently published report of the Committee of Inquiry into a National Health Insurance System.[309]

This Division also deals with matters that fall within the jurisdiction of various departments, including the Departments of Education and of Welfare. Provision should therefore be made in the Health Act for some form of intersectoral collaboration between the various departments. The main pieces of legislation dealing with these matters are briefly outlined below.

The National Welfare Act, 1978 (Act No. 100 of 1978) provides for the establishment of a National Welfare Council and various regional welfare boards. It also provides for the registration of welfare organisations. The functions of the National Welfare Council include the advising of Government on issues such as the measures necessary for protecting and promoting the welfare of the aged, children, and physically or mentally handicapped persons.

Pensions and other financial assistance for blind people, persons with other disabilities and the elderly are dealt with in: the Social Pensions Act, 1973 (Act No. 27 of 1973); the Social Assistance Act 1992 (Act No. 59 of 1992); the Aged

Persons Act, 1967 (Act No. 81 of 1967); the Blind Persons Act, 1968 (Act No. 26 of 1968); and the Community Welfare Act 1987 (Act No. 104 of 1987).

Section 12(1)(d) of the Education Affairs Act (House of Assembly), 1988 (Act No. 70 of 1988) provides that the Minister of Education may establish schools for specialised education, which is defined in section 1 to include the medical treatment and performance of operations on handicapped children, and the care of handicapped children in a hospital or other institution.

**Division 8.12 - Care of the elderly**

Care of the elderly is primarily a welfare function, although it also involves the provision of health care to the elderly. The motivation for including this in the Framework is not to remove the administration of services for the elderly from the Department of Welfare, but once again merely to allow provision for intersectoral collaboration between the two departments. No South African legislation currently exists which deals specifically with the provision of health services to the elderly.

**Division 8.13 - Poison Information Centres**

Provision is made in the Framework for the establishment, maintenance and management of poison information centres - centres which dispense information concerning poisons and the treatment of poisonings. There is at present no specific legislation governing poison information centres. Two Acts, however, are relevant to the control of poisonous substances.

The Hazardous Substances Act, 1973 (Act No. 15 of 1973) provides for the control of substances which may cause injury, ill health, or death to a human being by reason of their toxic, corrosive, irritant, strongly sensitising or flammable nature, and for the control of certain electronic products. The Act makes provision for the grouping of these substances or products in relation to their respective degrees of danger, and for controls over their use, application, installation, importation, disposal or sale. Section 29 of the Act gives the Minister of Health wide powers to make regulations controlling or prohibiting such activities, and prescribing the precautions to be taken for the protection from injury, ill-health or death of persons in control of, or employed in, the manufacture, operation, application and use of such "grouped" substances.

The Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965) provides for the registration and control of medicines and medical devices. Section 2 of the Act provides for the establishment of a Medicines Control Council to perform various functions in relation to the administration of this Act. Section 14 prohibits the sale of medicines which are subject to registration but are not registered, and section 23 provides for the disposal of undesirable medicines.

**Division 8.14 - Artificial Insemination Units**

Artificial insemination has already been considered in the discussion of Division Eight (family planning and reproductive health services). In retrospect, it would have been preferable to amalgamate Divisions 8.8 and 8.14, because artificial insemination is a type of reproductive health service.

**Division 8.15 - Health care for persons deprived of their freedom or in detention**

Section 25(1)(b) of the Interim Constitution provides that every person who is detained, including every sentenced prisoner, shall have the right to be detained under conditions consonant with human dignity, which shall include at least the provision of adequate nutrition, reading material and medical treatment at State expense. Laws which impact on health care for persons deprived of their freedom or in detention will need to be reviewed in the light of this constitutional provision.

Health care of persons in detention is currently dealt with by the Correctional Services Act, 1959 (Act No. 8 of 1959). Section 6 of the Act makes provision for the appointment of medical officers for prisons, who are to perform such functions as are assigned to them under the Act, including *inter alia*: certification that prisoners are fit to undergo corporal punishment (section 36). Section 73 provides for the removal of a prisoner from a prison to any other place, if the prisoner is seriously ill, or is about to give birth, and adequate facilities do not exist in the prison for the treatment of the prisoner.

The KwaZulu Correctional Services Act, 1990 (Act No. 3 of 1990) requires every prison in KwaZulu to have a medical officer, and provides for the appointment of such officers (section 7). Section 37 makes provision for the medical officer to: certify persons fit for corporal punishment; be present at the infliction of such punishment; and to intervene therein if the prisoner's health is not fit to stand its continuance.

Section 22(1)(c) provides that the KwaZulu Minister of Correctional Services may establish prisons for various purposes, including: to serve as observation centres for determining the health and mental condition of selected prisoners; for the detention and medical treatment of chronically sick prisoners who cannot be treated in an ordinary prison; and as hospital prisons for psychopaths or persons referred for observation in terms of any law related to mentally ill persons.

Section 85 concerns the issuance of medical certificates on the death of prisoners. Section 96 provides that the Minister of Correctional Services may make regulations with respect to, *inter alia*: the disposal of the bodies of prisoners who have died in prison; and the temporary detention of any sick prisoner whose sentence has expired but whose discharge or release is certified by the medical officer to be likely to result in that prisoner's death or in serious injury to her or his health, or to be a source of infection to others.

Although the Minister of Correctional Services is responsible for administration of existing laws regarding the provision of health care to prisoners, it is appropriate that the Minister of Health should also have input in this regard. It is therefore appropriate that the matter is now considered in the KwaZulu-Natal Health Act, provided that provision is made for collaboration with the Minister of Correctional Services in the carrying out of any relevant duties or functions prescribed in the Act.

**Division 8.16 - Screening and provision of health care for aliens**

The Aliens Control Act, 1991 (Act No. 96 of 1991) specifies circumstances in which aliens are regarded as prohibited persons in the Republic, and provides for the refusal of entry of such persons into the Republic, or the deportation of such persons, if they are already in the Republic. Section 39(2) of the Act defines categories of persons to be regarded as prohibited persons to include:

> *(a) any person who is likely to become a public charge by reason of infirmity of mind or body ...; ...*
>
> *(e) a mentally ill person, or any person who is deaf and dumb, deaf and blind, or dumb and blind, or is otherwise physically afflicted, unless in such case the person concerned or the person accompanying him or another person gives security, to*

*the satisfaction of the Minister, for his permanent support in the Republic or for his removal therefrom when required by the Minister;*

*(f) any person who is afflicted with any such contagious, communicable or other disease, or who is a carrier of such a virus, as may be prescribed ...*

Section 7(1) provides that an immigration officer may require any person presenting himself or herself to an immigration officer at a port of entry or any person who, in the opinion of such officer, is not entitled to be in the Republic, if it is suspected that such person is afflicted with any disease or physical infirmity which would render him or her a prohibited person under this Act, to submit to an examination by a medical practitioner designated by the Director General for this purpose.

It is recognised that it is undesirable to overburden the health and social services of the Republic by catering for the needs of economically unproductive persons who are not citizens, and that it is necessary to protect citizens of the Republic from communicable diseases transmitted by foreigners. However, it is submitted that it is unfairly discriminatory to prohibit persons falling into the section 39 categories from entering or remaining in the Republic, without first giving such persons an opportunity to be cured, rehabilitated or to attempt to fulfil a productive function in society. For example, provision might be made in legislation for mentally ill persons, or persons who are deaf and dumb, deaf and blind, dumb and blind, or otherwise physically afflicted, to be assessed by an Occupational Therapist for workskills prior to a decision being made as to her or his deportation.

**Part 9 - PRIVATE HEALTH**

The existing regulatory framework and policy options for the future regulation of the private health sector have already been considered in Chapter Two of this dissertation. It is therefore unnecessary to consider the issue again here. Suffice it to say that the final drafting of legislative provisions concerning the private sector must necessarily await the resolution of outstanding policy issues which were raised for discussion in the Report of the Committee of Inquiry into a National Health System, released for public comment on 20 June 1995.

## Part 10 - TRADITIONAL HEALING

The committee appointed by the Minister of Health in 1994 to investigate human resources for health recommended that regulatory mechanisms be developed to legally empower traditional healers, while facilitating the identification and prevention of harmful and exploitative practices.[310]

There are only two pieces of legislation in the Republic which currently regulate the practice of traditional healing. The regulations concerning the advertising of Black medicines and the financial protection of Black persons[311] made it an offence to advertise certain types of Black medicines.

Chapter 11 of the KwaZulu Act on the Code of Zulu Law, 1985 (Act No. 16 of 1985) concerns the practice of black medicine men (*izinyanga zokwelapha*), herbalists (*izinyanga zemithi*) and midwives (*umbelitisi*). Section 83 provides that these practitioners may only practise as such for gain if duly licensed, and section 84 provides for a nominal fee for such licence. Section 85 allows a licensed medicine man, herbalist or midwife to claim a fee. Section 86 renders such practitioners liable for negligence which causes harm to patients. Section 88 specifies certain activities which, if performed, constitute an offence, including: assuming the title of "doctor" or "chemist"; prescribing medicines other than *imithi yesintu* (which is defined in subsection 4) or to persons who are not *bona fide* patients; and advertising services.

This legislation does not provide a sound basis by which to regulate traditional healing and thereby to protect consumers, nor does it afford adequate legal recognition to the practice of traditional healers. It does not, for example, specify any criteria for the licensing of traditional healers, and provides no guarantee that practitioners have attained a minimum acceptable standard of knowledge or training. No provision is made for the development of rules of ethical behaviour or the control of traditional remedies. Other crucial issues such as the relationship between traditional healers and practitioners of allopathic medicine, standards of hygiene for consulting rooms, and the legal status of sick-leave notes written by traditional healers, are not mentioned.

The Part on traditional healing was included in the Framework in order to remedy the defects of existing laws. It was considered necessary to address the issue at

provincial level, because the practice of traditional healing varies substantially from region to region, and because regulation of traditional healing probably enjoys greater priority in KwaZulu-Natal than at a national level at present.

The Health Legislation Committee of the KwaZulu-Natal SMT subsequently drafted a Traditional Healers Bill which would be distributed as a discussion document, and would form the basis of consultation with interested parties. While provision for regulation of traditional healing was initially made in the framework of the Health Act, it was considered necessary to draft this separate Bill because it was felt that the Health Act should be confined to a broad enabling framework for government, and should not include detailed regulation of parastatal bodies such as the Traditional Healers Council.

The Bill proposes the establishment of a Traditional Healers Council of KwaZulu-Natal, to: supervise, control and regulate the practice of traditional healing; control the registration of traditional healers; set standards for the training of traditional healers; and investigate complaints and hold enquiries. Registration was proposed as a prerequisite for the practice of traditional healing. Registration would be made dependent on compliance with certain requirements regarding prior apprenticeship and successful completion of a practical examination. In this way, a legal instrument would be provided by which traditional healers themselves could organise their profession on a sound basis.

Several outstanding issues will need to be clarified before the proposed Bill can be tabled in Parliament. First, clarity is needed on which categories of traditional healers would be covered by the Act. This is vital to the definition of traditional healers and to the ambit of application of the Act. Secondly, a decision needs to be made whether the Act should only restrict the practice of traditional healing when it is for gain, or whether it should restrict the practice of traditional healing even when it is performed gratuitously. Thirdly, a decision needs to be taken concerning the composition of the Traditional Healers Council, in particular whether other professions such as medical practitioners, dentists, nurses and pharmacists should be represented on the Council. It is vital that all decisions in regard to these issues must be made after adequate consultation with all affected parties.

## Part 11 - APPROPRIATE HEALTH TECHNOLOGY

Provision is made for the regulation of medical devices in three South African Acts, namely: the Health Act, 1977 (Act No. 63 of 1977); the Hazardous Substances Act, 1973 (Act No. 15 of 1973); and the Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965).

Section 42(b) of the Health Act provides that the Minister may make regulations relating to "instruments, equipment or apparatus used or intended to be used in connection with the diagnosis, treatment, prevention or relief of physical defects or disease in man". The Hazardous Substances Act applies controls to electronic products generating radiation, and to other high or medium risk electromedical devices used for medical or dental applications. Section 35(1)(xxxB) of the Medicines and Related Substances Control Act empowers the Minister to make regulations "authorizing, regulating, controlling, restricting or prohibiting the registration, manufacture, modification, importation, storage, transportation, sale, use or destruction of any medical device or class of medical devices". To date no regulations have been approved under this provision, though draft regulations have been prepared and are at a discussion stage.[312]

The regulation of medical devices in South Africa has been criticised as being fragmented and incomplete, and subject to a danger of lack of co-ordination, due to the fact that responsibility for implementing the various pieces of legislation mentioned above rests with different directorates of the Department of Health.[313]

In an attempt to address some of the problems of existing regulation of health technology, it is proposed in the Framework that a Provincial Commission on Appropriate Health Technology be established. It is envisaged that the Commission would include participation of all relevant health disciplines. Such a Commission would assist in the effective implementation of national policy and legislation regarding health technology at provincial level, and would provide advice and assistance in regard to the development and implementation of an appropriate and rational policy on health technology in the province.

## Part 12 - FOODSTUFFS

Food safety is an important component of public health law because of the severe risks posed to human health by spoilt and unhealthy foods and by the unhygienic preparation of foods. Most food-borne infections and poisonings result from poor food safety and sanitary measures.[314]

Foodstuffs are currently regulated in large measure by the Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972), and the regulations made thereunder. Section 2 of the Act prohibits the sale, manufacture or import for sale of foodstuffs under certain circumstances, for example when that foodstuff "is contaminated, impure or decayed, or is, in terms of any regulation, deemed to be harmful or injurious to human health". Section 4 prescribes requirements in relation to labelling of products which are a mixture or compound of different foodstuffs, while section 5 prohibits the publication of false or misleading advertisements of foodstuffs. Section 15(1) provides the Minister of Health with wide-ranging powers to make regulations, including *inter alia*:

> *(a) prescribing the nature and composition of any foodstuff, cosmetic or disinfectant, or standards for the composition, strength, purity or quality or any other attribute of any foodstuff, cosmetic or disinfectant or any ingredient or part of a foodstuff, cosmetic or disinfectant; ...*
> *(e) prescribing any foodstuff, cosmetic or substance as a foodstuff, cosmetic or substance which shall for the purposes of this Act be deemed to be harmful or injurious to human health;*
> *(f) declaring any foodstuff to be perishable foodstuff for the purposes of this Act;*
> *(g) prohibiting the sale of any particular foodstuff, cosmetic or disinfectant, or of any foodstuff, cosmetic or disinfectant of a particular nature or class.*

Enforcement of the provisions of the Act are facilitated by the granting in section 11 of extensive powers to environmental health officers regarding entry and search of premises, and the examination, sampling and seizure of articles. In practice, these powers are exercised by the environmental health officers of local authorities. It is to be noted that the application of section 11 will now be subject

to scrutiny under section 13 of the Interim Constitution, which provides that "[e]very person shall have the right to his or her personal privacy, which shall include the right not to be subject to searches of his or her person, home or property, the seizure of private possessions or the violation of private communications". Any limitation on this right is only permissible to the extent that it is reasonable, justifiable in an open and democratic society based on freedom and equality, and does not negate the essential content of the right in question (section 33(1) of the Interim Constitution).

