Chapter 5

Law Of Contract In Health Service Delivery -Public Sector

5.1 Introduction

In the previous chapter the fundamental principles of the law of contract relating to the delivery of health care services were discussed in some detail. This chapter covers the relevant case law insofar as it involves public sector providers. In the following chapter the same exercise will be conducted with regard to private sector providers.

The question of whether a person enters into a contract with the state in seeking medical services from a public sector health facility is not one that is easily resolved with regard to both policy and law. The nature of the relationship between the patient and the state as a provider of health care services is complicated by the constitutional obligation of the state to achieve the progressive realisation of the right of access to health care services within the available resources. In South Africa, public health services are traditionally the safety net into which all patients can fall, including those

within the private sector who have exhausted their medical scheme benefits or whose membership of a scheme has been terminated for some reason or another. In recent years attempts, such as the introduction of a compulsory package of minimum benefits to be provided by medical schemes, have been made to avoid adverse selection practices by schemes by means of which the risks posed by high cost, high risk health problems such as those suffered by the elderly or the chronically ill, are effectively transferred to public health facilities. Private funders previously were able to risk rate members and thereby secure for themselves the luxury of dealing only with the comparatively manageable funding risks presented by the relatively young and healthy. There is still, however, the problem of the increasing unaffordability of medical schemes for the significant majority of the population coupled with the hard fact that most people who retire from employment are unable to pay medical scheme contributions from their retirement income despite the fact that this is when they are most in need of funding for medical expenses. From a constitutional perspective the state cannot refuse access to health care services to a person who has no alternatives available to them. This is a baseline which materially alters the position of public providers of health care services in relation to their private counterparts. Private health care providers, unlike the state, are not tasked by the Constitution with the progressive realisation of the right of access to health care services within available resources. If there is an obligation upon the state to provide health care services to those who have nowhere else to go the next policy question is whether it should do so also for those who have. In other words should the state with its limited resources also provide medical treatment to medical scheme patients and others who are 'externally funded' and if so, on what basis? Since it is difficult in practice for the state to distinguish between medical scheme patients and other externally funded patients from those who are obliged to use public health services, most provinces have adopted a means test as a way of identifying different categories of patients according to their financial status. Many provinces are desirous of attracting externally funded patients as they see them as generators of much needed income for public health establishments. Of late there have been increased moves, including regulations to the Medical Schemes Act[1], to allow medical schemes to designate state facilities as preferred providers of health care services to members so as to increase the numbers

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1 Medical Schemes Act No 131 of 1998

of scheme members that are using state health facilities. The wisdom of this remains to be seen due to certain infrastructural problems of constitutional origin relating to financial management in government. There is also the problem of limited capacity in the public sector. If the latter treats private patients in such volumes that access for the indigent is compromised, then the constitutionality of treating private patients who can afford to go elsewhere could become questionable. Although there are many potential problems with the running of public hospitals as businesses the question of whether public hospitals owned by provincial governments may make a 'profit' and retain the revenue they generate to improve their services, resources and facilities rather than paying it into the provincial revenue fund is one of the most obvious at this stage. Legislation such as the Public Finance Management Act, read in conjunction with the Constitution,[2] is problematic when it comes to the creation of trading

