

Spring 2001

# Public Health Law in South Africa, by Sundrasagaran Nadasen

Obijiofor Aginam

*University of British Columbia*

Follow this and additional works at: <http://www.repository.law.indiana.edu/ijgls>

 Part of the [Health Law and Policy Commons](#), and the [International Law Commons](#)

## Recommended Citation

Aginam, Obijiofor (2001) "Public Health Law in South Africa, by Sundrasagaran Nadasen," *Indiana Journal of Global Legal Studies*: Vol. 8: Iss. 2, Article 10.

Available at: <http://www.repository.law.indiana.edu/ijgls/vol8/iss2/10>

This Book Review is brought to you for free and open access by the Law School Journals at Digital Repository @ Maurer Law. It has been accepted for inclusion in *Indiana Journal of Global Legal Studies* by an authorized administrator of Digital Repository @ Maurer Law. For more information, please contact [wattn@indiana.edu](mailto:wattn@indiana.edu).



**JEROME HALL LAW LIBRARY**

INDIANA UNIVERSITY  
Maurer School of Law  
Bloomington

# Public Health Law in South Africa

By Sundrasagaran Nadasen

Butterworths, 2000, pp. 157

REVIEWED BY OBIJIOFOR AGINAM\*

## I. INTRODUCTION: HEALTH AND THE PROBLEM OF DEFINITION

Scholars of public health and related disciplines struggle with the difficult hurdle of definition. Health is analogous to the proverbial “mansion with many rooms” or “road traversed by many pathways.” Everyone has a view of what health means, what it does not mean, how to promote it, its parameters and determinants, its linkage with other socio-economic factors, and the paradigm—legal, legislative and social—for its realization. Thus, a discussion of health by scholars of diverse disciplines can easily resemble a cacophony of discordant voices reminiscent of the biblical *Tower of Babel*,<sup>1</sup> or what one scholar refers to as “characteristics of a dinner party conversation that endeavours to recall the plot of *The Two Gentlemen of Verona*.”<sup>2</sup>

Most legal scholars easily confuse the terms public health, primary health care, health care, medical services, and medicare. The confusion that trails much of the literature on the right to health under the International Covenant on Economic, Social, and Cultural Rights (1966)<sup>3</sup> is largely traceable to the confusion of these different terms. For instance, Roemer argued that the phrase “right to health” is an absurdity because it implies a guarantee of

---

\* Doctoral Candidate in Law, University of British Columbia, Vancouver, Canada. He is presently Global Health Leadership Officer, World Health Organization, Geneva, Switzerland. The views expressed herein are the personal views of this writer, and do not in any way represent the position of the World Health Organization.

1. “Come, let us go down and confuse their language so they will not understand each other. . . . That is why it was called Babel—because there the Lord confused the language of the whole world.” *Genesis* 11: 7-9 (New International 1973).

2. See Ivan L. Head, *The Contribution of International Law to Development*, 25 CAN. Y.B. INT’L L. 29, 31 (1987) (describing the confusion surrounding the definition of “development” and the role of international law in that dynamic).

3. International Covenant on Economic, Social, and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3.

perfect health.<sup>4</sup> She opted for the phrase “right to health care,” which encompasses “protective environmental services, prevention and health promotion and therapeutic services as well as related actions in sanitation, environmental engineering, housing and social welfare.”<sup>5</sup> Leary has pointed out that “such an extensive definition seems contrary to common understanding of the phrase “right to health care.”<sup>6</sup> The editors of *Right to Health in the Americas* recognized that the phrase “right to health” may be conceptually misleading and consequently suggested “a right to health protection” to include two components: a right to health care and a right to healthy conditions.<sup>7</sup>

With this in mind, Sundrasakaran Nadasen’s treatise, *Public Health Law in South Africa*,<sup>8</sup> commendably starts with an articulation of the definitions of health offered by various disciplines and attempts to find a locus for this discourse in the particular socio-economic, political, and jurisprudential context of South Africa. In the first chapter, Nadasen separates related concepts that are often confusingly lumped together in public health literature: health, public health, health determinants, primary health care, and health promotion. Paraphrasing Gilbert, Selikow and Walker,<sup>9</sup> he asserts that “definitions of health depend, to a large extent, on the origin or source of any particular definition. Thus, definitions of health differ according to the nuances of one’s profession, by culture, gender and age characteristics.”<sup>10</sup> Although the wordings of various definitions of health differ, two clearly discernible schools of thought exist: (1) the negative, where health is defined as the absence of disease, impairment, or infirmity;<sup>11</sup> and (2) the positive, where health is ambitiously defined as a state of complete physical and social well-being, not merely the absence of disease.<sup>12</sup>

Scholars exhibit considerable unanimity on what constitutes “determinants

---

4. Ruth Roemer, *The Right to Health Care*, in *THE RIGHT TO HEALTH IN THE AMERICAS* 17, 17 (Hernán Fuenzalida-Puelma & Susan Scholle Connor eds., 1989)[hereinafter *RIGHT TO HEALTH*].

5. *Id.* at 17.

6. VIRGINIA A. LEARY, *The Right to Health in International Human Rights Law*, 1 *HEALTH AND HUMAN RTS* 25, 31 (1994), available at <http://www.hsph.harvard.edu/fixcenter/VIN1leary.htm>.

7. *RIGHT TO HEALTH*, *supra* note 4, at 600.