The principles of sound health management demand that the Foodstuffs, Cosmetics and Disinfectants Act should provide the framework for all regulation of foods and beverages at national level. The reality is somewhat different. Section 35(1) of the Health Act, 1977, lists some sixteen powers of the Minister to make regulations relating to food and milk, including for example, regulations relating to:

> *(e) the examination of and the control and supervision of the manufacture, preparation, storage, keeping and dispatch of, any article of food intended for sale in or export from the Republic, and the prohibition of the manufacture, preparation, storage, keeping, dispatch or sale in or export from the Republic of any article of food which is, or contains an ingredient which is, diseased or unsound or unfit for human consumption, or which has been exposed to any infection or contamination.*

South African law concerning foods and beverages is made even more complex due to the fact that additional controls have been provided for at provincial and local levels. Section 194 of the (Natal) Local Authorities Ordinance 1974 (Ord No. 25 of 1974) provides for powers of entry, search and seizure of Medical Officers of Health and environmental health officers in respect of unsound food which is being prepared for sale or human consumption. Again, the exercise of these powers are now subject to the right to privacy, enshrined in section 13 of the Interim Constitution. Further, in terms of section 266(1), local authorities may make bylaws concerning food matters, such as the conditions under which food shall be kept, manufactured, stored, supplied, or handled. Several of the Standard Bylaws[315] framed by the Administrator, and which are appended to the Ordinance, concern the regulation of foodstuffs.

Chapter IV of the Standard Bylaws concerns the manufacture, storage and sale of foodstuffs. Part I of this Chapter contains general measures to prevent the consumption, sale and storage of unwholesome foods, as well as general hygiene requirements for premises, utensils, receptacles, etc. Part II contains special hygiene and structural provisions regarding a number of specified trades, including: manufacture of drinks; manufacture, storage, sale and delivery of bread and bakery products; sale and delivery of meat, fish and poultry; manufacture and sale of dairy products; refreshment shops; and hotels, boarding and lodging houses. The bylaws confer certain powers of entry, inspection and seizure with regard to food, persons handling food and their clothing are conferred on medical officers of health.

Chapter VI of the Standard Bylaws concerns the registration and regulation of dairies, cowsheds, milkshops, and milk dealers and purveyors. Chapter VII concerns markets, and includes a provision prohibiting the bringing into markets of any unhealthy foods, as well as provisions conferring powers of inspection and destruction.

The complexity of laws relating to foodstuffs makes enforcement difficult and voluntary compliance less likely as it is difficult for manufacturers, importers, distributors and retailers to determine the scope of their legal duties. It is vital that these laws be rationalised at all levels. If provinces are to legislate on foodstuffs, as is proposed in the Framework, it is essential that the formulation of provincial legislation is closely co-ordinated with the formulation of legislation at national level. It is also essential when formulating provincial legislation, that cognisance is taken of the need for uniform requirements to apply throughout the country in relation to food standards, and that provincial legislation is confined to issues where provincial variation is absolutely necessary. Unless this principle is observed, manufacturers, distributors and retailers may have to comply with different requirements in each of the provinces, which will cause an increase in food costs and a possible administrative catastrophe.

## Part 13 - ENVIRONMENTAL HEALTH PROTECTION

Section 29 of the Interim Constitution provides that every person shall have the right to an environment which is not detrimental to his or her health or well-being. This provision is an important recognition of the fact that effective health intervention aimed at the prevention of disease and ill-health is integrally dependent on the creation of a healthy environment. Indeed, it has been said that virtually every aspect of the environment may affect physical or mental health in some way.[316]

Typical environmental health concerns include: health aspects of air and water pollution; water supply and sanitation; waste disposal; chemical and food safety; housing; and settlements. In industrialised countries, typical environmental health issues include, for example, radon in homes and schools, lead in drinking water, non-ionising electromagnetic radiation, asbestos in building materials, pesticide residues in food, and indoor air pollution. Environmental health problems in developing countries are frequently poverty-related and arise largely as a result of factors such as rapid and uncontrolled urbanisation, and agricultural and land-use practices.[317]

Damage to the environment has been causally related to many adverse health conditions. Air pollution, for example, may cause both acute health effects and chronic effects associated with relatively low levels of pollution. In addition to the adverse health effects, it may have considerable nuisance value, causing irritation to the eyes and mucous membranes and objectionable odours.[318]

Waterborne diseases such as typhoid, cholera, polio, hepatitis A and gastro-enteritis may occur as a result of pathogenic micro-organisms in water. Diarrhoeal diseases are the most important of the water-and-excreta-related diseases. Safe water and basic sanitation are consequently an important component for achieving primary health care.[319]

Noise pollution at high levels and prolonged duration range from loss of hearing at certain frequencies to total deafness. Physiological effects include changes in heartbeat and respiration rate, eye and skin responses, and exacerbation of certain stress-related disorders such as hypertension. At lower levels, sound may have psychological effects, including sleep disturbance, annoyance and irritation.[320]

Hazardous wastes, which are widely dispersed in the environment and have accumulated over many decades, cause great risk to industrial workers and residents of communities living in the vicinity of toxic waste dumps.[321]

Clearly, much environmental damage may be measured in terms of its effect on human health. Therefore, while the Minister of Environment Affairs may hold the most important portfolio as far as environmental affairs are concerned, the Health Ministry should also participate in environmental decisions affecting health. It is thus proposed in the Framework that the health department asserts its substantial interest in environmental health concerns, by including a Part on environmental health protection. It is, however, crucial that legislative mechanisms for intersectoral collaboration between the two Departments be established. The major pieces of legislation dealing with environmental health are outlined below.

The most comprehensive piece of legislation dealing with environmental protection is the Environment Conservation Act, 1989 (Act No. 73 of 1989). This Act provides for the determination of environmental policy, and establishes advisory bodies for the formulation and implementation of policy, namely the Council for the Environment and the Committee for Environmental Co-ordination. Sections 21 and 22 provide for the control or prohibition of activities which may have detrimental effect on the environment. Provision is made in section 25 for regulations controlling noise, vibration and shock, and a comprehensive set of noise pollution regulations has been made thereunder.[322] Issues of littering and waste management are extensively addressed in sections 19, 19A, 20, 24 and 24A.

The principal legislation for the control of air pollution is the Atmospheric Pollution Prevention Act, 1965 (Act No. 45 of 1965), which is administered by the Department of Health. The Act establishes a National Air Pollution Advisory Committee, an appeal board and it provides for the appointment of officers and designation of their functions. It also provides for comprehensive strategies to combat almost all air pollution, in particular: noxious or offensive gases (part II); smoke (part III); dust (part IV); and vehicle emissions (part V).

Provision is made in the Tobacco Products Control Act, 1993 (Act No. 83 of 1993) for the control of indoor air pollution caused by Environmental Tobacco Smoke (ETS). Section 2 of the Act enables the Minister and authorised local authorities to issue regulations whereby the smoking of tobacco products in any public place

or particular kinds of public places is prohibited, or whereby the smoking of tobacco products in such places may only take place on the conditions mentioned in the regulations. The Act also prohibits the sale of tobacco products to persons under the age of 16 years (section 4), and provides for health warnings to be placed on tobacco packages and advertisements (section 3) and for restrictions on the use of cigarette vending machines, in certain circumstances (section 5).

Limited aspects of air pollution control are also provided for in the Minerals Act 1991 (Act No. 50 of 1991) and the Road Traffic Act 1989 (Act No. 29 of 1989).

The Water Act, 1956 (Act No. 54 of 1956) controls freshwater pollution and marine pollution from land-based sources. Water pollution associated with mining is subject to special control by regulations issued under the Act.[323]

The Health Ministry also has an important stake in water pollution control, as almost all water pollution control is aimed at protecting the health of people.[324] Provision is therefore made in the 1977 Health Act for regulation of standards of water purity. Section 37 provides that the Minister of Health may, after consultation with the Minister of Water Affairs, Forestry and Environmental Conservation, make regulations in respect of water intended for human use or food processing, including, *inter alia*, the requirements in regard to purity, chemical composition and quality with which such water shall comply, and the regulation and control of the provision of such water.

The Health Act also makes provision for regulations concerning a number of other environmental health matters. Section 34 enables the Minister to make regulations relating to a variety of conditions which are dangerous to health, including, for example: the prevention and remedying of over-crowded, dirty, insanitary or verminous conditions in any dwelling or other building (paragraph (d)); and the periodical cleansing of premises, the removal from premises of rubbish, waste or spillage, the evacuation of any premises on which a condition exists which constitutes a danger to health, the prohibition of entrance upon such premises and the remedying of such condition (paragraph (l)). Section 38 enables the Minister to make regulations relating to rubbish, night-soil, sewage or other waste and reclaimed products. In terms of section 39(1), the Minister may make regulations regulating, controlling, restricting or prohibiting any activity, condition or thing which constitutes a nuisance in terms of this Act.[325]

The (Natal) Prevention of Environmental Pollution Ordinance 1981 (Ord. No. 21 of 1981) prohibits littering or pollution on land or in the sea or inland waters (section 2), and provides for the appointment of provincial and other inspectors to enforce this Ordinance (section 3).

Mechanisms to control ionising radiations are established in terms of the Nuclear Energy Act 1993 (Act No. 131 of 1993). This Act provides for the continued existence of the Atomic Energy Corporation of South Africa, Limited, and the Council for Nuclear Safety. It further regulates the licensing of nuclear activities and provides for the implementation of the Nuclear Non-Proliferation Treaty and the Safeguards Agreement.

Exposure of persons to ionising radiation from electronic products is controlled by the Hazardous Substances Act, 1973 (Act No. 15 of 1973), which also controls a wide variety of declared hazardous substances belonging to certain defined groups.

**Parts 14 & 15 - HEALTH PROMOTION AND ADDICTION CONTROL PROGRAMMES**[326]

The Ottawa Charter for Health Promotion[327] defines health promotion as "the process of enabling people to increase control over, and to improve their health". The objectives of health promotion therefore revolve around the need to create an environment in which individuals are able to make healthy choices and so to become actively involved in the creation of their own health.

Legislation is an important mechanism, together with others such as communication, education, fiscal measures, taxation, organisational change, and community development, which can be used to create an environment in which individuals are able to make choices about their health and environment. It is in fact a vital mechanism for many health promotion programmes to be effective. It would, for example, be futile and perhaps even unethical to educate women about the dangers of radioactive emissions to a foetus, when there are no legislative controls to prevent pregnant women from being forced by social circumstances to live next to a radioactive waste dump, or to go to work in an environment where they are exposed to radioactive emissions.

Secondly, legislation can assist individuals in ensuring that choices which they make are *informed* choices, in other words, that individuals are provided with information to enable them to distinguish between healthy and unhealthy options. An interesting application of this is the control of harmful advertising. This is an important mechanism to empower people to make informed choices about their own health and about potential risks to their health, and thereby to contribute actively to the creation and maintenance of their health. Other applications of this principle are, for example, legislation requiring health warnings on tobacco packages, and legislation requiring warnings on infant formulae to the effect that they do not provide the same nutritional advantages as breast-milk.

Thirdly, law strengthens the way in which communities act together to ensure healthy environments, by providing mechanisms whereby communities can prevent and redress harm caused to the health of their community. The recognition of class actions in South Africa would significantly strengthen the capacity of communities to act together in this way.[328] Section 22 of the Interim Constitution, which allows people to gain access to information held by the State in order to protect their rights, is also a significant tool for community action.

Finally, legislation can establish structures and programmes through which health promotion activities can be carried out. The Victorian Health Promotion Foundation, for example, was established in 1987 by the Parliament of the State of Victoria, Australia, under the Tobacco Act. The Act established a 5% levy on the wholesale price of tobacco products. This levy is used by the Victorian Health Promotion Foundation to replace tobacco in sport, to fund sponsorship of sports and arts organisations in order to raise health awareness, to fund research on public health and health promotion, and to fund health promotion and education.[329]

The proposed KwaZulu-Natal Health Act would be the first South African law to give explicit legislative recognition to the importance of health promotion activities, by making provision for health education and health promotion programmes to be established by the provincial department of health. This is appropriate in the light of the fact that health promotion was identified as a health policy priority in the ANC National Health Plan.[330] Two concerns arise, however, in relation to the inclusion of this Part on health promotion in the Framework.

The first concern is that there is a danger that considerations of health promotion will be limited to that part of the Act, and will not affect the overall development of health legislation in the province. All health legislation must be formulated with an appreciation of the need for legislation to underpin healthy public policy, to create supportive environments, to strengthen community action, to support the development of personal lifeskills, and to reorient health services away from the current overriding emphasis on disease prevention and curative activities. In this way, legislation can be instrumental in building healthy environments so that optimal health benefit can result.

The second concern is that the enabling provisions in the Act which provide for the establishment of health promotion programmes are in danger of not being effectively implemented, due to health promotion being neglected in budgetary allocations in favour of curative interventions which might be perceived to have greater priority. For this reason, it is submitted that serious consideration be given to the imposition of a levy on tobacco and alcohol products sold in the province, in much the same way as was done by Victoria's Tobacco Act. The levy would be dedicated to the development and funding of health promotion projects and programmes in the governmental and non-governmental sectors. Not only would money be available for health promotion activities, without impacting on the general health budget, but harmful dependence-inducing substances would become less affordable, with corresponding health benefits.

## Part 16 - OCCUPATIONAL HEALTH AND INDUSTRIAL HYGIENE

The law relating to industrial health and industrial hygiene and some of the policy debates surrounding these issues have been dealt with extensively in Chapter Two of this dissertation, and it is therefore considered unnecessary to discuss this Part of the Framework. Suffice it to say that should provision be made in the KwaZulu-Natal Health Act for regulation of occupational health and industrial hygiene, it is vital that all interested parties such as the Department of Labour, the Department of Mineral Affairs, the business sector and trade unions should be consulted on the formulation of the provisions.

## Part 17 - DISEASE PREVENTION

Disease prevention is a matter which must be addressed in national legislation, because diseases do not confine themselves to provincial boundaries. It is, however, imperative that disease prevention should also be addressed at provincial level, in order to allow for provincial variations to cater for differing circumstances, and to enable the adoption of local intervention programmes where swift action is essential to combat the spread of disease. When existing legislation concerning disease prevention is reviewed with a view to its revision, several laws require consideration.

The Health Act, 1977, contains several provisions which concern the prevention of the spread of communicable diseases. Section 20(1)(d)(i) provides that every local authority shall take all lawful, necessary and reasonably practicable measures to render in its district primary health care services for the prevention of communicable diseases. An additional obligation is placed on local authorities to notify the Director-General each week of all cases of notifiable medical conditions identified by it during the week, and of all information which it may possess as to any outbreak or prevalence or absence of any communicable disease within its district (section 28). The Minister may declare any medical condition to be notifiable under section 45.

Wide-ranging powers are conferred on the Minister by section 33 of the Health Act to make regulations relating to the control of communicable diseases. These regulations may concern, for example: closure of teaching establishments and other public places; imposition of quarantines; conveyance of corpses; preventive measures at inland borders, ports or airports; prevention of transmission of diseases from animals, insects and plants; compulsory immunisation; prevention of spread of disease by carrying on of any trade; disposal of diseased waste; disinfection, inspection, and demolition of premises; and compulsory medical examination of persons.

Section 46 of the Health Act provides that the Director-General or a magistrate may order the post-mortem examination of the body of a person who is suspected of having died of a communicable disease, if this is necessary to prevent the spread of that disease.

The International Health Regulations Act, 1974 (Act No. 28 of 1974) makes applicable to South Africa the International Health Regulations adopted by the World Health Assembly at Boston on 25 July 1969. The International Health Regulations are set out in a schedule to the Act. The Minister may further, in terms of section 3(1)(a), make a proclamation to the effect that any regulation adopted by the World Health Assembly to amend or supplement the International Health Regulations will apply to the Republic. The International Health Regulations are important measures aimed at combating the spread of disease from one country to another. The Regulations provide for notification to the World Health Organisation (WHO) of incidence of cholera, plague, smallpox and yellow fever, in certain circumstances (art 3), and for the supply of certain other epidemiological information to the WHO. Requirements are laid down for hygiene, sanitation, medical services and public health services at ports and airports.