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2 Act No 1 of 1999 read with Section 213 of the Constitution which stipulates:
(1) There is a National Revenue Fund into which all money received by the national government must be paid, except money reasonably excluded by an Act of Parliament.
(2) Money may be withdrawn from the National Revenue Fund only-
(a) in terms of an appropriation by an Act of Parliament; or
(b) as a direct charge against the National Revenue Fund, when it is provided for in the Constitution or an Act of Parliament.
(3) A province's equitable share of revenue raised nationally is a direct charge against the National Revenue Fund.
Section 226 stipulates:
(1) There is a Provincial Revenue Fund for each province into which all money received by the provincial government must be paid, except money reasonably excluded by an Act of Parliament.
(2) Money may be withdrawn from a Provincial Revenue Fund only-
(a) in terms of an appropriation by a provincial Act; or
(b) as a direct charge against the Provincial Revenue Fund, when it is provided for in the Constitution or a provincial Act.
(3) Revenue allocated through a province to local government in that province in terms of section 214 (1), is a direct charge
against that province's Revenue Fund.
(4) National legislation may determine a framework within which-
(a) a provincial Act may in terms of subsection (2) (b) authorise the withdrawal of money as a direct charge against a Provincial Revenue Fund; and
(b) revenue allocated through a province to local government in that province in terms of subsection (3) must be paid to municipalities in the province.
The Public Finance Management Act No 1 of 1999 provision for and regulates various kinds of state or stated owned entities and further elaborates on the principles of government finances laid down in the Constitution. Thus it allows for the creation of national and provincial government business enterprises. The Act defines 'national government business enterprise' as an entity which (a) is a juristic person under the ownership control of the national executive; (b) has been assigned financial and operational authority to carry on a business activity; (c) as its principal business, provides goods or services in accordance with ordinary business principles; and (d) is financed fully or substantially from sources other than (i) the National Revenue Fund; or (ii) by way of a tax, levy or other statutory money". The definition of a provincial government business enterprise is similar. There is also provision for national and provincial public entities. 'Provincial public entity' is defined in the Act as (a) a provincial government business enterprise; or (b) a board, commission, company, corporation, fund or other entity (other than a provincial government business enterprise) which is (i) established in terms of legislation or a provincial constitution; (ii) fully or substantially funded either from a Provincial Revenue Fund or by way of a tax, levy or other money imposed in terms of legislation; and (iii) accountable to a provincial legislature. Under section 13 of the Public Finance Management Act, with relatively few exceptions none of which are relevant to the present discussion, all money received by the national government must be paid into the National Revenue Fund. Section 22 of the Act contains a similar stipulation with respect to provincial governments and Provincial Revenue Funds. Regulation 15.5 of the Treasury regulations under the Public Finance Management Act stipulate that all revenue received by a department must be paid daily into its Paymaster-General account or, for amounts less than R500, as soon as practicable, but at least by the last working day of the month. No provincial department may receive a transfer payment from a national department or public entity directly; such funds must be deposited into the nominated banking account of the province as required by paragraph 15.2.3.Money collected by a department, which is not classified as revenue, must be paid into the department's Paymaster-General account and accounted for in its ledger. This includes money received for agency services provided to another department. Regulation 15.3.2 stipulates that

accounts and other mechanisms whereby health departments of provincial governments can generate and use funds that do not form part of their equitable share raised nationally to fulfil their constitutional obligations[3]. Although these obstacles are not peculiar to a contractual relationship between public provider and patient since they would be applicable to funds generated in other ways as well, the contractual relationship more than any other is associated with the idea of trade and commerce and what in administrative law might be termed the managerialistic approach to public health administration. The existence of a *contractual* relationship between patient and public provider, more than any other would promote the notion that the state is 'selling' health care goods and services and patients are 'purchasing' them creating a wealth of completely different legal and social implications for and perceptions of the relationship between the public provider and the patient and possibly even casting the public provider in the same light as the private provider of health care services to a much greater extent.[4] It must be stated at the outset, however, that a contractual relationship does not necessarily imply a commercial objective. This would depend upon the government policy behind the promotion of a specifically contractual relationship as opposed to any other kind (i.e. the intention of the parties). There may be many reasons for preferring a contractual relationship as the basis for a public provider-patient relationship that are not related to revenue generation or profit. One of these might be to empower consumers to play a more active role in ensuring

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money deposited into the Paymaster-General account must immediately be available to the relevant treasury for funding expenditure or investment according to its central cash management responsibilities.

3 According to section 227 of the Constitution -

(1) Local government and each province-

(a) is entitled to an equitable share of revenue raised nationally to enable it to provide basic services and perform the functions allocated to it; and

(b) may receive other allocations from national government revenue, either conditionally or unconditionally.