8. SUNDRASAGARAN NADASEN, *PUBLIC HEALTH LAW IN SOUTH AFRICA* (2000).

9. LEAH GILBERT ET AL., *SOCIETY, HEALTH AND DISEASE: AN INTRODUCTORY READER FOR HEALTH PROFESSIONALS* 7 (1996).

10. NADASEN, *supra* note 8, at 2.

11. *Id.*

12. Constitution of the World Health Organization, opened for signature July 22, 1946, in *WORLD HEALTH ORGANIZATION, BASIC DOCUMENTS* 1, 1 (40th ed., 1994), at preamble (“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”).

of health," "health promotion," and "primary health care." The determinants of health include: biological, behavioral, environmental, health system, socio-economic factors, socio-cultural factors, aging of the population, science and technology, information and communication, gender, equity, and social justice.<sup>13</sup> Nadasen draws from such widely cited multilateral documents as the Ottawa Charter for Health Promotion (1986),<sup>14</sup> and the Declaration of Alma-Ata (1978),<sup>15</sup> which defined "health promotion" and "primary health care" respectively in both positive and broad terms.

The realization of the lofty ideals of both "health promotion" and "primary health care" contained in such international declarations poses enormous challenges for post-apartheid South Africa. Nadasen highlights the tenets of the reconstruction and development program of the ruling African National Congress (ANC), which arguably are consistent with the canons of the Declaration of Alma-Ata and the Ottawa Charter on Health Promotion. The ANC's Reconstruction and Development Programme asserts what can hardly

---

13. Geneviève Pinet, *Health Challenges of the 21st Century: A Legislative Approach to Health Determinants*, 49 INT'L DIG. OF HEALTH LEGIS. 131, 133-34 (1998).

14. Ottawa Charter for Health Promotion, Nov. 21, 1986, available at <http://www.who.dk/policy/ottawa.htm> (visited Apr. 8, 2001). The Ottawa Charter for Health Promotion emerged from the First International Conference on Health Promotion, Ottawa, Canada in November 1986. The Charter defines health promotion as

the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is . . . a resource for everyday life. . . Health is a positive concept emphasising social and personal resources, as well as physical capacities. . . Health promotion is not just the responsibility of the health sector, but goes beyond health lifestyles to well-being.

*Id.*

15. The Alma-Ata Declaration on Primary Health Care was the result of a joint World Health Organization-United Nations Children's Fund (WHO-UNICEF) sponsored International Conference held at Alma-Ata in the former Soviet Union in September 1978, WHO-UNICEF, Primary Health Care, Report of the International Conference on Primary Health Care, Alma-Ata, USSR, Sept. 6-12, 1978, 'Health for All' Series No. 1 (Geneva: WHO, 1978), available at <http://www.who.int/hpr/docs/almaata.html> (visited Apr. 8, 2001). This Declaration defined primary health care as:

essential health care based on practical, scientifically sound and socially acceptable methods and technology made accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

*Id.*

be denied—disparities in wealth affect the health of populations. Thus, health discourse and programs must address the complex challenges of poverty and under-development. According to the World Health Organization (WHO):

Poverty is the main reason why babies are not vaccinated; clean water and sanitation are not provided, and curative drugs and other treatments are unavailable and why mothers die in childbirth. Poverty is the main cause of reduced life expectancy, of handicap and disability, and of starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration, and substance abuse.<sup>16</sup>

According to the United Nations Development Programme, income disparities within countries—including industrialized countries—are increasing.<sup>17</sup> In Russia, the income share of the richest twenty percent is eleven times that of the poorest twenty percent.<sup>18</sup> In Australia and the United Kingdom, it is nearly ten times as much.<sup>19</sup> Nadasen's analysis of the socio-economic context of public health in South Africa captures these disparities as well as the inexorable linkage between public health and poverty/under-development. As Nadasen observes:

[A]lthough South Africa is classified as a middle income country, spending 8.5% of the GDP on health care, it nevertheless still exhibits major discrepancies and inequalities: the majority of the population have inadequate access to basic services including health, clean water and basic sanitation. Not only is poverty a scourge, but it is also estimated that the Infant Mortality Rate, the Under-five Mortality Rate, and the Maternal Mortality Rate are much higher than expected of a country with South Africa's income levels.<sup>20</sup>

---

16. WORLD HEALTH ORGANIZATION, WORLD HEALTH REPORT 1995: BRIDGING THE GAPS 1 (1995).

17. See generally UNITED NATIONS DEVELOPMENT PROGRAMME, HUMAN DEVELOPMENT REPORT (1998).

18. *Id.*

19. *Id.* For my views on how global wealth disparities affect health in both the global South and North, see Obijiofor Aginam, *Global Village, Divided World: South-North Gap and Global Health Challenges at Century's Dawn*, 7 IND. J. GLOBAL LEGAL STUD. 603 (2000).

20. See NADASEN, *supra* note 8, at 21 (quoting *Health Transformation White Paper*).

Citing Yach and Buthelezi,<sup>21</sup> Nadasen argues that health status of South Africans depends on a combination of socio-economic growth that depends on non-health indicators such as poverty and development and other generic factors, including illiteracy, erosion of the moral and social fiber of society, unemployment, and provision of basic needs.<sup>22</sup>

From a legal perspective, Nadasen construes South Africa's socio-economic context through the judicial opinions expressed by D.P. Mohammed in *Azanian People's Organisation v. President of the Republic of South Africa*<sup>23</sup> and P. Chaskalson, in *Soobramoney v. Minister of Health, KwaZulu-Natal*.<sup>24</sup> These judicial pronouncements, while commendable, nonetheless reiterate the age-old argument about the justiciability of health entitlements within the body of human rights law. The constitutions of developing countries often provide health entitlements for their populations under so-called "Fundamental Objectives and Directive Principles of State Policy," which are not justiciable before courts or other adjudicatory tribunals.<sup>25</sup> In the international legal context, these types of provisions are analogous to so-called "soft law" declarations which have moral but no direct legal force.

Although Nadasen cites the two South African cases approvingly, it is not clear whether the opinions of Mohammed and Chaskalson are legally binding statements of law or mere *orbiter dicta* or soft-law. If they are legally binding, then they represent an advancement of the position that the right to health is largely non-justiciable. If they are merely soft law, then they simply represent an endorsement of the activist/liberal judicial interpretation of non-justiciable constitutional provisions in developing common law countries long championed by the Supreme Court of India under Chief Justice P.N. Bhagwati.<sup>26</sup>

---

21. Derek Yach & Goinile Buthelezi, *Health Status*, S. AFR. HEALTH REV. 27 (1995).

22. NADASEN, *supra* note 8, at 24 (citing Dingie von Rensburg et al., *Health and Development*, S. AFR. HEALTH REV. 17, 17 (1997)).