The spread of disease internationally is also controlled in terms of the Aviation Act 1962 (Act No. 74 of 1962), which provides in section 2 for the application to aircraft in South Africa of the Convention on International Civil Aviation. Article 14 of this Convention provides that States take effective measures to prevent the spread of communicable diseases by means of air navigation.

In addition, the Aliens Control Act, 1991 (Act No. 96 of 1991) provides controls over the entry into the Republic of persons suffering from certain communicable diseases (see discussion of Division 8.16, above). Section 15(1)(d) further provides that the master of a ship, on entry into a port, must deliver to an immigration officer on request a return stating infectious diseases which occurred or which were suspected on the voyage.

A number of other pieces of legislation concern the control of communicable diseases among particular sectors of the population. The Occupational Diseases in Mines and Works Act provides for the withholding of medical certificates of fitness from any potential mining employee, if that person is suffering from a communicable disease. Members of the South African National Defence Force may be required to submit to immunisation against certain communicable, infectious or epidemic diseases, in terms of section 144*bis* of the Defence Act, 1957 (Act No. 44 of 1957). Section 69(a) of the Correctional Services Act, 1959 (Act No. 8 of 1959) provides that prisoners serving a sentence in prison may at any time, on the recommendation of the prison medical officer, be placed on parole.

South African laws relating to disease prevention must be periodically reviewed in order to determine whether they are adequate to cope with emerging challenges, and whether they are in line with international trends. For example, existing laws urgently need to be reviewed in order to determine whether they provide sufficient mechanisms for the combating of HIV and AIDS. Legislative models adopted internationally should be considered with a view to informing the further development of our laws in this regard. In this regard, Italian law provides some valuable precedent.

In 1990, Italy made a law designed to increase the effectiveness of intervention strategies against HIV/AIDS. Italy's Law 135 of June 1990[331] established an urgent action programme for the prevention of and the fight against AIDS. Article 1 authorises State expenditure in relation to various AIDS prevention strategies, including: epidemiological surveillance and support to voluntary activities; construction and restructuring of health facilities; expansion of health staff in infectious disease wards; in-service training; and the establishment of home care services for AIDS sufferers. An Interministerial Committee for the Fight against AIDS is established by article 8, with participation of the Ministers of: Health; Social Affairs; University and Scientific and Technological Research; Education; Labour and Social Welfare; Defence; Justice; Interior; and Public Works.

Provision is made in article 5 for important measures relating to patient privacy and to the detection of HIV. Statistical data relating to AIDS must be non-identifiable. Consent is required prior to HIV-infection tests being undertaken, and HIV infection test are allowed in epidemiological programmes only if the same samples to be analysed are anonymous and identification of the persons tested is absolutely impossible. The results of direct or indirect diagnostic tests for HIV infection may only be communicated to the person who submitted to the tests. Further, it is provided that confirmed HIV infection may in no way constitute a reason for discrimination, in particular concerning enrolment at schools, participation in sports, and access to and maintenance of employment. In fact, article 6 makes it a criminal offence for employers, whether public or private, to carry out surveys on employees or candidates for employment in order to ascertain a state of seropositivity.

The Italian Minister of Health was also given powers in terms of this law to issue Decrees providing for rules and regulations concerning certain aspects of HIV/AIDS

prevention. Acting in terms of these powers, the Minister issued a Decree on 28 September 1990, which contained regulations concerning the protection against HIV infection in professional practice in health care facilities, both public and private. The regulations concern, *inter alia*: the use of surgical gloves in specified circumstances; the safe disposal of needles and other sharp instruments; hygiene and isolation requirements in infectious disease wards; special precautions to be undertaken by dental professionals, personnel assigned to autopsies, laboratory personnel, and personnel engaged in emergency operations or in the transportation of injured or disabled people. Various responsibilities are placed on health care facilities and on health care professionals in relation to, for example, the reporting of casual exposure to blood or other biological fluids.

The Italian Minister of Health also issued a Decree on 30 October 1990 containing regulations concerning compulsory in-service training and refresher courses for the staff of infectious disease wards.

## Part 18 - EPIDEMIOLOGICAL SURVEILLANCE AND CONTROL

It is stated in the ANC National Health Plan that a comprehensive health information system that begins at the local level and feeds into provincial and national levels will be put into place. It will consist of the collection, organisation, reporting, storage and use of data for planning and managing promotional activities and health care services. Information collected by the system will be used for: strategic planning; policy formulation; monitoring health care delivery; evaluating specific health care programmes; and assessing and reviewing progress on district, provincial and national health plans. It is further stated that legislation will be amended or developed to facilitate the introduction of the national health information system and the enforcement of its ethical aspects. In addition, it is stated that, where necessary, the confidentiality of information collected will be assured.[332] The issue of confidentiality of health information is considered above in the discussion of Part Five of the Framework.

The envisaged changes to existing legislation will need to take cognisance of several South African statutes which impact on epidemiological surveillance and on the collection of statistics and data on the health status of the population. These statutes are briefly discussed below.[333]

Section 2(1)(a) of the National Policy for Health Act, 1990 (Act No. 116 of 1990) provides that the Minister of Health may determine the national policy to be applied in respect of the obtaining and processing of statistical returns.

The Statistics Act, 1976 (Act No. 66 of 1976) provides for the collection, compilation, processing and publication of particulars and information relating to, *inter alia*: vital events; morbidity; fertility; and medical, dental and other health services.[334]

The registration of births and deaths, which is vital for the planning and management of the health care system, is regulated by the Births and Deaths Registration Act, 1992 (Act No. 51 of 1992).

Deaths due to natural causes must be registered in terms of section 14 of the Births and Deaths Registration Act, while section 17 provides that deaths due to unnatural causes may only be registered following an investigation as to the cause of death in terms of section 3 of the Inquests Act, 1992 (Act No. 51 of 1992).

A potential gap in statistical data arises in the application of section 9(1) of the Births and Deaths Registration Act, which provides that notification of live births must be made to the registrar or assistant registrar of births within seven days of the birth. In the event that a child dies in those seven days, and notice of the birth has not yet been given in terms of section 9(1), section 9(4) provides that the birth shall not be registered. This may potentially give rise to inadequate data on infant mortality, and the legislation may need to be amended to rectify this problem.

Section 29(1) of this Act contains a secrecy provision to the effect that information derived from documents relating to births and deaths required under the Act shall not be published or communicated, except in certain specified circumstances. Subsection (2) provides that the Director-General may furnish any such information to: any department of State, local authority or statutory body for any statutory purposes; or any person who has applied for that information, provided the Director-General is satisfied that the furnishing of that information is in the interest of the person regarding whom particulars are requested or is in the public interest. There is no requirement that information so furnished by the Director-General should be restricted by the removal of information which may

identify the person whose particulars are disclosed. Subsection (2) thus contains substantial limitations on the confidentiality provisions of subsection (1).

The Health Act, 1977, also contains a number of provisions relating to the collection of health information. In terms of section 23(b), medical officers of health are required to furnish the Director-General with quarterly reports and an annual report on the health of the inhabitants of the district for which she or he was appointed, and furnish the local authority concerned with copies of the said reports. Local authorities are required to furnish to the Director-General weekly reports concerning notifiable medical conditions (section 28). Further, section 29 provides that the Minister may require any local authority, at any time or at stated intervals, to furnish her or him with a report or statistical return relating to the health of the inhabitants of its district or any part thereof, or to hygiene conditions therein. Section 33(2) provides that the Minister may, at the request of a local authority, make regulations relating to the compulsory notification of births to that local authority.[335]

Section 7 of the Abortion and Sterilisation Act, 1975 (Act No. 2 of 1975) makes provision for the collection of statistical data concerning abortion and sterilisation procedures which had been performed legally. The criminalisation of abortion procedures otherwise than in accordance with the Act has resulted in an inability to procure accurate data on the incidence of illegal abortions.

**Part 21 - FINAL PROVISIONS**

Parts 19 to 22 of the Framework essentially contain operational and procedural provisions, as opposed to substantive provisions. There is therefore no discussion of most of these issues, which are generally not conceptually problematic.

The clause concerning the operation of other laws in relation to the Health Act, however, does merit discussion as it has profound implications for the effectiveness of new Health Acts at national and provincial levels.

Section 55(1) of the current Health Act (Act No. 63 of 1977) provides that the provisions of this Act shall not apply in respect of any matter to which the provisions of the Factories, Machinery and Buildings Act 1941, the Mines and

Works Act 1965, and the Shops and Offices Act 1964, apply. Section 55(2) provides that the provisions of the Health Act shall be in addition to and not in substitution for any provision of the Animal Diseases Act 1984, the Water Act 1956, and the Abattoir Hygiene Act 1992, which is not in conflict or inconsistent with the provisions of this Act. Further, if any provision of any of these laws is in conflict with any provision of the Health Act, the relevant provision of that law shall prevail.

Section 55 is a major limitation on the application of the Health Act. Section 55(1), for example, not only renders the Health Act inapplicable to a large proportion of workplaces in South Africa but in effect also to areas in the vicinity of such workplaces.

It is crucial that health is prioritised in the period of reconstruction and development in South Africa. The South African Department of Health has stood back to the priorities of other government departments for too long. One legislative mechanism to prioritise health would be for new health legislation to replace section 55 with a provision similar to section 156 of the now repealed Public Health Act, 1919 (Act No. 36 of 1919) which provided:

> *Save as is specially provided in this Act, the provisions of this Act shall be deemed to be in addition to and not in substitution for any provisions of any other law which are not in conflict or inconsistent with this Act. If the provisions of any other law are in conflict with or inconsistent with this Act, the provisions of this Act shall prevail.*

However, while desirable from a health perspective, the political implications of such a provision would be enormous, as such a provision might be perceived to be an erosion of the powers of other ministries. Once again, it is essential that all role-players are involved in the formulation of such a provision, which may impact on the activities of other departments.

**CONCLUSION**

The sheer diversity of the legislative and policy issues and the huge volume of legislation described above, should alert legislators at national and provincial levels to the enormity of the task which awaits them in reviewing and revising existing

legislation in order that it will provide a sound basis for the implementation and management of the new National Health System.

The magnitude of this task should, however, not deter health authorities from undertaking a comprehensive review of South African health legislation, because the health system transition currently under way and the accompanying commitment to change provides an opportunity for radical change to existing legislation which, if missed now, is unlikely to reoccur.

# EPILOGUE

This dissertation has considered the evolution of South African health legislation from Union until the present, as well as a number of specific issues which require consideration in the further development of South African health law. The theoretical and constitutional context within which this development of health law must take place has also been considered. Combined, these various inquiries provide a basis on which to evaluate and critique contemporary legislative options which confront those persons and bodies responsible for reform of the health system.

In this concluding chapter, it is not intended to repeat the observations, conclusions and recommendations which have been made throughout the dissertation. It is, however, appropriate to make a few general observations which are relevant to the ongoing development of South African health legislation.

Since Union, South African health legislation has developed in a piecemeal fashion, responding to exigencies which arose from time to time. Many of the peculiarities of existing health laws may be explained by investigating the special circumstances which motivated the passing of the laws in question.

While these laws were often appropriate to the policies prevailing at the time in which they were formulated, much South African health law is no longer suitable for current policies and trends. Many existing statutes, regulations, ordinances and bylaws are obsolete, deficient, unenforced and contradictory. In particular, South Africa's health laws have contributed towards the creation of a deeply fragmented health system. The same laws cannot support moves towards the creation of a National Health System.

Clearly, optimal utilisation of South Africa's health resources and the successful implementation of policy articulated by the new government, require an effective and appropriate legal framework, and this in turn requires comprehensive reform of the existing body of health law. New health legislation which is developed must be capable of meeting new challenges, as well as being appropriate to meet traditional problems.

Unfortunately, there appears to be an inadequate appreciation among South African lawyers, health professionals, health service managers and health planners concerning the pivotal role which health legislation can and should play in protecting, improving and promoting public health. It is crucial that a greater public awareness is generated concerning the potential of legislative intervention to promote and improve health, because interested parties now have an opportunity, which is unlikely to be repeated, to lobby the departments of health and the health portfolio committees in the various legislatures for legislative change.

Furthermore, debate regarding aspects of health law should not only be encouraged among health professionals and lawyers. An intersectoral approach is necessary in order to develop appropriate legislation. For analysis of health law to be critical and questioning, it must also be viewed from the differing perspectives of environmental specialists, public health practitioners, economists, anthropologists, political scientists, sociologists, epidemiologists, and so on. Such debate can only enrich processes of health legislation reform currently under way in South Africa. Optimal participation by the community and by all interested parties is vital to the reform of health legislation.

Indeed, appropriate methodology in the formulation of health legislation is likely to hold significant advantages for the content and effective implementation of resulting health laws.

When formulating legislation, it is also useful to adopt a comparative legal approach in order that the experience of a number of countries may provide some guidance with regard to the way in which laws might operate. It is therefore important that research activities in health law should be encouraged in South Africa at present. It is particularly important that international comparative legislative studies be made of areas which have been identified as priorities for the development of health legislation in South Africa.

While emphasising that suitable methodology is crucial to the development of appropriate health legislation in South Africa, it is acknowledged that some of the provinces may lack sufficient human and financial resources to devote to the proper development of health legislation at a provincial level. The onus on the provinces to effect legislative reform is particularly great since not only do they need to put in place legislation which will adequately facilitate the radical

restructuring of health services, but they also have to harmonise the morass of legislation which they have inherited from former provincial administrations and homelands - a legacy of apartheid.

It is therefore of crucial importance that provincial and national legislative initiatives are co-ordinated, and that resources and experiences which might assist the development of health legislation are shared. The National Health Legislation Review Committee appears to be a particularly well-placed mechanism to co-ordinate and to facilitate sharing between legislative initiatives at present. In the long term, these functions could be performed by the health portfolio committees in the national assembly and the Senate.

Other mechanisms may also need to be investigated to assist the development of health legislation at provincial levels. There may, for instance, be aspects of health services in which a degree of legislative uniformity should be encouraged between the provinces, but where it would be undesirable to enforce absolute uniformity between the provinces by attempting to enforce national legislation in terms of the exceptions listed in section 126(3) of the Interim Constitution.

In such circumstances, it may be appropriate for the Minister of Health to make "standard provincial laws".[336] Standard provincial laws would be analogous to "standard bylaws", which were framed by the provincial Administrators in terms of the old Local Authority Ordinances of the provinces. Provinces would be at liberty not to adopt any such standard Act or regulation, or to adopt the standard Act or regulation, either with or without amendments, as an Act or regulation made by it. The standard Act or regulation would then be deemed to be an Act or regulation made by the province concerned. In this way, individual processes of making Acts and regulations on health services in each of the provinces could be avoided. Standard provincial laws would also in no way impinge on the freedom of provinces to formulate their own legislation on health services within the constraints of section 126, if they so wished.

While the appropriate formulation of new health legislation at national and provincial levels is crucial, and has been the major focus of this dissertation, it is necessary in conclusion to reiterate the concern expressed in Chapter One that adequate enforcement and implementation are also vitally important to the success of health law initiatives. Serious questions arise as to whether the normal

enforcement agencies are appropriate to enforce public health laws, and it is important that innovative methods of ensuring proper enforcement are investigated.