(2) Additional revenue raised by provinces or municipalities may not be deducted from their share of revenue raised nationally, or from other allocations made to them out of national government revenue. Equally, there is no obligation on the national government to compensate provinces or municipalities that do not raise revenue commensurate with their fiscal capacity and tax base.

(3) A province's equitable share of revenue raised nationally must be transferred to the province promptly and without deduction, except when the transfer has been stopped in terms of section 216.

(4) A province must provide for itself any resources that it requires, in terms of a provision of its provincial constitution, that are additional to its requirements envisaged in the Constitution.

4 See Burns Y 'Government Contracts and the Public/Private Law Divide' 1998 *SA Public Law* 13 p 234 where she observes that one of the significant changes to American administrative law as a result of the increasing privatisation of state functions if a market discourse which narrows the role of public interest values and replaces them with that of cost-benefit analysis. She notes that the cumulative effect of a market approach to regulation, regulatory structure and procedures is to introduce a new mix of public and private power. In South African law this would have considerable implications for state operations in ways that are not at obvious at first - for instance in the context of competition law. The Competition Act No 89 of 1998 applies to all economic activity within, or having an effect within, the Republic except collective bargaining in the labour relations context and significantly for purposes of the present discussion "concerted conduct designed to achieve a non-commercial socio-economic objective or similar purpose." The State is not per se exempt from the provisions of the Competition Act. The national government and the provincial governments and municipalities are not a single entity but may well be seen under the Competition Act as 'firms' in their own right. The definition of 'firm' in the Competition Act is disturbingly vague In terms of section 1'firm' "includes a person, partnership or a trust."

they receive services of an appropriate and acceptable standard, another may be to foster a culture of competitive service provision between public health establishments for the benefit of patients. When a public provider provides health care services in its capacity as part of the executive branch of government as opposed to a capacity which is much closer to that of an ordinary private sector supplier of the same services, the dynamic has the potential to change quite considerably as illustrated later on in this section by experience in New Zealand.

As the dynamics of state operations change so too do the legal considerations governing them. Burns[5] points out that if one accepts that an outsourcing contract, or service provision contract, is an administrative law agreement in the sense that the administrative authority retains a measure of state authority with the result that the relationship between the state and the other party is one of inequality), it may be argued that the agreement should be subject to principles of public law. The same is true of a contractual relationship in terms of which the state provides services such as health care. As was noted in the previous section on administrative law, the stage is already set, at least to some extent, in South African law for the application of administrative law to contractual relationships even where both parties to the contract are private entities. In terms of section 3 of the Promotion of Administrative Justice Act (PAJA)[6], "administrative action" means any decision taken, or any failure to take a decision, by *inter alia* a natural or juristic person, other than an organ of state, when exercising a public power or performing a public function in terms of an empowering provision which adversely affects the rights of any person and which has a direct, external legal effect. It is submitted that the careful boundaries that were previously drawn between public and private law, and different areas of law under the previous legal order are becoming transparently thin[7]. This is as much the result of changing

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5 Burns fn 4 *supra*

6 Promotion of Administrative Justice Act No 3 of 2000

7 Cockrell A 'Can you paradigm? – Another perspective on the public/private law divide 1993 *Acta Juridica* p 227 points out that "...the rules of 'private law' are doctrinal artefacts by means of which the state regulates and coerces all civil society and as such might equally qualify to be categorized as a matter of 'public law'. That is to say, the community as a whole has a legitimate interest in the matter in which 'private' transactions are regulated, and this interest goes far beyond the minimalist enforcement of rules to which individuals have given their prior consent. The law of contract provides (ironically enough), the best example of this shift in emphasis. A long tradition in legal scholarship has sought to portray the rules of contract as being no more than the natural expression of the wills of the contracting parties. But this idea was subjected to a process of corrosive critique in the early part of the century by American Realists who sough to show that the real concern of contract law centred on the circumstances in which the sovereign power of the state would be put at the disposal of one party in order to coerce another. Seen in this light, the rules governing contractual liability begin to look remarkably like part of public law" See also Pretorius DM ('The Defence of the Realm: Contract and Natural Justice' 2002 *South African Law Journal* 119 p 374). He notes: "The *audi alteram partem* principle applies