23. 1996 (4) S. Afr. L. Rep. 671 (CC).

24. 1998 (1) S. Afr. L. Rep. 765 (CC).

25. See e.g., NIG. CONST. (1979) §§ 17(3)(c) & (d). These sections provide that the State shall direct its policies towards ensuring that "the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused," and that "there are adequate medical and health facilities for all persons." These provisions are made non-justiciable before the courts by § 6(C) of the Constitution.

26. See Hon. Justice P.N. Bhagwati, *The Role of the Judiciary in the Democratic Process: Balancing Activism and Judicial Restraint*, 18 COMMW. LAW BULL. 1262 (1992). The liberal vision of the Indian Supreme Court under Bhagwati in interpreting non-justiciable rights liberally has inspired a series of high-level judicial colloquia under the auspices of the Commonwealth Office in London. In 1988, the Commonwealth Office organized a judicial colloquium in Bangalore, India, which led to the adoption of

Nadasen's analysis demonstrates that South Africa, like other developing countries, is caught in the conundrum of trying to advance ambitious notions of health within the context of poverty and underdevelopment. As with other countries, the conundrum has led South Africa to limit the justiciability of the right to health, making this right a frustrating amalgam of hard and soft law that continues to be difficult to develop.

## II. PUBLIC HEALTH DELIVERY: THE INSTITUTIONAL SETTING IN SOUTH AFRICA

The distribution and delivery of health services in countries with federal governments entail devolution of responsibilities between the central government and provincial and local units. Nadasen discusses the devolution of public health responsibilities between the South African central government and the provinces in Chapter 2 and thus provides insights into the structural challenges health promotion and protection faces in South Africa.

The functions of the federal South African Department of Health enumerated in § 14(1)(a) of the Health Act 63 of 1977 (Health Act) are numerous. They include, among others, the promotion of a safe and healthy environment, promotion of family planning, and provision of additional health services necessary to establish a comprehensive health service for the population of South Africa with due regard for health services provided by provincial and local authorities.<sup>27</sup> At the national level, the Mental Health and Substance Abuse Directorate has varied functions, including the evaluation of mental health problems and promotion of strategies to address identified problems, promotion of inter-sectoral co-ordination, collaboration with traditional healers, and evaluation of legislation relating to mental health and substance abuse.<sup>28</sup>

Sections 16(1)(a)-(i) of the Health Act provide for the functions of the provincial governments with respect to health services. Nadasen argues that

---

the famous "Bangalore Principles." See *Developing Human Rights Jurisprudence: The Domestic Application of International Human Rights Norms (Judicial Colloquium held in Bangalore, India, 24-28 February 1988)* (Commonwealth Secretariat: London, 1988). In 1989, the "Bangalore Principles" were affirmed in Harare, Zimbabwe; re-affirmed in Banjul, Gambia in 1990; confirmed in Abuja, Nigeria in 1991, and re-visited in two subsequent colloquia in Oxford, UK and Bloemfontein, South Africa in 1992 and 1993 respectively. For a discussion of these judicial colloquia, see The Hon. Justice Michael D. Kirby, *The Bangalore Principles in the Domestic Application of International Human Rights Norms*, 14 *COMMW. LAW BULL.* 1196 (1988).

27. See NADASEN, *supra* note 8, at 25-26.

28. See *id.* at 26-27.

the Health Transformation White Paper is more far-reaching than § 16 of the Health Act in terms of the responsibilities given to provincial health authorities.<sup>29</sup> These far-reaching provisions are to be based on “the principles of primary health care.”<sup>30</sup> Provincial responsibilities envisioned by the Health Transformation White Paper cover communicable diseases, planning, co-ordination and supervision, monitoring and evaluation of mental health services, health promotion, and international health.<sup>31</sup>

Sections 20(1)(a)-(d) of the Health Act provide for the functions of local authorities. These include, among others, maintenance of hygiene; prevention of nuisance, unhygienic, or any other condition(s) which could be harmful to the health of any person; prevention of pollution of any water intended for use by inhabitants of the district; and the purification of any polluted water.<sup>32</sup> Subject to certain provisos, district governments shall render primary health services that are approved by the federal Minister of Health for the prevention of communicable diseases, health promotion, rehabilitation of persons cured of medical conditions, treatment of injuries and diseases normally treated by general practitioners, and provision of essential medicines.<sup>33</sup> Nadasen notes the innovation of the creation of a district health system that must strive to meet twelve principles. These principles include overcoming fragmentation, equity, comprehensive services, effectiveness, efficiency, quality, access to services, local accountability, community participation, decentralization, developmental and intersectoral approach, and sustainability.<sup>34</sup>

Disparities in socio-economic conditions exist, however, among provinces, making uniform health governance in South Africa difficult at the district levels. Consequently, experts have suggested three governance approaches: (1) the provincial option, in which the province is responsible for all district health services; (2) the statutory district health authority option, in which the province, through legislation, creates a district health authority for each district; and (3) the local government option in which a local community is responsible for all district health services.<sup>35</sup> Nadasen emphasizes that critical and equitable resource allocation decisions and interventions at the provincial and district levels influence health delivery in the larger federal system. He

---

29. *Id.* at 27.

30. *Id.*

31. *Id.* at 28.

32. *Id.* at 29.