Furthermore, it is critical for the successful application of laws that public awareness is generated on the content of the laws that affect them. Drafting new health laws in plain language is an important start to making legislation more accessible to the public. However, once laws are drafted, even more attention needs to be given to publicising laws in an accessible way. Radio talk shows, street theatre and picture booklets are some of the means which need to be investigated for conveying messages concerning legal rights and obligations simply yet effectively.

A daunting, yet necessary, task awaits health authorities responsible for developing a sound body of health legislation which will further the ideal of providing every South African with access to effective care which is provided equitably, efficiently, and in a manner which is generally acceptable. If this opportunity is seized for comprehensive reform of South African health legislation, this will be a major contribution to the implementation of the Reconstruction and Development Programme. The experience gained in this fundamental area of legislative reform also has significant potential to serve as a useful model for other countries in the process of political and health system transition.

## NOTES

1. Republic of South Africa Restructuring the National Health System for Universal Primary Health Care (Main Report of the Committee of Enquiry into a National Health Insurance System) Department of Health: Pretoria, 1995.

2. Quoted in: Fluss S.S. "International Public Health Law: an overview", a contribution to the 3rd edition of the Oxford Textbook on Public Health (to be published by Oxford University Press in 1995).

3. Quoted in: Fluss S.S. "International Public Health Law: an overview", a contribution to the 3rd edition of the Oxford Textbook on Public Health (to be published by Oxford University Press in 1995).

4. Grumet B.H. "Legal Medicine in Medical Schools: A survey of the state of the art" in Journal of Medical Education Oct. 1979 **54** @ 755-758.

5. Curran W., A. Arif and D. Jayasuriya "Guidelines for Assessing and Revising National Legislation on the Treatment of Drug- and Alcohol Dependent Persons" in International Digest of Health Legislation (IDHL) 1987 **38 Suppl 1** @ 1.

6. Friedman H. "The Significance of Law and Policy for Adolescent Health: observations on a new WHO publication" in IDHL 1987 **38(3)** @ 665.

7. Roemer R. In "Foreword" to World Health Organisation's Legislative Responses to Tobacco Use Martinus Nijhoff Publishers: The Netherlands, 1991.

8. Gevers J. "Approaches to Occupational Health Legislation in the Member States of the European Community" in IDHL 1986 **37(2)** @ 384-387.

9. Kapp M.B. "Medicine and Law: A Symbiotic Relationship?" in The American Journal of Medicine June 1985 **78** @ 903.

10. See overview of these measures in: Fluss S.S. "International Public Health Law: an overview", a contribution to the 3rd edition of the Oxford Textbook on Public Health (to be published by Oxford University Press in 1995).

11. See too: Article 24 on the Convention of the Rights of the Child (1989); Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (1979); Article 28 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990); The Proclamation of Teheran (proclaimed by the International Conference on Human Rights on 13 May 1968), on Reproductive Health; Art XI of the American Declaration of the Rights and Duties of Man (1948); and Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988).

12. For example, the Vienna Declaration and Programme of Action (adopted by the World Conference on Human Rights, 14-25 June 1993), which includes a statement that: "The World Conference on Human Rights notes that certain advances, notably in the biomedical and life sciences as well as in information technology, may have potentially adverse consequences for the integrity, dignity and human rights of the individual, and calls for international cooperation to ensure that human rights and dignity are fully respected in this area of universal concern." There are also a large number of international instruments directed at the ethical and legal dimensions of human experimentation.

13. For example, the International Atomic Energy Agency's Convention on Early Notification of a Nuclear Accident (1986); Convention on Assistance in the Case of a Nuclear Accident (1987); and Convention on Nuclear Safety (1994).

14. For example: the Bamako Convention on the Ban of the Import into Africa and the Control of Transboundary Movement of Hazardous Wastes within Africa (adopted 30 January 1991); Code of Ethics on the International Trade in Chemicals (developed by the UN Environment Programme); Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal (1989); Cairo Guidelines on Environmentally Sound Management of Hazardous Wastes (1987); and the London Guidelines for the Exchange of Information on Chemicals in International Trade (most recently amended in 1989).

15. For example, the Declaration on the Promotion of Patients' Rights in Europe (published by WHO (1994)).

16. For example, the International Health Regulations (adopted by the World Health Assembly at Boston on 25 July 1969, and incorporated into South African law by the International Health Regulations Act 28 of 1974).

17. For example, Resolution WHA41.24 of the World Health Assembly (May 1988).

18. For example: the Recommendations of the Council of the Organisation for Economic Co-operation and Development (OECD) on "procedure for the registration of pharmaceutical specialities" (25 September 1962) and on "procedure for labelling pharmaceutical specialities" (2 April 1963); and the Ethical Criteria for Medicinal Drug Promotion (endorsed by the World Health Assembly in May 1988).

19. For example: Resolution WHA28.72 on "Utilisation and supply of human blood and blood products" (adopted by the twenty-eighth World Health Assembly of May 1975), under which Member states were urged "to enact effective legislation governing the operation of blood services and to take other actions necessary to protect and promote the health of blood donors and of recipients of blood and blood products"; Requirements for the

collection, processing and quality control of blood, blood components and plasma derivatives (WHO 1994); and Consensus Statement on Screening of Blood Donations for Infectious Agents Transmissible Through Blood Transfusion (WHO, 1991).

20. For example: the Codex Alimentarius, which consists of food standards, recommended codes of practice, and guidelines (administered by the Food and Agriculture Organisation of the United Nations (FAO), in collaboration with WHO); Code of Ethics for International Trade in Food (developed by the Joint FAO/WHO Food Standards Programme/Codex Alimentarius Commission (1985)).

21. For example, the International Code of Marketing of Breast-milk Substitutes (adopted by the World Health Assembly in 1981).

22. For example, Guiding Principles on Human Organ Transplantation (adopted by the 44th World Health Assembly in May 1991).

23. For example: the Single Convention on Narcotic Drugs (1961); Convention on Psychotropic Substances (1971).

24. For example: The Radiation Protection Convention (1960); The Benzene Convention (1971); The Occupational Cancer Convention (1974); The Working Environment (Air Pollution, Noise and Vibration) Convention (1977); The Occupational Safety and Health Convention (1981); The Occupational Health Services Convention (1985); The Asbestos Convention (1986); The Chemicals Convention (1990); The Night Work Convention (1990); and The Prevention of Major Industrial Accidents Convention (1993).

25. For example, the Programme of Action of the United Nations International Conference on Population and Development (13 September 1994).

26. For example: Standard Minimum Rules for the Treatment of Prisoners (United Nations, 1957 and 1977); Basic Principles for the Treatment of Prisoners (UN 1990); Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (UN 1988); United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990); Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture, and other Cruel, Inhuman or Degrading Treatment or Punishment (1982).

27. For example, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (adopted by the UN General Assembly resolution 46/119 of 17 December 1991).

28. See recent examples in: s 33 Romanian Constitution of 1991 (IDHL 1992 **43(2)** @ 254); Art 12 Constitution of the Third Republic of Niger 1993 (IDHL 1992 **44(4)** @ 573); section 29 Constitution of the Seychelles 1993

(IDHL 1993 **44(4)** @ 573).

29. Decree No. 65-91 of 14 June 1991 promulgating the Health Code (IDHL 1992 **43(4)** @ 702). See also: section 1 of Law No. 48 of 24 August 1990 of Portugal establishing basic principles with regard to health (IDHL 1993 **44(3)** @ 424; section 1 of the Spanish General Law on Health 14 of 1986 (IDHL 1987 **38(1)** @ 1); and section 1 of Iraq's Ordinance No. 1057 of 8 August 1981 promulgating the Public Health Law 89 of 1981 (IDHL 1982 **33(2)** @ 201).

30. Mexico's General Law on Health of 26 December 1983 (IDHL 1986 **37(3)** @ 475).

31. See too: sections 8 - 11 of Honduras's Decree No. 65-91 of 14 June 1991 promulgating the Health Code (IDHL **43(4)** @ 702); and sections 5 - 11 of Navarre's Foral Law No. 10/1990 of 23 November 1990 on health (IDHL 1992 **43(1)** @ 4).

32. Portugal's Law No. 48 of 24 August 1990 establishing basic principles with regard to health (IDHL **44(3)** @ 426).

33. Quebec's Act (1991, Chapter 42) respecting health services and social services and amending various legislation (IDHL 1992 **43(2)** @ 250).

34. See too: section 7 of Navarre's Foral Law No. 10/1990 on health (IDHL 1992 **43(1)** @ 7); and section 6 of Bolivia's Decree-Law No. 15629 of 18 July 1978 promulgating the Health Code (IDHL 1983 **34(2)** @ 225).

35. As amended by Mexico's Decree of 11 June 1991 amending and repealing various provisions of the General law on health (IDHL 1992 **43(4)** @ 710).

36. The long title of this Act is "An Act to Restrict the Privatisation of Medical Services".

37. See for example: Botswana's Private Hospitals and Nursing Homes Act 1989 (IDHL 1991 **42(3)** @ 428-429); the Czech Republic's Law No. 160 of 1992 of 19 March 1992 on the dispensing of health care in private health establishments (IDHL 1992 **43(3)** @ 498); and sections 83-89 of Iraq's Public Health Law 89 of 1981 (IDHL 1982 **33(2)** @ 217-218).

38. Bulgaria's Order No. 5 of 22 April 1991 on the conditions and rules governing the private practice of medicine (IDHL 1992 **43(4)** @ 719).

39. Mexico's General Law on Health of 26 December 1983 (IDHL 1986 **37(3)** @ 492-493).

40. Republic of South Africa White Paper on Privatisation and Deregulation in the Republic of South Africa (WPG/1987) Government Printer: Pretoria, 1987.

41. South Africa Competition Board Gesondheidsregulering by die produksie en verspreiding van melk (Deregulering: Memorandum D 6) Government Printer: Pretoria, 1988 @ 3.

42. Kinzer D. "The Decline and Fall of Deregulation" in The New England Journal of Medicine 1988 **318(2)** @ 13.

43. Yach D. "The Case for an Increased Tobacco Tax in South Africa" in South African Medical Journal March 1983 **83** @ 162.

44. Polsby D. "The False Promise of Gun Control" in The Atlantic Monthly March 1994 @ 58.

45. Grinspoon L. and J. Bakalar "The War on Drugs - A Peace Proposal" in Sounding Board 3 February 1994 **330(5)** @ 357.

46. Le Blang T., M. Henderson, P. Kolm and R. Paiva "The Impact of Legal Medicine Education on Medical Students' Attitudes towards Law" in Journal of Medical Education April 1985 **60** @ 279-287.

47. Sections 7 and 16 of Legislative Decree No. 70 of 14 April 1981 promulgating the Law on the Organisation of the Health Sector (International Digest of Health Legislation (IDHL) 1983 **34(1)** @ 38).

48. Le Blang T. *et al, loc. cit.*

49. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care In South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 59.

50. *Ibid.* @ 56.

51. Cluver E.H. Medical and Health Legislation in the Union of South Africa Central News Agency: South Africa, 1949 @ 317.

52. See comment on the Act in: Union of South Africa Report of the National Health Services Commission on the Provision of an Organised National Health Service for All Sections of the People of the Union of South Africa, 1842 - 1944 Government Printer: Pretoria, 1944 @ 20.

53. Section 3 of Public Health Act 1919 (Act No. 36 of 1919).

54. Cluver E.H., *op. cit.* @ 318.

55. Van Rensburg H.C.J, A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 60.

56. Union of South Africa Report of the National Health Services Commission on the Provision of an Organised National Health Service for All Sections of the People of the Union of South Africa, 1942 - 1944 Government Printer: Pretoria, 1944 @ 21.

57. Holtshousen W.S.J. Bestuurde Gesondheidsorg: Paradigmaverskuiwing in die Verskaffing van Gesondheidsdienste in Suid-Afrika Thesis for Masters of Community Dentistry, University of Pretoria, 1993 @ 31.

58. Union of South Africa Report of the National Health Services Commission on the Provision of an Organised National Health Service for All Sections of the People of the Union of South Africa, 1942 - 1944 Government Printer: Pretoria, 1944 @ 11.

59. *Ibid.* @ 2.

60. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 60.

61. Union of South Africa Report of the National Health Services Commission on the Provision of an Organised National Health Service for All Sections of the People of the Union of South Africa, 1942 - 1944 Government Printer: Pretoria, 1944 @ 2.

62. *Ibid.* @ 20.

63. Holtshousen W.S.J. Bestuurde Gesondheidsorg: Paradigmaverskuiwing in die Verskaffing van Gesondheidsdienste in Suid-Afrika Thesis for Masters of Community Dentistry, University of Pretoria, 1993 @ 32.

64. Van Rensburg H.C.J *et al, loc. cit.*

65. Union of South Africa Report of the National Health Services Commission on the Provision of an Organised National Health Service for All Sections of the People of the Union of South Africa, 1942 - 1944 Government Printer: Pretoria, 1944 @ 2.

66. Quoted in: Union of South Africa Report of the National Health Services Commission on the Provision of an Organised National Health Service for All Sections of the People of the Union of South Africa, 1942 - 1944 Government Printer: Pretoria, 1944 @ 4.

67. For example:
    i. the Carnegie Commission - the Commission report was published in 1932, after a four year investigation into the economic, psychological, educational, health and sociological aspects of the poor white problem;
    ii. the Vos Committee of Enquiry re Public Hospitals and Kindred Institutions of 1925;
    iii. the Loram Committee of 1928 to Inquire into the Training of Natives in Medicine and Public Health;
    iv. the Holloway Native Economic Commission of 1930-1932;
    v. the Interdepartmental Committees of Enquiry into Old Age Pensions and National Health Insurance of 1927-1928 and 1936; and

vi. the Stals Report of the Committee of Inquiry on Adverse Social Conditions in the George-Knysna-Tsitsikama Area of 1935, which stressed the necessity for a comprehensive solution by way of the co-ordination of health and social welfare services, and unified control of all health services.

68. Union of South Africa Report of the National Health Services Commission on the Provision of an Organised National Health Service for All Sections of the People of the Union of South Africa, 1942 - 1944 Government Printer: Pretoria, 1944 @ 4-5.

69. Page 12 of the report.

70. See summary of recommendations at 181 of the report.

71. Page 173 of the report.

72. Page 17 of the report.

73. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 63.

74. *Ibid.* @ 72.

75. See discussion in: Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 72; and in Harrison D. and S. Tollman "Pivotal Issues in the Reorganisation of the South African Health sector", Background Paper prepared for Seminar on Health Systems Reorganisation, Mexico, July 1993 @ 26.

76. Section 14.

77. Section 20.

78. Section 16.

79. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 73.

80. *Ibid.* @ 74.

81. Republic of South Africa Final Report of the Commission of Inquiry into Health Services Government Printer: Pretoria, 1986 @ 2.

82. *Ibid.* @ 18.

83. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 76.

84. Republic of South Africa Final Report of the Commission of Inquiry into Health Services Government Printer: Pretoria, 1986 @ 22.

85. Harrison D. and S. Tollman "Pivotal Issues in the Reorganisation of the South African Health sector", Background Paper prepared for Seminar on Health Systems Reorganisation, Mexico, July 1993 @ 26.

86. Republic of South Africa A New Dispensation: Health Plan for South Africa Government Printer: Pretoria, 1986 @ 8.

87. *Ibid.* @ 11-12.

88. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 77.

89. Harrison D. and S. Tollman, *op. cit.* @ 9.

90. Pick W. M. "Working Paper No 2: The Fragmentation of South African Health Services" Health Economics Unit, Department of Community Health, University of Cape Town @ 13-14.