views on how governments and the private sector should operate and interact as it is on the Constitutional legal order. Some of the changes are worldwide. Burns[8] notes that the emphasis on global competition and economic growth coupled with the general weakness of any single individual state in the face of globalization processes encourages more negotiation on the part of the state as well as regulatory approaches more sympathetic to the cost conscious demands of multinational businesses and government as well. It is not so much the nature of the powerbearer as the nature of the power that is to determine which legal principles apply[9]. Burns[10] observes that South African law has not as yet fully recognised the administrative agreement, despite the conclusion of a large number of these agreements. She states that the question is whether these administrative agreements are ordinary commercial contracts, which are subject to the principles of private law and the provisions of the State Liability Act[11] or whether they are subject to separate public law rules. The public sector is increasingly taking on every appearance of private sector style operations while the degree and nature of power that is being increasingly wielded by

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whenever a statute empowers a public body of official to perform an act or to give a decision prejudicially affecting a person in his liberty or property or existing rights, or whenever he has a legitimate expectation that he will be heard before that act is performed or that decision given. It is sometimes asserted that the application of the rules of natural justice is confined to the field of administrative law and, more specifically that the audi principle is not applicable to the exercise of 'purely contractual rights'. However this assertion is fallacious: the twin pillars of natural justice, as Sir William Wade famously declared, are statute and contract" (footnotes omitted). Pretorius observes that: "There is another difficulty with the public power/contractual rights dichotomy. It fails to draw an adequate jurisprudential distinction between powers and rights. It has been suggested that public authorities, like natural and juristic persons, may 'acquire' powers by contract. It has also been said that the act of a public body would be subject to judicial review if the source of the power concerned is statutory but not if the relevant power is derived from contract. Statements of this nature are dogmatically unsound. Public bodies cannot 'acquire' powers from contracts. Public powers are derived from statute, and, in England, also from the prerogative and, in the case of certain incorporated bodies, from their charters. A public body may have a contractual or common-law right to cancel a contract. A distinction must be drawn between a right and the antecedent powers that inhere in the body concerned by virtue of its constituent statute or charter or, in some cases, by virtue of the prerogative. If the body concerned were to exercise its contractual or common-law right to cancel a contract, it would ultimately be acting by virtue of some pre-existing power in much the same way as a company's contractual or common-law right to cancel a contract can only be exercised by virtue of the fact that its incorporation clothed it with juristic personality and conferred upon it the power or capacity to enter into contracts within the scope of its legal capacity, as determined by its memorandum of association. Thus, in Hohfeldian terms, the ability or capacity to conclude contracts is a 'power'; the legally enforceable claims that are derived from contracts are rights" (footnotes omitted)

8 Burns fn 4 *supra*

9 But see Pretorius (fn 7 *supra*) who observes that: "There is another difficulty with the public power/contractual rights dichotomy. It fails to draw an adequate jurisprudential distinction between powers and rights. It has been suggested that public authorities, like natural and juristic persons, may 'acquire' powers by contract. It has also been said that the act of a public body would be subject to judicial review if the source of the power concerned is statutory but not if the relevant power is derived from contract. Statements of this nature are dogmatically unsound. Public bodies cannot 'acquire' powers from contracts. Public powers are derived from statute, and, in England, also from the prerogative and, in the case of certain incorporated bodies, from their charters. A public body may have a contractual or common-law right to cancel a contract. A distinction must be drawn between a right and the antecedent powers that inhere in the body concerned by virtue of its constituent statute or charter or, in some cases, by virtue of the prerogative. If the body concerned were to exercise its contractual or common-law right to cancel a contract, it would ultimately be acting by virtue of some pre-existing power in much the same way as a company's contractual or common-law right to cancel a contract can only be exercised by virtue of the fact that its incorporation clothed it with juristic personality and conferred upon it the power or capacity to enter into contracts within the scope of its legal capacity, as determined by its memorandum of association. Thus, in Hohfeldian terms, the ability or capacity to conclude contracts is a 'power'; the legally enforceable claims that are derived from contracts are rights" (footnotes omitted)