33. *Id.*

34. *Id.*

35. *Id.* at 30.



notes that the implementation strategies for these governance options include “the position whereby a district will serve both as a provider and purchaser of health.”<sup>36</sup>

In addition to the Health Act, a host of other statutes affect health directly in South Africa. These statutes often create bodies with jurisdiction over a wide range of public health issues. These bodies include the South African Pharmacy Council; Health Professions Council of South Africa; the Chiropractors, Homeopaths and Allied Health Service Professions Interim Council; the South African Nursing Council; Agricultural Research Council; Council for Medical Schemes; and the South African Medicines and Medical Services Regulatory Authority.<sup>37</sup> Others include the Advisory Council for Occupational Health and Safety; South African Sports Commission; South African Council for Non-Proliferation of Weapons of Mass Destruction; Liquor Boards; National Air Pollution Advisory Committee; Compensation Board; Mine Health and Safety Council; Executive Council for the Genetically Modified Organisms; National Home Builders Registration Council; Policy Council for Academic Health Centres; Drug Advisory Board; and the National Development Agency.<sup>38</sup> This list of statutory bodies indicates how broadly health promotion and protection cuts across governance areas in South Africa, adding to the complexity created by the federal system of government.

Nadasen’s analysis of the federal structure and statutory complexity in South Africa demonstrates how multifaceted public health is as a governance challenge. South Africa is not unusual in reflecting this fact because developed countries, such as the United States, also present a system of public health law that is complex structurally and substantively.<sup>39</sup> As a developing country trying to deal with the awful legacy of *apartheid* and the mounting pressures of globalization, the structural and statutory framework of public health law in South Africa complicates its efforts to protect and promote public health.

### III. ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE AND PUBLIC HEALTH IN SOUTH AFRICA

In an era of globalization marked by liberalization of global trade rules, the

---

36. *Id.*

37. *Id.* at 31-32.

38. *Id.* at 32.

39. *See, e.g.*, LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2000) (analyzing public health law in the United States).

difficult question of alternative therapies has engaged scholars of international public health because the cost of Western medicine is often beyond the reach of populations in most of the developing world. Fidler has argued that globalization will likely affect populations in developing countries by destroying traditional medicine and simultaneously doing little to place Western medicine within their reach.<sup>40</sup> Is there an escape from the double jeopardy of globalization's potential destruction of traditional medicine and its placing of Western medicine beyond the reach of many in the developing world?

Nadasen argues that complementary therapies are "those which can work alongside and in conjunction with orthodox medical treatment. Alternative therapies are seen as those which are given in place of orthodox medical treatment."<sup>41</sup> Against the background of WHO's description of all forms of health-care provisions that usually lie outside the official health sector, Nadasen states that alternative therapies would include, among others, "formalised traditional systems of medicine, traditional healers, biofeedback, chiropractic, naturopathy, osteopathy, homeopathy, acupuncture, aromatherapy, crystal therapy, healing, herbalism, hypnotherapy, iridology, kinesiology, massage, radionics, reflexology and shiatsu."<sup>42</sup>

Lack of affordable access to Western medicines and medical technologies makes it necessary that developing countries create an effective legal and socio-political framework to encourage alternative therapies and to integrate them with orthodox medical treatment. South Africa has enacted statutes that regulate "complementary medicine."<sup>43</sup> Section 1 of the South African Medicines and Medical Devices Regulatory Authority Act defines "complementary medicine" elaborately as any substance or mixture of substances, which:

- (a) originates from a plant, mineral, or animal, and which may be, but is not limited to, being classified as herbal, homeopathic, ayurvedic or nutritional; and (b) is used, or

---

40. See David P. Fidler, *Neither Science Nor Shamans: Globalization of Markets and Health in the Developing World*, 7 *IND. J. GLOBAL LEGAL STUD.* 191, 219 (1999).

41. NADASEN, *supra* note 8, at 32 (citing BRITISH MEDICAL ASSOCIATION, *COMPLEMENTARY MEDICINE: NEW APPROACH TO GOOD PRACTICE* 6-7 (1993)).

42. *Id.* (adopting the views of the contributors in *SOC. OF HEALTH AND ILLNESS* (Dr. Carol Allais ed., 1995)).

43. Chiropractors, Homeopaths and Allied Health Service Professions Act 63 of 1982; South African Medicines and Medical Devices Regulatory Authority Act 132 of 1998.

intended to be used for, or manufactured, or sold for use in, or purported to be useful in, complementing the healing power of a human or animal body or for which there is a claim regarding its effect in complementing the healing power of a human or animal body in the treatment, modification, alleviation or prevention of disease, abnormal physical or mental state or the symptoms thereof in a human being or animal; and (c) is used in, but not limited to, the disciplines of Western herbal, African traditional, traditional Chinese, Homeopathy, Ayurveda, Unani, Antroposophy, Aromatherapy and Nutritional supplementation . . . .<sup>44</sup>

South Africa's legislation on alternative medicine suggests that the government recognizes the need both to respect traditional medicine and to regulate it. Whether the legal framework South Africa has established adequately deals with the problems developing countries have with melding traditional and Western approaches to health remains, however, to be seen.

#### IV. PUBLIC HEALTH LAW: ITS MEANING AND PARAMETERS IN SOUTH AFRICA

Scholarly efforts to define public health law raise the same difficult questions as efforts to define health itself.<sup>45</sup> Because health promotion and health determinants vindicate a broad view of health, Nadasen argues that public health law can be perceived from two vantage points: within the context of law *stricto sensu*, and as a strategy to protect and promote public health.<sup>46</sup> One popular usage in public health literature, which links the legal context and the health promotion strategy is the phrase "health legislation." A scholarly view that articulates the meaning of "health legislation," has been expressed by Jayasuria as "a wide range of laws dealing with quality of life issues affecting health and welfare."<sup>47</sup> These laws have as their primary concern the

---

44. NADASEN, *supra* note 8, at 33 (quoting the South African Medicines and Medical Devices Regulatory Act 132 of 1998, §1).

45. Grad states that "the reach of public health law is as broad as the reach of public health itself." Frank P. Grad, *Public Health Law: Its Form, Function, Future and Ethical Parameters*, 49 INT'L DIG. HEALTH LEGIS. 19, 20 (1998).