91. Harrison D. and S. Tollman, *op. cit.* @ 26.

92. Van Rensburg H.C.J. *et al, op. cit.* @ 79.

93. Harrison D. and S. Tollman "Pivotal Issues in the Reorganisation of the South African Health Sector", Background Paper prepared for Seminar on Health Systems Reorganisation, Mexico, July 1993 @ 11.

94. The Administrators Health Council was dissolved by Act No. 118 of 1993.

95. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 85.

96. Harrison D. and S. Tollman, *op. cit.* @ 11.

97. Page 10 of the report.

98. Harrison D. and S. Tollman, *op. cit.* @ 12.

99. African National Congress A National Health Plan for South Africa ANC: Johannesburg, 1994.

100. African National Congress Reconstruction and Development Programme Umanyano Publications: Johannesburg, 1994.

101. African National Congress A National Health Plan for South Africa ANC: Johannesburg, 1994 @ 19.

102. African National Congress Reconstruction and Development Programme Umanyano Publications: Johannesburg, 1994 @ 44.

103. African National Congress A National Health Plan for South Africa ANC: Johannesburg, 1994 @ 59.

104. *Ibid.*

105. African National Congress Reconstruction and Development Programme Umanyano Publications: Johannesburg, 1994 @ 51.

106. Union of South Africa Debates of the House of Assembly 1926 Cape Times Ltd: Cape Town, 1926 @ 2222.

107. *Ibid.* @ 2220.

108. Cluver E. H. Medical and Health Legislation in the Union of South Africa Central News Agency, Ltd: South Africa, 1949 @ 4.

109. Union of South Africa House of Assembly Debates (Hansard) 1944 Cape Times, Ltd: Parow, 1944 @ 8532-8535.

110. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 268.

111. Union of South Africa House of Assembly Debates (Hansard) 1944 Cape Times Limited: Parow, 1944 @ 8532.

112. *Ibid.* @ 8538.

113. Union of South Africa Debates of the House of Assembly (Hansard) 1945 Cape Times Ltd: Parow, 1945 @ 4389.

114. Republic of South Africa Debates of the House of Assembly (Hansard) 1979 Government Printers: Cape Town, 1979 @ 763.

115. Republic of South Africa Debates of the House of Assembly (Hansard) 1974 Government Printer: Pretoria, 1974 @ 2886.

116. *Ibid.* @ 2748.

117. *Ibid.* @ 2916.

118. *Ibid.* @ 2914-1926.

119. *Ibid.* @ 2919.

120. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 317.

121. Republic of South Africa Debates of the House of Assembly (Hansard) 1982 Government Printer: Pretoria, 1982 @ 2905.

122. *Ibid.* @ 2906-2907.

123. Union of South Africa Debates of the House of Assembly (Hansard) 1957 Cape Times: Parow, 1957 @ 7830-7831.

124. *Ibid.* @ 7835.

125. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 278.

126. Republic of South Africa Debates of the House of Assembly (Hansard) 1979 Government Printer: Pretoria, 1979 @ 768.

127. *Ibid.* @ 970.

128. For example: occupational therapists, chiropodists, physiotherapists, medical technologists, health inspectors, optometrists, orthopaedic orthotists and prosthetists, orthopaedic bootmakers, radiographers, psychotechnicians, psychometrists, speech therapists and audiologists, blood transfusion technicians, optical dispensers, chemical pathologists, dieticians, electro-encephalographic technicians, medical physicists, health assistants, haemotology technicians, histopathology technicians, masseurs, microbiology technicians, oral hygienists, anaesthetists' assistants, orthoptists, audiometricians, remedial gymnasts, cytotechnicians, food inspectors, radiotherapy laboratory technicians, hearing aid acousticians, biomedical engineers, supplementary diagnostic radiographers, community speech and hearing workers, teachers of the speech and hearing impaired, clinical technologists, speech and hearing correctionists, radiation technologists, medical scientist, clinical biochemists, dental therapists, physiotherapy assistants, dental hygienists and orthopaedic footwear technicians. [The list was derived from: Strauss S.A. Legal Handbook for Nurses and Health Personnel (7th ed) King Edward VII Trust: Cape Town, 1992 @ 68.]

129. Professional Boards have been established in terms of this section for: Dental Therapy; Emergency Care Personnel; Medical Science; Clinical Technology; Optical Dispensers; Dietetics; Oral Hygiene; Radiography; Health Inspectors; Medical Orthotists and Prosthetists; Medical Technology; Occupational Therapy; Optometry; Oral Hygiene; Orthopaedic Orthotists and Prosthetists; Physiotherapy; Podiatry; Psychology; and Speech Therapy and Audiology.

130. Union of South Africa Summary of the Report of the Commission for the Socio-Economic Development of the Bantu Areas within the Union of South Africa Government Printer: Pretoria, 1955 @ 160.

131. Union of South Africa Memorandum: Government Decisions on the Recommendations of the Commission for the Socio-Economic Development of the Bantu Areas within the Union of South Africa Government Printer: Pretoria, 1956 @ 13.

132. Holtshousen W.S.J. Bestuurde Gesondheidsorg: Paradigmaverskuiwing in die Verskaffing van Gesondheidsdienste in Suid-Afrika, Thesis for Masters of Community Dentistry, University of Pretoria, 1993 @ 54.

133. *Ibid.*

134. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 296.

135. Harrison D. and S. Tollman "Pivotal Issues in the Reorganisation of the South African Health Sector", Background Paper prepared for Seminar on Health Systems Reorganisation, Mexico, July 1993 @ 12.

136. Holtshousen W.S.J., *loc. cit.*

137. Pick, W M "Working Paper No 2: The fragmentation of South African Health Services" Health Economics Unit, Department of Community Health, University of Cape Town @ 13.

138. Van Rensburg H.C.J. *et al, op. cit.* @ 70.

139. Proclamation No. R21, 1993 in: Republic of South Africa Government Gazette No. 14682, 26 March 1993 @ 21.

140. Myers J. and I. Macun "The Sociological Context of Occupational Health in South Africa" in American Journal of Public Health February 1989 **79(2)** @ 217.

141. Republic of South Africa Report of the Commission of Enquiry into Industrial Health Government Printer: Pretoria, 1976 @ 5.

142. Myers J. and I. Macun, *loc. cit.*

143. Republic of South Africa Report of the Commission of Enquiry into Industrial Health Government Printer: Pretoria, 1976 @ 5.

144. Zwi A., S. Fonn and M. Steinberg "Occupational Health and Safety in South Africa: The Perspectives of Capital, State and Unions" in Social Science Medicine 1988 **27(7)** @ 692.

145. Myers J. and I. Macun, *loc. cit.*

146. Department of Mineral and Energy Affairs Report of the Commission of Inquiry into Compensation for Occupational Diseases in the Republic of South Africa Government Printer: Pretoria, 1981 @ 3.

147. Zwi A., S. Fonn and M. Steinberg " Occupational Health and Safety in South Africa: The Perspectives of Capital, State and Unions" in Social Science Medicine 1988 **27(7)** @ 693.

148. Republic of South Africa Report of the Commission of Enquiry into Industrial Health Government Printer: Pretoria, 1976 @ 5.

149. Zwi A., S. Fonn and M. Steinberg "Occupational Health and Safety in South Africa: The Perspectives of Capital, State and Unions" in Social Science Medicine 1988 **27(7)** @ 692; and Myers J. and I. Macun "The Sociological Context of Occupational Health in South Africa" in American Journal of Public Health February 1989 **79(2)** @ 217.

150. Department of Mineral and Energy Affairs Report of the Commission of Inquiry into Compensation for Occupational Diseases in the Republic of South Africa Government Printer: Pretoria, 1981 @ 4.

151. Zwi A. *et al, op. cit.* @ 692.

152. Myers J. and I. Macun "The Sociological Context of Occupational Health in South Africa" in American Journal of Public Health February 1989 **79(2)** @ 217.

153. Union of South Africa Report of the National Health Services Commission on the Provision of an Organised National Health Service for All Sections of the People of the Union of South Africa, 1942 - 1944 Government Printer: Pretoria, 1944 @ 693.

154. See discussion of the report in: Zwi A., S. Fonn and M. Steinberg "Occupational Health and Safety in South Africa: The Perspectives of Capital, State and Unions" in Social Science Medicine 1988 **27(7)** @ 693.

155. Republic of South Africa Report of the Commission of Enquiry into Industrial Health Government Printer: Pretoria, 1976.

156. Page 38 of the report.

157. Pages 26 to 35 of the report.

158. Page 35 of the report.

159. Page 37 of the report.

160. Pages 8 and 35 of the report.

161. Page 36 of the report.

162. Page 46 of the report.

163. Page 46 of the report.

164. Page 36 of the report.

165. The Commission's terms of reference were promulgated under Government Notice 2575, 1978 in: Republic of South Africa Government Gazette No. 6251, 22 December 1978 @ 6.

166. Department of Mineral and Energy Affairs Report of the Commission of Inquiry into Compensation for Occupational Diseases in the Republic of South Africa Government Printer: Pretoria, 1981 @ 7.

167. Pages 47 to 40 of the report.

168. Zwi A., S. Fonn and M. Steinberg "Occupational Health and Safety in South Africa: The Perspectives of Capital, State and Unions" in Social Science Medicine 1988 **27(7)** @ 697.

169. Myers J. and I. Macun "The Sociological Context of Occupational Health in South Africa" in American Journal of Public Health February 1989 **79(2)** @ 221.

170. *Ibid.*

171. Myers J. and I. Macun "New Developments in South African Health and Safety Legislation" in South African Medical Journal Jan 1993 **83** @ 1.

172. Abdullah F., M. Jeebhay and J. Myers "Occupational Diseases in Mines and Works Amendment Act, 1993" in South African Medical Journal March 1994 **84** @ 132.

173. See discussion in: Abdullah F., M. Jeebhay and J. Myers "Occupational Diseases in Mines and Works Amendment Act, 1993" in South African Medical Journal March 1994 **84** @ 132.

174. Government Notice No. R889, 1994 in: Republic of South Africa Government Gazette No. 15721, 6 May 1994 @ 1.

175. Republic of South Africa Report of the Commission of Inquiry into Safety and Health in the Mining Industry Government Printer: Pretoria, 1995 @ 189.

176. *Ibid.* @ 113.

177. Bozalek L., R. Ehrlich and N. White "Compensation for Occupational Injuries and Diseases Bill, 1993" in South African Medical Journal October 1993 **83** @ 720.

178. Bozalek L., R. Ehrlich and N. White "Compensation for Occupational Injuries and Diseases Bill, 1993" in South African Medical Journal October 1993 **83** @ 720. Note that administration of the Occupational Diseases in Mines and Works Act was transferred from the Department of Mines to the Department

of National Health and Population Development by s 7(b) of the Pensions Amendment Act 1989 (Act No. 89 of 1989). This was essentially a financial measure to eliminate red tape, as the pensions division of the Department of National Health and Population Development was excellent: Republic of South Africa Debates of the House of Assembly (Hansard) 1988 Government Printer: Pretoria, 1988 @ 14978.

179. Republic of South Africa Report of the Commission of Inquiry into Safety and Health in the Mining Industry Government Printer: Pretoria, 1995 @ 44.

180. *Ibid.* @ 66.

181. *Ibid.* @ 103.

182. Business Day Reporters "Labour policy body approved" in Business Day 16 February 1995 @ 3.

183. Personal communication: Mr André Du Plessis (Chief Director of Occupational Health Services, Department of Labour), 6 March 1995.

184. Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 80.

185. See discussion in: Van Rensburg H.C.J., A. Fourie and E. Pretorius Health Care in South Africa: Structure and Dynamics Academica: Pretoria, 1992 @ 81.

186. s 49(1) Hospitals Ordinance (Cape), 1946 (Ordinance 18 of 1946); s 16(1) Provincial Hospitals Ordinance (Natal), 1961 (Ordinance 13 of 1961); s 15 Hospitals Ordinance (Orange Free State), 1971 (Ordinance 8 of 1971); and s 70(1) Hospitals Ordinance (Transvaal), 1958 (Ordinance 14 of 1958). Note that the above provisions applicable to Natal and the Orange Free State have now been repealed by s 4 Natal Ordinance 10 of 1982 and s 2 of Procl 16 of 1988, respectively.

187. The Commission was appointed in terms of Proclamation No. R293, 1972 in: Republic of South Africa Government Gazette No. 3704, 17 November 1972 @ 3.

188. Republic of South Africa Report of the Commission of Inquiry into Private Hospitals and Unattached Operating-Theatre Units Government Printer: Pretoria, 1974 @ 7-9 &14.

189. These regulations were made by the Minister of Health by virtue of the powers vested in him by the Health Act of 1977.

190. Regulation 2.

191. See: Republic of South Africa Interim Report on Hospitals and State Health Services (Eighth Interim Report of the Commission of Inquiry into Health Services) Government Printer: Pretoria, 1986 @ chapters 7 and 8. See too discussion in: Broomberg J. "The Role of Private Hospitals in South Africa Part II - Towards a National Policy on Private Hospitals" in May 1993 SAMJ **83** @ 324.

192. Broomberg J. "The Role of Private Hospitals in South Africa Part II - Towards a National Policy on Private Hospitals" in May 1993 SAMJ **83** @ 324-325.

193. African National Congress A National Health Plan for South Africa ANC: Johannesburg, 1994 @ 72.

194. Holtshousen W.S.J. Bestuurde Gesondheidsorg: Paradigmaverskuiwing in die Verskaffing van Gesondheidsdienste in Suid-Afrika Thesis for Masters of Community Dentistry, University of Pretoria, 1993 @ 37.

195. Section 2(c).

196. Republic of South Africa Report of the Commission of Inquiry into High Cost of Medical Services and Medicines Government Printer: Pretoria, 1962 @ 1-2.

197. *Ibid.* @ 137.

198. *Ibid.* @ 166-168.

199. Holtshousen W.S.J. Bestuurde Gesondheidsorg: Paradigmaverskuiwing in die Verskaffing van Gesondheidsdienste in Suid-Afrika Thesis for Masters of Community Dentistry, University of Pretoria, 1993 @ 44.

200. *Ibid.* @ 71.

201. Financial Mail Reporters "The Medicine Goes Down" in Financial Mail 26 February 1993 @ 25.

202. African National Congress A National Health Plan for South Africa ANC: Johannesburg, 1994 @ 71.

203. Republic of South Africa Restructuring the National Health System for Universal Primary Health Care (Main Report of the Committee of Enquiry into a National Health Insurance System) Department of Health: Pretoria, 1995 @ 10.

204. *Ibid.* @ 18-19.

205. *Ibid.* @ 71-84.

206. Section 73(1).

207. Schedule 4, read with section 71.

208. Proclamation Nos. 107 to 115, 1994 in: Republic of South Africa Government Gazette No. 15813, 17 June 1994 @ 2.

209. Government Notice No. R152, 1994 in: Republic of South Africa Government Gazette No. 16049, 31 October 1994 @ 15.

210. Section 62(2). See too Constitutional Principle XVIII of Schedule 4.

211. Strategic Management Team: Ministry of Health and Social Services (Western Cape) Draft Provincial Health Plan February 1995 @ 18-19.

212. African National Congress Reconstruction and Development Programme Umanyano Publications: Johannesburg, 1994 @ 44.

213. Section 7(1).

214. Du Plessis L. and H. Corder Understanding South Africa's Transitional Bill of Rights Juta: Kenwyn, 1994 @ 185.

215. *Ibid.* @ 186-187.