10 Burns fn 4 *supra*

11 State Liability Act No 20 of 1957

major multinational private sector corporations is in many cases greater than that of governments. It is submitted that the boundaries between state and private sector are becoming less distinct in South Africa where there is a comprehensive set of Treasury regulations governing public private partnerships[12]. There are increasing numbers of these partnerships in the area of health services delivery[13]. If the rigid split between public and private law is to be maintained, which branch of law will govern the relationship between a public-private partnership delivering health care services and its patients? One could argue that the definition of public-private partnership is such that the private provider is performing the functions of the public entity – i.e. a public function - and that therefore public law should apply even when it is a private provider that is performing it but this argument loses much of its logical impetus when that same private sector provider, operating outside of the public-private partnership, is delivering exactly the same health care services in a purely private capacity. The nature of the function of health care services delivery is not such that it is a uniquely or even routinely public function as opposed to a private one. The problems that arise with the classification of law into categories of public and private are demonstrated by the judgment of the court in *Cape Metropolitan Council v Metro Inspection Services (Western Cape) CC*[14]. The criticism of this judgment by Pretorius has already been referred to earlier[15]. To briefly recap, Pretorius argues that the court did not take sufficient cognisance of the fact that the contract effected the outsourcing of a public function to a private entity in terms of a statutory authorisation to do so

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12 See Treasury Regulations For Departments, Trading Entities, Constitutional Institutions And Public Entities Government Notice R740 in GG 23463 of 25 May 2002 which define 'public-private partnership' as a commercial transaction between an institution and a private party in terms of which-
(a) the private party either performs an institutional function on behalf of the institution for a specified or indefinite period; or acquires the use of state property for its own commercial purposes for a specified or indefinite period;
(b) the private party receives a benefit for performing the function or by utilising state property, either by way of:
(i) compensation from a revenue fund;
(ii) charges or fees collected by the private party from users or customers of a service provided to them; or
(iii) a combination of such compensation and such charges or fees.

13 A public-private partnership in healthcare, the first of its kind in South Africa, was launched on November 2002 when the Free State health department signed an agreement with Network Healthcare Holdings Limited (Netcare) and its empowerment partner Community Healthcare Holdings for the Pelonomi and Universitas hospitals in Bloemfontein. The partnership involves the use of spare space between the two institutions. In terms of the agreement the Netcare/Community Healthcare Joint Venture consortium manage over 200 private beds and five operating theatres at the two hospitals, which are the largest public hospitals within the Free State. The consortium and its partners will invest R80-million in the project over the next two years. In terms of the agreement, Community Healthcare holds 40% shares of the consortium, Netcare holds 25% and the remaining 35% is held by black empowerment companies and groups consisting of healthcare practitioners, women's groups and other investors.
http://www.safrica.info/ess_info/sa_glance/health/pelonomi.htm. There is also a public-private partnership involving the Inkosi Albert Luthuli Hospital, the R3 billion, 846 bed public hospital in KwaZulu-Natal, where a range of non-clinical functions has been outsourced. The underlying objective is to achieve better service especially in fields where the public sector has not been particularly effective. These include the provision and maintenance of medical technology and information technology (http://www.doh.gov.za/docs/sp/2003/sp0610a.html). See also Thomas A and Hensley M 'Public-Private Partnerships in Healthcare' (http://www.ip3.org/publication2002_013.htm)

14 *Cape Metropolitan Council v Metro Inspection Services (Western Cape)CC and Others* 2001 (3) SA 1013 (SCA)