46. NADASEN, *supra* note 8, at 52.

47. *Id.* (citing D.C. Jayasuria, *The Nature and Scope of Health Legislation*, in GLOBAL HEALTH LAW: PROCEEDINGS, SELECTED PAPERS AND RECOMMENDATIONS PRESENTED AT THE INTER-DISCIPLINARY INTERNATIONAL CONFERENCE ON GLOBAL HEALTH LAW 43, 43-44 (Radhakant Nayak ed., 1998) [hereinafter

good or welfare of the public at large. There are about thirty different constituents of such legislation,<sup>48</sup> and these laws perform five major functions: conferring rights, providing protection, promoting health, financing health, and exercising surveillance over the quality of health care.<sup>49</sup> From a strictly legal perspective, Nadasen gives a good summary of definitions of public health law advanced by scholars such as Gostin, Roemer, and Grad. Applying these perspectives to South African jurisprudence dealing with liberal judicial interpretation of the Medicines and Related Substances Control Act of 1965, health emerges as a public good<sup>50</sup> to be advanced by legislation and activist judicial interpretation.<sup>51</sup> These cases notwithstanding, Nadasen adopts the view of Gostin and others that public health law is not contained within specific parameters but rather is as wide and complex as the field of public health itself.<sup>52</sup>

Attempts have been made by a few scholars to earmark the types of laws that come within the generic but fuzzy boundaries of public health law. Roemer refers, for example, to environmental laws prohibiting the dumping of toxic chemicals; laws preventing the spread of diseases; laws controlling drug abuse; laws regulating the quality of health care; laws authorizing programs to provide health services for specific persons (e.g., mothers, children and the elderly); laws on specific diseases and conditions (e.g. heart disease, HIV/AIDS); laws for specific services in various fields (e.g. occupational health, mental health); laws authorizing or providing financing for hospitals; laws regulating the production, import, and export of drugs; laws establishing national health insurance or a national health service; laws setting minimum standards for health personnel and facilities for peer review of the

---

GLOBAL HEALTH LAW]).

48. For an enumeration of these constituents, see NADASEN, *supra* note 8, at 52.

49. *Id.*

50. For a discussion of health as a public good in global health policies, see Lincoln C. Chen *et al.*, *Health as a Global Public Good*, in GLOBAL PUBLIC GOODS: INTERNATIONAL COOPERATION IN THE 21ST CENTURY 284 (Inge Kaul *et al.* eds., 1999) [hereinafter GLOBAL PUBLIC GOODS]. For application of the global public goods concept to infectious disease surveillance, see Mark W. Zacher, *Global Epidemiological Surveillance: International Cooperation to Monitor Infectious Diseases*, in GLOBAL PUBLIC GOODS, *id.*, at 266.

51. Nadasen cites the cases of *Administrator, Cape v. Raats Rontgen & Vermuelen (Ppty) Ltd*, 1992 (1) S. Afr. L. Rep. 245 (A) (Kreigler, AJA held that the Act has the aim of protecting the entire citizenry); *Mistry v. Interim Medical and Dental Council of South Africa and Others*, 1998 (4) S. Afr. L. Rep. 1127 (CC) (Sachs, J. held that the purpose of the Act was manifestly beneficent); *Reitzer Pharmaceuticals (Pt) Ltd. v. Registrar of Medicines*, 1998 (4) S. Afr. L. Rep. 660 (TPD) 691 1-J (De Villiers, J. held that Minister of Health and Registrar of Medicines were public authorities charged with the duty of promoting and protecting public interest, through the mechanisms of the Act).

52. NADASEN, *supra* note 8, at 56.

quality of health care; and laws directed at controlling malpractice.<sup>53</sup> Nadasen commendably shows how a compendium of South African statutes sketches the boundaries of public health by creating linkages among laws that deal with multifaceted issues that are inexorably connected to public health.<sup>54</sup>

While in keeping with the broad concept of public health that prevails today, the great expanse of laws that Nadasen and others place within “public health law” makes this field of law very difficult to contain for analytical purposes. It almost appears that there is no area of law not connected directly or indirectly with public health. The scope of public health law is one of the things that make it an exciting and important area of jurisprudence, but this scope also poses conceptual and practical challenges that Nadasen’s analysis brings out. More studies like Nadasen’s are needed, particularly in developing country contexts, to bring public health law into better focus because it is such an important aspect of health protection and promotion.

#### V. PROMOTING AND PROTECTING PUBLIC HEALTH AND HUMAN RIGHTS IN SOUTH AFRICA

Like all federal systems, the South African Constitution provides for exclusive, concurrent, and residual legislative competence for the national, provincial, and local authorities. Public health traverses most of the competencies enumerated in each of three legislative jurisdictions. However, the supreme organic and juridical foundation of health promotion in connection with the protection of human rights is the South African Constitution. The vision of the Constitution as the supreme law of the Republic is to, among others, “improve the quality of life of all citizens and to free the potential of each person.”<sup>55</sup> To achieve this vision, Nadasen argues that positive action by the government at all levels is necessary. To address the basic need for health care, water, and social security, §27 of the Constitution provides:

---

53. See *id.* (citing Ruth Roemer, *Comparative National Public Health Legislation*, in 3 OXFORD TEXTBOOK OF PUBLIC HEALTH 351 (Roger Detels et al. eds, 1997) [hereinafter OXFORD TEXTBOOK]). See also Derek Yach, *The Emerging Role of Public Health Law in the New Health Policy for the 21st Century*, in GLOBAL HEALTH LAW, *supra* note 48, at 60 (identifying laws relating to food safety, regulation of tobacco advertising and sponsorship, consumer protection measures, violence and injury, ethical practices in medicare and research, regulation of private-sector health care, and safety of pharmaceuticals, as coming within public health law).