216. Basson D. South Africa's Interim Constitution: Text and Notes Juta: Kenwyn, 1994 @ 24.

217. It is also at least arguable that criminalising abortion is an infringement of a woman's right to privacy (section 10). Compare Roe v Wade 410 US 113 (1973).

218. SAPA "Tobacco men claim access to health info" in Weekend Argus 20/21 August 1994.

219. The writer has been integrally involved in legislative processes since the elections. As research officer of the Health Legislation Project of the Medical Research Council, he interacted with legislators at a variety of levels. He was also a member of the National Health Legislation Review Committee, and was consultant to the Health Legislation Committee in KwaZulu-Natal.

220. Personal communication: Prof Paul Benjamin, 14 March 1995.

221. Section 30 of second draft Health Act discussion document.

222. Personal communication: Dr JHB Steenekamp (then Western Transvaal Head of the Department of National Health and Population Development), 23 June 1994.

223. Additional committees were later appointed to investigate other critical areas of the health system, as the need for these committees arose.

224. The National Health Legislation Review Committee was convened under the chairpersonship of Advocate P.N.Langa. Shortly after his appointment as chairperson, he resigned from the Committee to take up a position on the bench of the Constitutional Court. He was replaced as chairperson by Dr K.N. Ginwala, who served in this capacity until January 1995, when she vacated this position to take up the post of South African Ambassador in Rome. Mr G. Budlender was appointed chairperson after Dr Ginwala's departure.

225. The writer served on this committee from October 1994 until June 1995.

226. Personal communication: Dr O Shisana (Special Advisor to Minister of Health), 4 October 1994.

227. Revised Minutes: Provincial Health Legislation Seminar Medical Research Council, Pretoria, 24 November 1994 @ 2-3.

228. Personal communication: Dr K N Ginwala (then Acting Chairperson of the National Health Legislation Review Committee), 4 January 1995.

229. Personal communication: Dr O Shisana (Special Advisor to Minister of Health), 4 October 1994.

230. Revised Minutes: Provincial Health Legislation Seminar Medical Research Council, Pretoria, 24 November 1994 @ 3.

231. The Maternal, Child and Women's Health Committee, for instance, commissioned the writer to prepare a review of international legislation impacting on health.

232. These appointments were made in terms of section 149 of the Constitution of the Republic of South Africa, 1993 (Act No. 200 of 1993).

233. Strategic Management Team, Ministry of Health and Social Services (Western Cape) Draft Provincial Health Plan February 1995 @ 4.

234. Strategic Management Team, Ministry of Health and Social Services (Western Cape) Draft Provincial Health Plan February 1995 @ 6. The other terms of reference of the SMTs were:
    a) to develop a strategy and a detailed work plan for presentation to the MEC responsible and the Provincial Task Force on the rationalisation of the various regional administrations, institutions and structures relevant to a particular ministry;
    b) to conduct an evaluation of existing institutions, structures, tasks, size of staff including staffing policies and mission statements;
    c) to give advice to the MEC and the Provincial task force on the best way of rationalising public resources, within the context of national and provincial frameworks, including human and financial resources in such a manner as to prevent disruption of service delivery;

d) to evaluate existing management systems with a view to maximise performance and improve the quality of services;
e) to give advice to the MEC and the Provincial Task Force on the appropriate structures for the implementation of Schedule 6 functions taking into account the need for cost-effectiveness of government, administration and service delivery; and
f) to propose appropriate mechanisms to ensure regular interaction with other provinces and central government ministries to ensure horizontal and vertical uniformity of policy where necessary.

235. Revised Minutes: Provincial Health Legislation Seminar Medical Research Council, Pretoria, 24 November 1994 @ 2.

236. Strategic Management Team, Ministry of Health and Social Services (Western Cape) Draft Provincial Health Plan February 1995 @ 7-12.

237. The task teams included:
a) Mental Health
b) STDs, AIDS and HIV
c) Maternal and Child Health;
d) Nutrition;
e) TB;
f) Chronic Diseases of Lifestyle;
g) Violence, injury and health;
h) Oral health;
i) Occupational Health;
j) Rural health;
k) Environmental health;
l) Rehabilitation; and
m) Care of the elderly.

238. Namely:
a) Drug Policy;
b) Provincial Health Information Systems;
c) Health Status Review; and
d) Ambulance Services.

239. These task teams investigated:
a) Private Hospitals and Medical Aid Schemes;
b) Private practitioners; and
c) Non-governmental organisations / Medical Benefit Societies.

240. Strategic Management Team, Ministry of Health and Social Services (Western Cape) Draft Provincial Health Plan February 1995 @ 13.

241. Personal communication: Dr F Abdullah (Convenor of Western Cape SMT), 8 June 1995.

242. This demand was made to the KwaZulu-Natal health legislation task force by Mrs M.A. Tarboton (Christian Science Committee on Publication for KwaZulu-Natal), on behalf of the Christian Science Churches in KwaZulu-Natal.

243. Sunday Times Reporters "Plain language will save SA millions of rands" in Sunday Times 20 March 1995.

244. Part 1b of Victoria's Health Act 1958 (Act No. 6270 of 1958), Reprint No. 6 (International Digest of Health Legislation (IDHL) 1992 **43(4)** @ 701).

245. African National Congress Reconstruction and Development Programme Umanyano Publications: Johannesburg, 1994 @ 44-45.

246. Precedent for such a provision may be found in section 3 of Viet Nam's Law of 30 June 1989 on the protection of public health (International Digest of Health Legislation (IDHL) 1990 **41(1)** @ 16).

247. African National Congress Reconstruction and Development Programme Umanyano Publications: Johannesburg, 1994 @ 44.

248. See, for example, sections 213 and 236 of Paraguay's Law 836 of 1980 promulgating the Health Code (IDHL 1981 **32(4)** @ 634-635).

249. IDHL 1987 **38(1)** @ 2 & 7 respectively.

250. Law 85-05 of 16 February 1985 (IDHL 1985 **36(4)** @ 913).

251. IDHL 1990 **41(1)** @ 17. See too sections 9, 10, 22, 27, 28, 29, and 41 of Cuba's Law 41 of 1983 on public health (IDHL 1985 **36(1)** @ 2-8).

252. World Health Organisation Strengthening Ministries of Health for Primary Health Care Technical Report Series 766, Geneva 1988 @ 86.

253. IDHL 1986 **37(3)** @ 481.

254. Roemer R. Legislative Approaches to Primary Health Care (Unpublished, 1985) @ 58.

255. IDHL 1986 **37(3)** @ 481.

256. Transcript of speech by Dr N C Dlamini Zuma, Minister of Health, at the budget vote in the National Assembly: 19 June 1995.

257. This dictum was quoted in Jansen van Vuuren and another NNO v Kruger 1993 (4) SA 842 (A) @ 850.

258. Jansen van Vuuren and another NNO v Kruger 1993 (4) SA 842 (A) @ 850.

259. Margolis S. In Search of a Practical Access Strategy for the Maintenance of Confidentiality in Teaching Hospitals, Thesis for Bachelor of Commerce (Honours) Degree in Accounting, University of Cape Town, 1989 @ 2.

260. Government Notice No. R2278, 1976 in: Republic of South Africa Government Gazette No. 5349, 3 December 1976 @ 81.

261. Strauss S.A. Legal Handbook for Nurses and Health Personnel (7th ed) King Edward VII Trust: Cape Town, 1992 @ 15.

262. *Ibid.* @ 10.

263. Esterhuizen v Administrator, Transvaal 1957(3) SA 710 (T).

264. For example, section 33(j) of the Health Act, 1977 provides for the compulsory immunisation of persons against communicable diseases.

265. Strauss S.A., *op. cit.* @ 14.

266. See discussion under Division 8.7 of the Framework (Maternal, Child and Women's Health), below.

267. Comment by Mrs M.A.Tarboton, Christian Science Committee on Publication for KwaZulu-Natal.

268. Volschenk B. "Access to Medical Records: Is the South African Law Fair to Patients?" Paper presented to the National Medico-Legal Conference, Sandton Holiday Inn, 23-24 February 1994 @ 1.

269. Verschoor T. Verdicts of the Medical Council Digma: Pretoria, 1990 @ 67.

270. Volschenk B. "Access to Medical Records: Is the South African Law Fair to Patients?" Paper presented to the National Medico-Legal Conference, Sandton Holiday Inn, 23-24 February 1994 @ 11.

271. African National Congress Reconstruction and Development Programme Umanyano Publications: Johannesburg, 1994 @ 4.

272. World Health Organisation Strengthening Ministries of Health for Primary Health Care WHO Technical Report Series 766, Geneva 1988 @ 35.

273. *Ibid.* @ 73-74.

274. Decree-Law 350/1979 (IDHL 1981 32(3) @ 392).

275. See: Flynn B., D. Ray and M. Rider "Healthy Cities: The Indiana Model of Community Development in Public Health" in Health Education Quarterly Fall 1991 18(3) @ 331-447.

276. Flynn B., D. Ray and M. Rider "Healthy Cities: The Indiana Model of Community Development in Public Health" in Health Education Quarterly Fall 1991 **18(3)** @ 339.

277. El Salvador's Decree 955/1988 promulgating the Health Code (IDHL 1990 **41(1)** @ 11).

278. Law 548/1991 of the Czech National Council (IDHL 1992 **43(3)** @ 473-474).

279. IDHL 1988 **39(3)** @ 596-597.

280. Section 100 of Algeria's Law 85-05 of 16 February 1985 on health protection and promotion (IDHL 1985 **36(4)** @ 920).

281. Sections 87 and 97 respectively of Bolivia's Decree-Law 15629/1978 promulgating the Health Code (IDHL 1983 **34(2)** @ 230).

282. Section 194 of Paraguay's Law 836/1980 promulgating the Health Code (IDHL 1981 **32(4)** @ 633).

283. Section 55 of Sao Tome and Principe's 1980 Health Code (IDHL 1981 **32(4)** @ 642).

284. IDHL 1981 **32(4)** @ 626.

285. IDHL 1987 **38(1)** @ 17.

286. Law 59 of 1 June 1983 (IDHL 1985 **36(2)** @ 344).

287. Law 9 of 24 January 1979 (IDHL 1981 **32(2)** @ 219).

288. IDHL 1987 **38(1)** @ 6.

289. African National Congress Reconstruction and Development Programme Umanyano Publications: Johannesburg, 1994 @ 44.

290. Strategic Management Team, Ministry of Health and Social Services (Western Cape) Draft Provincial Health Plan February 1995, chapter 6.

291. The health-related issues concerning which local authorities can make bylaws include:
    i. keeping of animals and birds;
    ii. prevention of atmospheric pollution;
    iii. structural requirements of buildings and premises, in particular to promote health and safety;
    iv. food supply, such as the conditions under which food shall be kept, manufactured, stored supplied, handled, etc;
    v. control of environmental pollution;
    vi. prevention and abatement of nuisances;

vii. safeguarding the health and physical welfare of children attending schools, nursery schools, creches and play schools;

viii. measures to preserve and safeguard the public health and personal safety of the inhabitants of the local area, including: restriction of acts likely to be dangerous to health or to cause the spread of infectious diseases; cleanliness and sanitary precautions; unhealthy conditions in buildings; suppression of fires; control of poisons, weapons etc; and regulation of pests;

ix. sanitation;

x. trades, business, and occupations, including regulation of cleanliness, hygiene and sanitary arrangements for safeguarding and preserving the health and safety of employees and the public, as well as regulation and control of nuisances emanating from such undertakings; and

xi. water supply and drainage, *inter alia* preventing pollution of water for domestic uses and the regulation of drainage areas.

292. Provincial Notice No. 473, 1961 in: The Official Gazette of the Province of Natal No. 3060, 19 October 1961 @ 1383.

293. African National Congress Reconstruction and Development Programme Umanyano Publications: Johannesburg, 1994 @ 44.

294. Regulation 30 of Provincial Notice No. 473, 1961 in: The Official Gazette of the Province of Natal No. 3060, 19 October 1961 @ 1383.

295. Provincial Notice No. 662, 1978 in: The Official Gazette of the Province of Natal No. 4083, 14 December 1978 @ 2592.

296. African National Congress A National Health Plan for South Africa ANC: Johannesburg, 1994 @ 45-46.

297. General Notice No. 657, 1994 in: Republic of South Africa Government Gazette No. 15817, 1 July 1994 @ 73.

298. "Institution" is defined in section 1 to mean a reform school, school of industries or a children's home.

299. Regulation 111(3)(b) of Government Notice No. R2080, 1965 in: Republic of South Africa Government Gazette No. 1326, 31 December 1965 @ 73.

300. African National Congress A National Health Plan for South Africa ANC: Johannesburg, 1994 @ 83.

301. In formulating the structure of this division of the framework, reference was had to: Harrison S. A Review of International Maternal and Child Health Legislation (2nd ed) Parow: Medical Research Council, 1994 (prepared at the request of the Maternal, Women's and Child Health Committee of the Department of Health).

302. Proclamation No. R152, 1994 in: Republic of South Africa Government Gazette No. 16049, 31 October 1994 @ 15.

303. Government Notice No. R1182, 1986 in: Republic of South Africa Government Gazette No. 10283, 20 June 1986 @ 28.

304. Article 8, Chp 12, Title 54, Part II of the Health laws of Virginia, USA (IDHL 1983 **34(2)** @ 268); Honduras's Resolution 141-84 of 18 June 1984 of the Ministry of Public Health prescribing provisions governing the practice of voluntary and therapeutic sterilisation in public and private health establishments (IDHL 1984 **35(4)** @ 766-768).

305. Finland's Law 125 of 31 December 1985 amending the law on sterilisation (IDHL 1985 **36(4)** @ 978).

306. Honduras's Resolution 141-84 of 18 June 1984 of the Ministry of Public Health prescribing provisions governing the practice of voluntary and therapeutic sterilisation in public and private health establishments (IDHL 1984 **35(4)** @ 766-768).

307. Proclamation No. R133, 1975 in: Republic of South Africa Government Gazette No. 4735, 6 June 1975 @ 1.

308. Proclamation No. R95, 1989 in: Republic of South Africa Government Gazette No. 11965, 23 June 1989 @ 1.

309. Republic of South Africa Restructuring the National Health System for Universal Primary Health Care (Main Report of the Committee of Enquiry into a National Health Insurance System) Department of Health: Pretoria, 1995 @ 12.

310. Department of Health Report of the Committee on Human Resources for Health (Draft) Submitted to the Minister of Health in December 1994, @ 47.

311. Government Notice No. R1673, 1968 in: Republic of South Africa Government Gazette No. 2165, 20 September 1968 @ 23.

312. Submission to National Health Legislation Review Committee by Health Technology Research Group of the Medical Research Council, concerning legislation related to medical devices (30 May 1995).

313. *Ibid.*

314. Fuggle R.F. and M.A. Rabie (eds) Environmental Management in South Africa Juta: Cape Town, 1992 @ 615.

315. In terms of s 271 of Ordinance 25 of 1974, the Administrator may frame bylaws to be known as "standard bylaws" for any purpose in respect of which a town council may make bylaws. A town council may then adopt such standard bylaws, either with or without amendment, as a bylaw made

ANNEXURE FIVE

*PROVINCE OF VAZULU-NATAL* | *ISIFUNDAZWE SAKWAZULU-NATAL* | *PROVINSIE KWAZULU-NATAL*

# MEDIA RELEASE

## KWAZULU-NATAL DEPARTMENT OF HEALTH

## PROVINCIAL HEALTH ACT

:rategic Management Team for the province of KwaZulu-Natal has formulated a document cting the proposed principles and summary of the proposed framework of a Health Act he Province.

der to provide an opportunity for comments to be submitted to the Strategic ement Team for consideration the document has been made available for perusal at:-

(a) All KwaZulu-Natal Provincial Hospitals;

(b) The Department of Health - Ulundi - Ground Floor - Zone No. 8 - Tender Section.