54. NADASEN, *supra* note 8, at 57-76.

55. S.AFR. CONST., Preamble (1996).

**Health care, food and social security**

- (1) Everyone has the right to have access to -
  - (a) health care services, including reproductive health care;
  - (b) sufficient food and water; and
  - (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
- (2) The state must take all reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
- (3) No one may be refused emergency medical treatment.<sup>56</sup>

Section 27 has been the subject of judicial interpretation in the *Soobramoney* case.<sup>57</sup> Like other human rights, the right to health is not absolute and limitless. Judicial interpretation of rights, as Combrink J. at the court of first instance in the *Soobramoney* case stated, involves a delicate balancing of individual rights with the rights of others. The difficult question of determining who in a pool of patients with comparatively similar medical conditions gets priority in the allocation of scarce and limited medical resources poses a challenge to all governmental organs. What criteria should the courts use to decide such priorities when they are confronted with the interpretation of constitutional provisions that guarantee a right to health?

In the *Soobramoney* case, Sachs J. of the South African Constitutional Court held that:

[T]he provisions of the bill of rights should furthermore not be interpreted in a way which results in Courts feeling themselves unduly pressurised by the fear of gambling with the lives of claimants into ordering hospitals to furnish the most expensive and improbable procedures, thereby diverting scarce medical resources and prejudicing the claims of others.<sup>58</sup>

**Other difficult questions that arise from judicial interpretation of § 27 of**

---

56. *Id.* at § 27.

57. *Soobramoney v. Minister of Health, KwaZulu-Natal*, 1998 (1) S. Afr. L. Rep. 765 (CC).

58. NADASEN, *supra* note 8, at 82 (quoting *Soobramoney*, 1998 (1) S. Afr. L. Rep. 765 (CC) 784E-F).

the Constitution include access to emergency medical treatment<sup>59</sup> and resource allocation. The wording of § 27 of the Constitution raises the same type of issues that trouble right to health discourse in international human rights law: justiciability, sufficiency, and allocation of resources.<sup>60</sup> To resolve these difficult issues, Nadasen paraphrases Sachs, J. in *Soobramoney* by referring to guidelines drawn and applied by the province of KwaZulu-Natal, which accorded with those drawn by the Department of Health of the national government.<sup>61</sup> The primary requirement for admission into the renal program (the subject of contention in *Soobramoney*) was eligibility for renal transplantation, which was determined using specific medical, psychological, and social criteria as well as factors related to the patient's personal circumstances.<sup>62</sup> Adherence to these guidelines ensured that more patients benefitted and that the outcome of the treatment was more beneficial. If every person was admitted for treatment, this not only endangered those patients who complied with the guidelines, it could also jeopardize the entire renal treatment program. Applying the guidelines to *Soobramoney*, Combrink, J. at the court of first instance held:

In the present case there is nothing to suggest to me that the applicant has been unfairly discriminated against or that unreasonable criteria have been applied in deciding whether he should receive the haemodialysis or not. The guidelines referred to are of application throughout South Africa and

---

59. In *Soobramoney*, Combrink J. held that § 27(3) "does not create a right to emergency medical treatment . . . . It prohibits anyone from refusing emergency medical treatment." 1998 (1) S. Afr. L. Rep. 430 (D&CLD) 439G-H. Section 27(3) means that "'emergency medical treatment' is possible and available." NADASEN, *supra* note 8, at 83. It does not mean that persons who need such treatment shall receive them irrespective of their costs and availability. *Id.* See also Chaskalson P. holding that the purpose of § 27(3) "seems to be to ensure that treatment is given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities. A person who suffers a sudden catastrophe which calls for immediate medical attention should not be refused ambulance or other emergency services which are available and should not be turned away from a hospital which is able to provide the necessary treatment. What the section requires is that remedial treatment that is necessary and available be given immediately to avert that harm." *Soobramoney*, 1998 (1) S. Afr. L. Rep. 765 (CC) 767E-F.

60. See Virginia A. Leary, *Justiciability and Beyond: Complaint Procedures and the Right to Health*, 55 REV. OF THE INT'L COMMISSION OF JURISTS 1 (1995); David P. Fidler, *International Law and Global Public Health*, 48 U. KAN. L. REV. 1 (1999); Brigit Toebes, *Towards an Improved Understanding of the International Human Right to Health*, 21 HUM. RTS. Q. 661 (1999); Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 53 (1994); Makau Mutua, *Looking Past the Human Rights Committee: An Argument for De-Marginalizing Enforcement*, 4 BUFF. HUM. RTS. L. REV. 211 (1998).

61. NADASEN, *supra* note 8, at 82.

62. *Id.* at 82-83 (citing "Annexure A" affidavit of Sarladevi Naicker of the pleadings in *Soobramoney*, 1998 (1) S. Afr. L. Rep. 765 (CC)).

have been formulated on sound medical grounds. It is indisputable that the applicant cannot be cured by receiving the treatment though his life may be prolonged. It is equally so that there are other patients who may be cured by receiving the treatment.<sup>63</sup>

One lesson from this judicial view as well as Nadasen's analysis is that the application of guidelines on access to health care by South African government agencies and courts must be reasonably fair and non-discriminatory.

Connected to the synergy that exists between the promotion of health and the protection of human rights is the right to a healthy environment in the South African Constitution. Section 24 of the Constitution provides:

Every one has the right

(a) to an environment that is not harmful to their health or well-being; and

(b) to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that -

(i) prevent pollution and ecological degradation

(ii) promote conservation; and

(iii) secure economically sustainable development and use of natural resources while promoting justifiable economic and social development.<sup>64</sup>

Again, these environmental rights provisions, which also raise difficult questions in international environmental law,<sup>65</sup> have been the subject of

---

63. *Id.* at 83 (quoting *Soobramoney*, 1998 (1) S. Afr. L. Rep. 430(D) 438D-F).