(b) The Department of Health - Pietermaritzburg - Natalia Building Longmarket Street - Ground Floor Foyer -Bulletin Board

Such comments should be in writing and:-

(a) Be fully motivated; and

(b) Confined to:-

(i) The principles of the proposed legislation;

(ii) The evaluation of existing legislation for weaknesses and omissions; and

(iii) Suggestions of health legislation of other countries/provinces which may be of value or applicable.

r comments should please be forwarded to the following address by 31 uary 1995:-

venor of the Legislation Task Group
vate Bag 9051
termaritzburg
0

Attention : Mr G. Tromp Room 10-116

'the comments have been received the following process will take place:-

(a) Administrative evaluation of the comments with assistance from experts in the legal profession;

(b) Hearings by the Strategic Management Team Legislation Task Group only where this is considered necessary;

(c) Drafting of the act and publication thereof for further comment; and

(d) Enactment of the legislation.

by it.

316. Fuggle R.F. and M.A. Rabie (eds) Environmental Management in South Africa Juta: Cape Town, 1992 @ 590.

317. *Ibid.* @ 591.

318. *Ibid.* @ 596.

319. *Ibid.* @ 605.

320. *Ibid.* @ 615.

321. *Ibid.* @ 611.

322. Government Notice No. R2544, 1990 in: Republic of South Africa Government Gazette No. 12816, 2 November 1990 @ 1.

323. Government Notice No. R287, 1976 in: Republic of South Africa Government Gazette No. 4989, 20 February 1976 @ 29.

324. Fuggle R.F. and M.A. Rabie, *op. cit.* @ 479.

325. "Nuisance" is defined in section 1 to mean:
   (a) any stream, pool, marsh, ditch, gutter, watercourse, cistern, watercloset, earthcloset, urinal, cesspool, cesspit, drain, sewer, dung pit, slop tank, ash heap or dung heap so foul or in such a state or so situated or constructed as to be offensive or to be injurious or dangerous to health;
   (b) any stable, kraal, shed, run or premises used for the keeping of animals or birds and which is so constructed, situated, used or kept as to be offensive or to be injurious or dangerous to health;
   (c) any accumulation of refuse, offal, manure or other matter which is offensive or is injurious or dangerous to health;
   (d) any public building which is so situated, constructed, used or kept as to be unsafe or to be injurious or dangerous to health;
   (e) any occupied dwelling for which no proper and sufficient supply of pure water is available within a reasonable distance;
   (f) any factory or industrial or business premises not kept in a cleanly state and free from offensive smells arising from any drain, watercloset, earthcloset, urinal or any other source, or not ventilated so as to destroy or render harmless and inoffensive as far as practical any gases, vapours, dust or other impurities generated, or so overcrowded or so badly lighted or ventilated as to be injurious or dangerous to the health of those employed therein or thereon;
   (g) any factory or industrial or business premises causing or giving rise to smells or effluvia which are offensive or which are injurious or dangerous to health;
   (h) any area of land kept or permitted to remain in such a state as to be

offensive;

(i) any other activity, condition or thing declared to be a nuisance by the Minister in terms of the provisions of section 39(2).

326. Chapter 15 (Addiction Control Programmes) would more appropriately have been incorporated as a subsection of Chapter 13 (Health Promotion), as programmes designed to inform the public about the dangers of substance abuse are an integral component of health promotion activities which aim to enable individuals to make healthy choices.

327. The Ottawa Charter was the product of the First International Conference on Health Promotion, which met in Ottawa, Ontario (Canada), from 17 to 21 November, 1986. The Conference was primarily a response to growing expectations for a new public health movement around the world.

328. It is now possible, in terms of section 7(4)(b)(iv) of the Interim Constitution, for a person to act as a member of or in the interest of a group or class of persons, when seeking relief against an alleged infringement of, or threat to, any right entrenched in Chapter 3 of the Interim Constitution.

329. Personal communication: Ms Rhonda Galbally (Chief Executive Officer of the Victorian Health Promotion Foundation), 6 March 1995.

330. African National Congress A National Health Plan for South Africa ANC: Johannesburg, 1994 @ 83.

331. Published in Italy's Official Gazette on 6 August 1990.

332. African National Congress A National Health Plan for South Africa ANC: Johannesburg, 1994 @ 80.

333. For a more extensive review of some of this legislation, see: Bradshaw D. and M. Schneider Vital Registration and Statistics in South Africa: Case Study Metropolitan Cape Town Centre for Epidemiological Research in Southern Africa (Medical Research Council): Cape Town, July 1995 @ 13-17.

334. Section 3(a) of the Statistics Act read with Government Notice No. R139 in: Republic of South Africa Government Gazette No. 5395, 4 February 1977 @ 10.

335. Such regulations have been made in Government Notice No. R1575 in: Republic of South Africa Government Gazette No. 9846, 19 July 1985 @ 11.

336. A recommendation to this effect has been made by the writer to the National Health Legislation Review Committee.

## ANNEXURE ONE

# DEPARTMENTAL ADMINISTRATION OF LAWS WHICH IMPACT ON HEALTH

***Department of Health***

* *Abortion and Sterilisation Act 1975 (Act No. 2 of 1975)*
* *Academic Health Centres Act 1993 (Act No. 86 of 1993)*
* *Atmospheric Pollution Prevention Act 1965 (Act No. 45 of 1965)*
* *Chiropractors, Homeopaths and Allied Health Service Professions Act 1982 (Act No. 63 of 1982)*
* *Dental Technicians Act 1979 (Act No. 19 of 1979)*
* *Foodstuffs, Cosmetics and Disinfectants Act 1972 (Act No 54 of 1972)*
* *Hazardous Substances Act 1973 (Act No. 15 of 1973)*
* *Health Act 63/1977*
* *Health Donations Fund Act 1978 (Act No. 11 of 1978)*
* *Human Tissue Act 1983 (Act No. 65 of 1983)*
* *International Health Regulations Act 1974 (Act No. 28 of 1974)*
* *Medical, Dental and Supplementary Health Service Professions Act 1974 (Act No. 56 of 1974)*
* *Medical Schemes Act 1967 (Act No. 72 of 1967)*
* *Medicines and Related Substances Control Act 1965 (Act No. 101 of 1965)*
* *Mental Health Act 1973 (Act No. 18 of 1973)*
* *National Policy for Health Act 116/1990*
* *Nursing Act 1978 (Act No. 50 of 1978)*
* *Occupational Diseases in Mines and Works Act 1973 (Act No. 78 of 1973)*
* *Pharmacy Act 1974 (Act No. 53 of 1974)*
* *Public Health Act 1919 (Act No. 36 of 1919)*
* *South African Medical Research Council Act 1991 (Act No. 58 of 1991)*♪
* *Tobacco Products Control Act 1993 (Act No. 83 of 1993)*

♪ *Note: this Act is administered jointly with the Department of Arts, Culture, Science and Technology*

**Department of Agriculture**

* Abattoir Hygiene Act 1992 (Act No. 121 of 1992)
* Animal Diseases Act 1984 (Act No. 35 of 1984)
* Agricultural Products Standards Act 1990 (Act No. 119 of 1990)
* Fertilisers, Farm Feeds, Agricultural Remedies and Stock Remedies Act 1947 (Act No. 36 of 1947)
* Marketing Act 1968 (Act No. 59 of 1968)

**Department of Correctional Services**

* Correctional Services Act 1959 (Act No. 8 of 1959)

**Department of Defence**

* Defence Act 1957 (Act No. 44 of 1957)

**Department of Education**

* Archives Act 1962 (Act No. 6 of 1962)
* Education Affairs Act 1988 (Act No. 70 of 1988)
* Education and Training Act 1979 (Act No. 90 of 1979)
* Indians Education Act 1922 (Act No. 2 of 1922)
* Medical University of Southern Africa Act 1976 (Act No. 78 of 1976)
* National Policy for General Education Affairs Act 1984 (act No. 76 of 1984)
* Natural Scientific Professions Act 1993 (Act No. 106 of 1993)

**Department of Environmental Affairs and Tourism**

* Environment Conservation Act 1989 (Act No. 73 of 1989)
* Seashore Act 1935 (Act No. 21 of 1935)
* Sea Fisheries Act 1988 (Act No. 12 of 1988)

**Department of Finance**

* State Tender Board Act 1968 (Act No. 86 of 1968)
* Exchequer and Audit Act 1975 (Act No. 66 of 1975)

**Department of Home Affairs**

* Aliens Control Act 1991 (Act No. 96 of 1991)
* Births and Deaths Registration Act 1992 (Act No. 51 of 1992)
* Statistics Act 1976 (Act No. 66 of 1976)
* Marriage Act 1961 (Act No. 25 of 1961)

**Department of Housing**

* Housing Act 1966 (Act No. 4 of 1966)
* Less Formal Township Establishment Act 1991 (Act No. 113 of 1991)
* Prevention of Illegal Squatting Act 1951 (Act No. 52 of 1951)
* Slums Act 1979 (Act No. 76 of 1979)

**Department of Justice**

* Administration of Estates Act 1965 (Act No. 66 of 1965)
* Criminal Procedure Act 1977 (Act No. 51 of 1977)
* Drugs and Drug Trafficking Act 1992 (Act No. 140 of 1992)
* Inquests Act 1959 (Act No. 58 of 1959)
* Justices of the Peace and Commissioners of Oaths Act 1963 (Act No. 16 of 1993)
* Prevention of Family Violence Act 1993 (Act No. 133 of 1993)
* Sexual Offences Act 1957 (Act No. 23 of 1957)

**Department of Labour**

* Basic Conditions of Employment Act 1983 (Act No. 3 of 1983)
* Compensation for Occupational Injuries and Diseases Act 1993 (Act No. 130 of 1993)
* Labour Relations Act 1956 (Act No. 28 of 1956)
* Manpower Training Act 1981 (Act No. 56 of 1981)
* Occupational Health and Safety Act 1993 (Act No. 85 of 1993)
* Unemployment Insurance Act 1966 (Act No. 30 of 1966)
* Wage Act 1957 (Act No. 5 of 1957)

**Department of Land Affairs**

* Abolition of Racially-Based Land Measures Act 1991 (Act No. 108 of 1991)
* Physical Planning Act 1991 (Act No. 125 of 1991)

**Department of Mineral and Energy Affairs**

* Minerals Act 1991 (Act No. 50 of 1991)
* Nuclear Energy Act 1993 (Act No. 131 of 1993)

**Department of Provincial Affairs and Constitutional Development**

* Civil Protection Act 1977 (Act No. 67 of 1977)
* Constitution of the Republic of South Africa Act 1993 (Act No. 200 of 1993)
* KwaZulu and Natal Joint Services Act 1990 (Act No. 80 of 1990)
* Local Government Transition Act 1993 (Act No. 209 of 1993)
* Promotion of Local Government Affairs Act 1983 (Act No. 91 of 1983)
* Regional Services Councils Act 1985 (Act No. 109 of 1985)

**Department of Public Service and Administration**

* Public Service Act 1994 (Proclamation R.103 of 1994)
* Public Service Commission Act 1984 (Act No. 65 of 1984)
* Public Service Labour Relations Act 1993 (Act No. 102 of 1993)

**Department of Safety and Security**

* Police Act 1958 (Act No. 7 of 1958)

**Department of Sport and Recreation**

* Boxing and Wrestling Control Act 1954 (Act No. 39 of 1954)

**Department of Trade and Industry**

* Businesses Act 1991 (Act No. 71 of 1991)
* Companies Act 1973 (Act No. 61 of 1973)
* Dumping at Sea Control Act 1980 (Act No. 73 of 1980)
* Liquor Act 1989 (Act No. 27 of 1989)
* National Buildings Regulations and Building Standards Act 1977 (Act No. 103 of 1977)
* Standards Act 1993 (Act No. 29 of 1993)

**Department of Transport**

* Maritime Traffic Act 1981 (Act No. 2 of 1981)
* Merchant Shipping Act 1951 (Act No. 57 of 1951)
* Motor Vehicle Accidents Act 84/1986
* Multilateral Motor Vehicle Accident Fund Act 1989 (Act No. 93 of 1989)
* Prevention and Combating of Pollution of the Sea by Oil Act 1981 (Act No. 6 of 1981)
* Road Traffic Act 1989 (Act No. 29 of 1989)

**Department of Water Affairs and Forestry**

* Water Act 1956 (Act No. 54 of 1956)

**Department of Welfare and Population Development**

* Aged Persons Act 1967 (Act No. 81 of 1967)
* Child Care Act 1983 (Act No. 74 of 1983)
* Children's Status Act 1987 (Act No. 82 of 1987)
* Fund-raising Act 1978 (Act No. 107 of 1978)
* Government Service Pension Act 1973 (Act No. 57 of 1973)
* National Welfare Act 1978 (Act No. 100 of 1978)
* Prevention and Treatment of Drug Dependency Act 1992 (Act No. 20 of 1992)
* Probation Services Act 1991 (Act No. 116 of 1991)
* Social Assistance Act 1992 (Act No. 59 of 1992)
* Social Pensions Act 1983 (Act No. 37 of 1983)
* Social Work Act 1978 (Act No. 110 of 1978)
* Temporary Employees Pension Fund Act 1979 (Act No. 75 of 1979)

ANNEXURE TWO

# SCHEDULE 4 CONSTITUTIONAL PRINCIPLES WHICH ARE OF PARTICULAR RELEVANCE TO HEALTH AND HEALTH SERVICES

V

The legal system shall ensure the equality of all before the law and an equitable legal process. Equality before the law includes laws, programmes or activities that have as their object the amelioration of the conditions of the disadvantaged, including those disadvantaged on the grounds of race, colour or gender.

XX

Each level of government shall have appropriate and adequate legislative and executive powers and functions that will enable each level of government to function effectively. The allocation of powers between different levels of government shall be made on a basis which is conducive to financial viability at each level of government and to effective public administration, and which recognises the need for and promotes national unity and legitimate provincial autonomy and acknowledges cultural diversity.

XXI

The following criteria shall be applied in the allocation of powers to the national government and the provincial governments:

1. The level at which decisions can be taken most effectively in respect of the quality and rendering of services, shall be the level responsible and accountable for the quality and rendering of the services, and such level shall accordingly be empowered by the Constitution to do so.
2. Where it is necessary for the maintenance of essential standards, for the establishment of minimum standards required for the rendering of services, the maintenance of economic unity, the maintenance of national security or the prevention of unreasonable action taken by one province which is prejudicial to the interests of another province or the country as a whole, the Constitution shall empower the national government to intervene through legislation or such other steps as may be defined in the Constitution.
3. Where there is necessity for South Africa to speak with one voice, or to act as a single entity - in particular in relation to other states - powers should be allocated to the national government.
4. Where uniformity across the nation is required for a particular function, the legislative power over that function should be allocated predominantly, if not wholly to the national government.
5. The determination of national economic policies, and the power to promote interprovincial commerce and to protect the common market in respect of the mobility of goods, services, capital and labour, should be allocated to the national government.
6. Provincial governments shall have powers, either exclusive or concurrently with the national government, *inter alia* -

(a) for the purposes of provincial planning and development of the rendering of services; and

(b) in respect of aspects of government dealing with specific socio-economic and cultural needs and the general well-being of the inhabitants of the province.

7. Where mutual co-operation is essential or desirable or where it is required to guarantee equality of opportunity or access to a government service, the powers should be allocated concurrently to the national government and the provincial governments.

8. The Constitution shall specify how powers which are not specifically allocated in the Constitution to the national government or to a provincial government, shall be dealt with as necessary ancillary powers pertaining to the powers and functions allocated either to the national government or provincial governments.

## XXII

The national government shall not exercise its powers (exclusive or concurrent) so as to encroach upon the geographical, functional or institutional integrity of the provinces.

## XXIV

A framework for local government powers, functions and structures shall be set out in the Constitution. The comprehensive powers, functions and other features of local government shall be set out in parliamentary statutes or in provincial legislation or in both.

## XXVI

Each level of government shall have a constitutional right to an equitable share of revenue collected nationally so as to ensure that provinces and local governments are able to provide basic services and execute the functions allocated to them.

ANNEXURE THREE

# PRINCIPLES FOR THE KWAZULU-NATAL HEALTH ACT

1. The legislation must be within the framework of the Constitution, the Reconstruction and Development Programme (RDP) and the ANC National Health Plan.

2. A single Act should cover all aspects of health.

3. Deregulation must be a means to an end, and not the end itself.

4. The legislation must be enforceable.

5. The Act must set the parameters (standardisation, co-ordination etc.) for the regulations. Thus an enabling document rather than a regulatory document.

6. The Act must be an expression of provincial policy.

7. The Act must strengthen the Provincial Ministry of Health to intervene in all health matters.

8. The Act must make provision for the delimitation of district health authorities.

9. The Act must define the functions of the various authorities rendering health services in the region.

10. The Act must contain provisions enabling community participation.

11. Provision must be made for accountability of health authorities to the general public and to other levels of authorities.

12. The Act must take cognisance of cultural and religious practices.

13. There should be co-ordination of all private and non-governmental initiatives if they involve public funds or assistance.

14. Private practice and institutions should be incorporated in the delivery of primary health care.

15. Provision must be made for subsidisation of organisations providing palliative and special care.

16. Provision must be made for the contracting out of services.

17. Interaction between the Departments of Health, Welfare and Education regarding nutrition should be clarified in the legislation.

18. Legislation must make provision for the district health system, including the community level, and the establishment of advisory boards representing professional bodies, non-governmental organisations and organised labour.

19. Provision must be made for special programmes to be implemented, if necessary, with community participation.

20. Provision must be made for direct liaison with health authorities of countries bordering the province.

21. National Legislation must make provision for co-ordination and standards on a macro level as well as uniformity on specific issues agreed to by all the provinces.

22. Provinces should not legislate on matters affecting other provinces without inter-provincial consultation.

23. Provincial legislation will provide administrative execution of national legislation as well as co-ordination and standards on a provincial level.

ANNEXURE FOUR

# FRAMEWORK: KWAZULU-NATAL HEALTH ACT

## 1. LONG TITLE

## 2. FUNDAMENTAL PROVISIONS

Provision for:
(a) definitions clause
(b) policy guidelines
(c) principles for the application, operation and interpretation of the Act
(d) statement of provincial government responsibility for the protection of health, within limits prescribed by law
(e) specification of what constitute the health authorities of the KwaZulu-Natal

## 3. COMMUNITY PARTICIPATION

Provision for:
(a) endorsement of principle and objectives of community participation in health services and health policy-making
(b) specific mechanisms of community participation, for example: community health forums; voluntary work; provision of incentives; and contracting out of services.

## 4. THE RIGHT TO HEALTH

Provision for:
(a) acknowledgement of right to "optimal" health, with statement of the objectives of this right and definition of its content
(b) a health ombud

## 5 RIGHTS OF HEALTH SERVICE USERS

Provision for:
(a) users' rights and obligations
(b) information to users concerning rights and available resources
(c) special measures relating to informed consent
(d) regulation of confidentiality of, and access to, user records
(e) channels for receiving, investigating, and reporting of user complaints

## 6 HEALTH IN THE CONTEXT OF MACRO-ECONOMIC POLICIES AND THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME

Provision for:

(a) health audits of the efficacy of health services

(b) health impact assessments for all major development projects in KwaZulu-Natal

## 7 THE PROVINCIAL HEALTH SYSTEM

### 7.1 The Provincial level

Provision for:

(a) the KwaZulu-Natal health authority to propose or participate in the formulation and implementation of laws of KwaZulu-Natal regarding specified issues which may have impact on health

(b) designation of the functions, powers, and jurisdiction of the KwaZulu-Natal health authority and its committees and officials

### 7.2 District level and community level

## 8 PUBLIC SECTOR HEALTH SERVICES

### 8.1 General

Provision for:

(a) an integrated network of public sector hospitals, with potential to link in private hospitals under certain conditions

(b) a primary care network, complemented by hospital activities

(c) publication of guidelines for the provision of mandatory health programmes

### 8.2 Public sector health establishments

Provision for:

(a) classification of health facilities according to objectives, equipment, technical level, and territorial jurisdiction

(b) designation of functions and responsibilities of health facilities

(c) regulation of planning and construction of health establishments in urban and rural areas

(d) regulation of organisation, staffing and operation of public health establishments, making provision *inter alia* for participatory management and mandatory training and research activities

(e) licensing / registration / approval requirements for certain activities

(f) total or partial closure of a facility in certain circumstances

(g) 24 hour emergency care, without reservations of any kind

(h) effective system of user referral and transmission of information

(i) hospital advisory boards for liaison with the Minister or the provincial health authority

(j) special provisions relating to the provision of services in: academic hospitals; other specialist hospitals; community hospitals; outpatient establishments; community health centres; health clinics; health posts; and health laboratories

(k) mechanisms for quality assurance and evaluation of activities of health establishments, including: quality requirements; hospital evaluation; and quality assurance committees

### 8.3 Emergency Services

Provision for:

(a) emergency care policy
(b) protocols for referral
(c) responsibilities of district health authorities in respect of emergency services
(d) use of services of voluntary organisations rendering emergency care
(e) regulation of ambulance and rescue services
(f) co-ordinated Crisis Control Centres
(g) qualifications of emergency workers
(h) first aid courses

### 8.4 Epidemics

Provision for:

(a) multidisciplinary disaster management committees at various levels
(b) specific measures for prevention of epidemics and principles for their implementation, including:
    (i) integration of health authorities into an information and communication system for emergencies
    (ii) inventories of epidemic preparedness resources at community level
    (iii) provincial and district epidemic plans
    (iv) alert procedures
(c) participation of South African National Defence Force
(d) emergency relief for affected community
(e) powers of Minister / Accounting Officer to proclaim an emergency and to mobilise financial resources
(f) compensation for seizure of land, building or thing

### 8.5 Emergencies or disasters

Provision for:

(a) special powers to enable the immediate, active participation of health services in the event of emergencies or disasters affecting the province or a sudden deterioration of the environment constituting an imminent danger to the population.

### 8.6 Mental health

Provision for:

(a) mental health policy
(b) additional patient rights
(b) conditions of treatment in mental health hospitals and in open hospitals
(c) admission for observation and voluntary commitment
(d) involuntary hospitalisation or treatment, including matters relating to: suspension; duration; termination of compulsory treatment; and hospitalisation in the event of relapse
(e) medical surveillance of mentally ill patients
(f) treatment of forensic patients
(g) mental health care services in schools, prisons, workplace, and national defence force
(h) intersectoral structures at all levels to co-ordinate mental health care provision
(i) support for non-governmental mental health care services

### 8.7 Maternal and child care (and family health)

Provision for:

(a) basic principles and objectives
(b) education and support programmes
(c) maternal and child health research
(d) co-ordination of activities of private sector and NGO's
(e) maternity facilities, antenatal and postnatal care
(f) obstetric services
(g) protection of health of unborn persons
(h) special rights of children
(i) health care for children and adolescents
(j) child immunisation
(k) special care for disabled children and their mothers
(l) special measures for the health and safety of pregnant women and employees
(m) special working conditions of, and facilities for, working children and pregnant/nursing mothers

### 8.8 Family planning services, including education and contraceptive services

### 8.9 School health programmes, and hygiene in schools, kindergartens, and creches

Provision for:

(a) a Commission to prepare compulsory health education courses for schools
(b) specific health programmes in schools
(c) school medical and dental services
(d) physical training and sports education

### 8.10 Rehabilitative services

8.11 **Social welfare, prevention of disability, and care and rehabilitation of the physically and mentally handicapped**

8.12 **Care of the elderly**

Provision for:
(a) rights of elderly
(b) community health centre and home care services for the elderly
(c) appropriate training of community health workers
(d) health education services for elderly

8.13 **Poison information centres**

8.14 **Artificial insemination units**

8.15 **Health care for persons deprived of their freedom or in detention**

8.16 **Screening and provision of health care for aliens**

## 9. PRIVATE HEALTH

Provision for, *inter alia*:
(a) contractual arrangements between private practitioners and the public health service

## 10. TRADITIONAL HEALING

## 11 HEALTH TECHNOLOGY

Provision for:
(a) a Provincial Commission on Health Technology

## 12 FOODSTUFFS

Provision for regulation of:
(a) food inspection regarding composition, presentation and serving
(b) preparation, cooking and cooking facilities
(c) food establishments
(d) protection, preservation, storage and transportation of foods
(e) marketing of foods and beverages
(f) personal hygiene and protective clothing

## 13 ENVIRONMENTAL HEALTH PROTECTION

### 13.1 Joint provisions

Provision for:

(a) environmental health policy and the right to a healthy environment
(b) registers of circumstances in which health intervention has been necessary, in order to substantiate future involvement
(c) restrictions on public or private activities that may have adverse consequences on health
(d) intervention to prevent and eliminate health hazards and nuisances and to promote safety

### 13.2 Effects of the environment on health

Provision for:

(a) an intersectoral Regional Advisory Committee on Environmental Health
(b) designation of responsibilities of health authorities at all levels, with joint coordination of certain activities
(c) environmental sanitation measures
(d) prevention of air pollution, radiation, noise, sound and vibrations which may be harmful to health or give rise to a nuisance
(e) Health requirements for urban planning and rural development
(f) Special powers of Minister to revoke licences and/or registration certificates and to close public places

### 13.3 Water supply, disposal and use

### 13.4 Waste water and sewage

### 13.5 Removal and disposal of refuse, and disposal sites

### 13.6 Control of industrial effluent

### 13.7 Solid residues and the soil

### 13.8 Scheduled trades

### 13.9 Sanitation

### 13.10 Accommodation and other establishments open to the public

### 13.11 Health resorts and beauty establishments, including spas and natural therapeutic springs

### 13.12 Public swimming pools and beaches

### 13.13 Nuisances

Provision for:

(a) duties of appropriate authorities to abate nuisances
(b) notification of nuisances
(c) notices to abate nuisances and power to execute work in default

### 13.14 Rodent control, insect vectors, and other animals

### 13.15 Health control of disposal of cadavers

Provisions relate to:
(a) burial, exhumation and transportation of cadavers
(b) cemeteries, crematoria and funeral undertakers
(c) autopsies
(d) disposal of partial human remains

## 14. HEALTH PROMOTION

Provision for:
(a) statement of objectives of, and activities encompassed by, health promotion, education and prevention strategies
(b) duties of provincial government agencies, local authorities, community workers, undertakings, organisations, and the broader population in respect of health promotion
(c) community health education programmes, and structures responsible for this
(d) establishment of an intersectoral Commission on the Planning of Health Education
(e) utilisation of mass media
(f) provincial variations and involvement in any national programmes relating to nutrition, health vis-a-vis sports and recreation, and injury prevention

## 15. ADDICTION CONTROL PROGRAMMES

Provision for provincial programmes against:
(a) smoking
(b) drug dependence
(c) alcoholism

## 16. OCCUPATIONAL HEALTH AND INDUSTRIAL HYGIENE

Provision for:
(a) execution of national standards
(b) routing of statistical data on industrial accidents and occupational diseases via the provincial health information system

## 17. DISEASE PREVENTION

Provisions relate to:

(a) responsibility of the Minister and other health authorities
(b) the Minister's power to make regulations to combat communicable diseases and epidemics, and to apply special control measures, including immunisation, compulsory treatment, quarantine and notification
(c) control of AIDS and other sexually transmitted diseases, subject to national policies and programmes
(d) chronic non-communicable diseases

## 18. EPIDEMIOLOGICAL SURVEILLANCE AND CONTROL

Provision for:

(a) establishment of a comprehensive provincial health information system
(b) allocation of resources for epidemiological surveillance
(c) establishment of a Provincial Health Laboratory Service

## 19. AUTHORISATIONS, LICENCES AND CERTIFICATES

Provision for:

(a) health registrations and licenses

## 20. SANCTIONS, OFFENSES AND ENFORCEMENT

### 20.1 Powers of officers and other health enforcement agencies

Provision for:

(a) inspections and powers of entry, search, seizure and closure
(b) interdictory relief
(c) appeals against, or review of, official action on grounds of *ultra vires*
(d) restriction on legal proceedings

### 20.2 Offenses

Provision for:

(a) penalties
(b) prescription

## 21. FINAL PROVISIONS

Provision for:

(a) designation of responsibility for implementation of the Act
(b) delegation of powers and functions
(c) advisory or technical committees to assisting in the administration of this Act
(d) regulations for the implementation of this law generally, or with regard to specified issues, and procedure for promulgation

(e) legal instruments to develop and supplement this law, in accordance with the Constitution
(f) procedure for the service of documents required by the Act
(g) commencement of the law
(h) operation of other laws in relation to this Act
(i) repealing provisions
(j) no state department to be exempted in any other Act form the application of this Act unless specific provisions have been made in this Act for such exemption
(k) short title

## 22. TRANSITIONAL PROVISIONS

Provision for:
(a) matters relevant to the incorporation of erstwhile former KwaZulu and Natal health departments under a single health authority
(b) plans for the revision and adaptation of existing legislation to this law

ANNEXURE SIX

# PRIORITIES OF THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME

(Maternal, Women's and Child Health Committee Report @ 2)

- Promotion of the UN Convention on the Rights of the Child
- Provision of free health care to improve antenatal care, delivery and postnatal care in the public sector and to children under six years of age
- Reduction of maternal mortality, perinatal mortality, infant mortality and under 5 mortality rates
- Expansion of immunisation coverage
- Eradication of poliomyelitis and neonatal tetanus
- Reduction in the incidence of moderate and severe dehydration from diarrhoeal disease in children under 5 years of age
- Reduction in mortality from diarrhoeal diseases in children under 5 years of age
- Reduction in mortality from acute respiratory infections
- Promotion of breast-feeding
- Reduction in levels of malnutrition and malnutrition-related illnesses
- Development of an education programme for scholars, adolescents and teachers around health promotion, including sexuality, safe sexual practices and substance abuse
- Improvement in universal access to antenatal, delivery and postnatal care, and to reproductive health services
- Enabling women to take control of their reproductive health and their reproductive lives
- Enabling women to have the right to choose whether or not to terminate pregnancy according to their beliefs
- Protecting the right of health workers to refuse participation in termination of pregnancy, according to their beliefs
- Development of comprehensive women's health care services, including contraceptive services, which will be geared towards the needs of all women throughout their lifespan

- Giving priority to cost-effective affordable screening programmes for diseases which affect women (including carcinoma of the cervix)
- Enactment of a law protecting women against rape and battery
- Training and reorientation of health workers and public officials to correct any negative attitudes to women
- Establishing programmes to combat the spread of sexually transmitted diseases (STDs) and acquired immune deficiency syndrome (AIDS)
- Protection of children and women against all forms of violence