64. S. AFR. CONST., § 24 (1996).

65. See ALEXANDRE KISS & DINAH SHELTON, INTERNATIONAL ENVIRONMENTAL LAW 173 (1st ed. Supp. 1994) (stating that the right to a healthy environment has continued to generate debate and contradictory developments). See generally Katrina Tomasevki, *Environmental Rights*, in ECONOMIC, SOCIAL AND CULTURAL RIGHTS 257 (Asbjorn Eide et al. eds., 1995); Dinah Shelton, *Human Rights, Environmental Rights, and the Right to Environment*, 28 STAN. J. INT'L L. 103 (1991); Alastair T. Ples, *Health and Environment: A Human Rights Agenda for the Future*, 2 HEALTH & HUM. RTS. 46 (1996); Melissa Thorne, *Establishing the Environment as a Human Right*, 19 DENV. J. INT'L L. & POL'Y (Winter 1991); J.T. McClymonds, *The Human Right to a Healthy Environment: An International Legal Perspective*, 37 N.Y.L. SCH. L. REV. 583 (1992). See also Obijiofor Aginam, *Two Sides of a Coin: Human Rights and Multinational Oil Investment in Africa: The Case of Nigeria*, AFR. LEGAL AID Q. 23 (Jan.-Mar. 2000) (discussing Article 24 of the African Charter of Human & Peoples Rights 1981, which provides for



judicial interpretation in South Africa.<sup>66</sup> In *Director: Mineral Development Gauteng Region v. Save the Vaal Environment*, Olivier, J.A. held that the South African Constitution requires that environmental considerations be accorded appropriate recognition and respect in the administrative processes of South Africa.<sup>67</sup> In *S v. Mumba*, the court ruled that it was of considerable importance to an open and democratic society that the environment be protected for the benefit of present and future generations.<sup>68</sup>

Can the enjoyment of rights be limited on public health grounds? Nadasen discusses this question extensively. Although § 36 of the South African Constitution sets out the grounds that may justify the limiting of rights enumerated in the Bill of Rights, this section does not mention “public health.”<sup>69</sup> But on the authority of South African case law, an avalanche of cases recognizes a multiplicity of public health grounds as valid reasons that would justify limiting rights.<sup>70</sup> Some of these cases expressly recognized the provisions of international and regional human rights instruments that limit the enjoyment of rights.<sup>71</sup> This is in line with the views of leading legal philosophers that rights are almost never absolute and may be limited, but that such limitations should be subject to strict scrutiny.<sup>72</sup>

## VI. INTERNATIONAL LAW AND PUBLIC HEALTH IN SOUTH AFRICA

Historically, international law has played a significant role in shaping public health issues, including infectious disease surveillance, health and human rights, food safety, and trade in narcotics and illicit drugs.<sup>73</sup> Nadasen

---

a right to environment, and the problems of its enforcement).

66. NADASEN, *supra* note 8, at 88-90 (reviewing *Van Huysteen v. Minister of Environmental Affairs and Tourism*, 1996 (1) S. Afr. L. Rep. 283 (C) and *Hekpoort Environmental Preservation Society v. Minister of Land Affairs*, 1998 (1) S. Afr. L. Rep. 349 (CC)).

67. 1999 (2) S. Afr. L. Rep. 709 (Supreme Court of Appeal).

68. 1997 (1) S. Afr. L. Rep. 854 (W) (*cited in* NADASEN, *supra* note 8, at 91).

69. S. AFR. CONST. § 36 (1996).

70. NADASEN, *supra* note 8, at 91-96.

71. *Id.* at 91. In *ANC (Border Branch) v. Chairman, Council of State, Ciskei* 1994 (1) BCLR 145 (Ck) the court noted that Article 5(1)(e) of the European Convention for the Protection of Human Rights and Fundamental Freedoms, November 4, 1950, 213 U.N.T.S. 222, provides six valid reasons (mainly public health reasons) for the limitation of enjoyment of the rights enumerated in the convention. These include lawful detention of persons to prevent the spread of infectious diseases, persons of unsound minds, alcoholics, drug addicts, or vagrants.

72. Ronald Dworkin, a leading American legal philosopher, belongs to this school of thought. See generally RONALD DWORIN, *TAKING RIGHTS SERIOUSLY* (1977). For a discussion of cases in which South African courts have applied strict scrutiny where rights have been infringed for public health reasons, see NADASEN, *supra* note 8, at 91-96.

73. See DAVID P. FIDLER, *INTERNATIONAL LAW AND PUBLIC HEALTH: MATERIALS ON AND ANALYSIS*

recognizes the role international law plays in the protection of public health. His analysis focuses mainly on the interaction of public health and international human rights treaties and conventions. Nadasen presents this interaction thus: international human rights law contributes to public health, but public health measures sometimes limit the enjoyment of human rights.<sup>74</sup> This dynamic in international law also connects to Nadasen's discussion of the right to health in the South African Constitution. Nadasen gives a good summary of the human rights approach to international protection of public health because he highlights both international legally binding and soft-law mechanisms.<sup>75</sup>

In addition to the emphasis on international human rights law, Nadasen gives a brief overview of the origins of public health multilateralism through the international sanitary conferences of the nineteenth century, which led to adoption of treaties that were the precursors of the present WHO's International Health Regulations (IHR).<sup>76</sup> The IHR are a regulatory tool for cross-boundary communicable disease prevention and control. The fundamental principle of the IHR is to ensure "maximum security against the international spread of diseases with a minimum interference with world traffic."<sup>77</sup> To achieve this purpose, WHO Member States must notify the Organization of any outbreak of cholera, plague, or yellow fever in their territories.<sup>78</sup> WHO Member States must also follow measures contained in the IHR during outbreaks to avoid unnecessary trade and economic embargoes that cannot be justified on scientific and public health grounds.<sup>79</sup>

---

OF GLOBAL HEALTH JURISPRUDENCE (2000) (analyzing the many areas of international law important to public health).

74. For instance, see Article 12(3) of the International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171, which provide that the right to liberty and freedom of movement may be limited for public health reasons. For similar restrictions, see also Article 10(2) of the United Nations Convention on the Rights of the Child, Nov. 20, 1989, 28 I.L.M. 1456 (1989).

75. NADASEN, *supra* note 8, at 97-110.

76. See WORLD HEALTH ORGANIZATION, INTERNATIONAL HEALTH REGULATIONS (1969) (3d ed. 1983) [hereinafter IHR]. For a detailed discussion of public health diplomacy and international sanitary conferences of the nineteenth century, see David P. Fidler, INTERNATIONAL LAW AND INFECTIOUS DISEASES 21-57 (1999); Sev S. Fluss, *International Public Health Law: An Overview*, in OXFORD TEXTBOOK, *supra* note 54, at 371; NORMAN HOWARD-JONES, THE SCIENTIFIC BACKGROUND OF THE INTERNATIONAL SANITARY CONFERENCES 1851-1938 (1975); NEVILLE M. GOODMAN, INTERNATIONAL HEALTH ORGANIZATIONS AND THEIR WORK (2d ed. 1971).

77. IHR, *supra* note 72, at 5.

78. *Id.* at Articles 1-2.

79. *Id.* at Articles 2-15. Note that enforcing the IHR has proved problematic for the WHO over the years. The IHR has been critiqued as virtually a "sleeping treaty," and its fundamental principle of "maximum security against the international spread of diseases with a minimum interference with world traffic" is now seriously questionable. IHR, *supra* note 72, at 5. See also FIDLER, *supra* note 72, at 58-80;

Nadasen's analysis of international law and public health reinforces in the South African context the importance of international law to the promotion and protection of health. This recognition stands in contrast to the historical neglect of international law as an instrument of public health.

## VII. ENFORCEMENT MECHANISMS AND PUBLIC HEALTH IN SOUTH AFRICA

Nadasen concludes his treatise with analysis of enforcement mechanisms for the promotion and protection of public health in South Africa. Here, he notes the dichotomy between criminal<sup>80</sup> and civil sanctions. For statutes that criminalize certain acts detrimental to public health, the state/prosecutor is always required to prove *mens rea*: the mental element that the accused intended wilfully to commit the act. It is noteworthy that in a long list of cases from other jurisdictions, the requirement of *mens rea* is no longer required where the statute creating the offense makes a provision for absolute or strict liability.<sup>81</sup> The trend in South Africa, as Kentridge A.J. of the Constitutional Court pointed out in *S v. Coetzee*, is that "it is in each case a matter of legislative policy."<sup>82</sup> Thus, the Court construes statutory provisions to ascertain if the statute permits the accused to establish a defense of due diligence, or if an absolute liability is intended.

A host of other statutes provide for civil sanctions for acts harmful to public health. These include the confiscation and destruction of articles under the Foodstuffs, Cosmetics, and Disinfectants Act; imposition of embargo under the Hazardous Substances Act; compliance with by-laws, regulations, and town planning schemes under the Town Planning Ordinance; and the search and seizure powers of inspectors under the Atmospheric Pollution Prevention Act.<sup>83</sup> Other civil sanctions involve the control and abatement of

---

David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. 771 (1997); David P. Fidler, *The Future of the World Health Organization: What Role for International Law?* 31 VAND. J. TRANSNAT'L L. 1079 (1998); Allyn L. Taylor, *Controlling the Global Spread of Infectious Diseases: Toward a Reinforced Role for the International Health Regulations*, 33 HOUS. L. REV. 1327 (1997).

80. There is a range of South African statutes that criminalize acts and omissions detrimental to public health: the Internal Security Act, National Water Act, Atmospheric Pollution Prevention Act, Natural Scientific Professions Act, Hazardous Substances Act, Foodstuffs, Cosmetics and Disinfectants Act, NADASEN, *supra* note 8, at 111-16.

81. In *S v. Coetzee and Others*, 1997 (3) S. Afr. L. Rep. 527 (CC), Kentridge, AJ of the South African Constitutional Court referred to Canadian and U.S. court decisions on strict or absolute liability. See NADASEN, *supra* note 8, at 116.

82. *Coetzee*, 1997 (3) S. Afr. L. Rep. 527 (CC).

83. NADASEN, *supra* note 8, at 128-37.

nuisance, unhygienic, and offensive conditions under the Health Act, and licensing requirements pursuant to a range of statutes for pharmacy, manufacture, importation, sale, and distribution of medicines and medical devices.<sup>84</sup>

### VIII. CONCLUDING THOUGHTS

Although Nadasen asserts in the preface that his treatise is no more than “a *basic introduction to an introduction* into public health law in South Africa,”<sup>85</sup> he has nonetheless filled a gap in legal scholarship, especially with respect to Africa. Legal and public health literature in many countries have lacunae because lawyers and public health experts have not forged an intellectual alliance. Regrettably, the result has been a segmented approach to public health issues rather than interdisciplinary and intersectoral approaches. Lawyers and doctors may not be the best of friends, but their respective professional callings and research/policy agendas require a collaborative entente on public health issues both nationally and globally. Epidemiology and law may be two sides of a coin, but they are nonetheless inexorably linked, and thus need urgently to engage each other to forge an effective cross-fertilization of ideas.

Nadasen realized this from the outset of his book when he stated in the preface that “[p]ublic health law is neither the sole preserve of lawyers nor that of public health providers and specialists. In its role as a public health strategy and as a vehicle to promote human rights, public health law emerges as part of intersectoral efforts to advance and promote the public[’s] health.”<sup>86</sup> *Public Health Law in South Africa* is not only mandatory reading for scholars interested in the interaction of law and public health, but is also a challenge to scholars in many countries (especially in the developing world) to explore similar issues from their respective socio-economic and jurisprudential backgrounds.

---

84. *Id.* at 137-42.

85. NADASEN, *supra* note 8, at v.

86. *Id.*