15 *Pretorius* fn 7 *supra*

and that the purely commercial flavour of the contract was questionable. It is submitted that if one thinks about the law not in terms of compartments of public and private but in terms of the underlying constitutional principles and values upon which it rests then many of these problems can be avoided. Concepts of fairness, reasonableness, *bona fides*, public interest and due process are not unique to public law and the power wielded by some private entities these days exceeds that of the state so it seems illogical to argue that the principles of natural justice, for instance, are applicable only in the public sector because the parties on not on an equal footing and there is a need to recognise this and avoid abuses of power by the state. In many instances in the private sector the parties are also not on an equal footing and there are significant power imbalances against consumers. The courts have used exactly the same arguments when dealing with restraint of trade clauses in employment contracts where the employer and the employee are both private entities. Questions of power imbalances are not unique to the public sector and should therefore be a concern of the law in general as opposed to just 'public law'. The distinctions between administrative action and other kinds of activity are valuable not so much because they seek to categorise actions into areas of public law as opposed to private law but because they identify acts and decisions in a context which significantly weights the power balance in favour of a particular entity and there is thus the potential for equally significant prejudice to those affected by its acts. A statutory power to act in a way that adversely affects the rights of others and which has a 'direct, external legal effect'[16] must therefore be balanced out by considerations of fairness and reasonableness if it is not to be exercised in a way that is offensive to constitutional principles and values and detrimental to the public interest. This is why administrative law has a tendency to be more visible in the public sphere of operation as opposed to the private sphere. Most of the powers exercised in the former are statutory and peculiar to the entity upon whom they are conferred. There is no equivalent or balancing power held by those against whom it is exercised or those who are affected by its exercise. It is submitted that the definition of 'administrative action' in the PAJA supports this argument.

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16 See the definition of administrative action in section 1 of the PAJA referred to previously.

Significantly, whether they are dealing with public or private sector issues, the language of the courts and the considerations they apply to public and private sector relationships are becoming increasingly similar. By way of example, there are a number of fundamental concepts which are being progressively applied within both the private and public spheres in keeping, it is submitted, with the South African constitutional order. They are canvassed briefly below but also come up for discussion elsewhere in this section.

5.2 Case Law

The relevant cases will be canvassed and discussed in this section in order to ground further discussion on the subject of the contractual relationship between public provider and patient in the sections that follow.

The case of *Behr v The Minister of Health*[17] is of relevance to the question of whether the state can contract with a patient for the delivery of health care services although it does not directly deal with the question of the legal basis of the relationship between a public sector provider of health care services and the patient but rather a husband's obligation to maintain his wife.

5.2.1 Behr v Minister of Health

Facts

Behr's wife deserted him after some marital problems. When a reconciliation attempt went awry he shot her. She was admitted to a government hospital in Bulawayo suffering from a severe gunshot wound to the abdomen. The question was whether the husband or wife was responsible for the charges for the medical treatment in view of the fact that she had deserted him previously. As Murray CJ put it, "The present case

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17 *Behr* 1976 (2) SA 891 (T)

concerns a husbands obligation to pay for what is conceded to be a necessary services supplied to his wife."

Judgment

The court remarked that there was a difference between the English law and the Roman-Dutch law as followed in South Africa and Southern Rhodesia in regard to the basis on which a husband's liability to pay for such household necessaries as have been supplied to his wife is founded. It noted that the D*u Preez v Cohen Bros*[18] Wessels J expressed the view that the wife's capacity to bind her husband's credit for necessaries was not a result of the relationship of principal and agent but was an incident necessarily flowing from the mere fact of marriage. After considering other cases the court observed that-

"this legal obligation appears to be clearly established as existing while there is a common household and presumably also where the parties are living apart by mutual consent."

At p 631 of the judgment Murray CJ said that he shared the view that the plaintiff must be held to his particulars as pleaded which placed the claim on the restricted basis that the defendant was liable *qua* husband for the cost of necessary medical attention supplied to his wife. In consequence, it would not be proper, he said, to base the court's decision on various points discussed during the hearing relating to implied authority from Behr, ratification of the supply of services to the wife, whether it was obligatory on the defendant in order to escape liability, to have given notice of desertion prior to the supply of services, to the hospital authorities who had previously in 1958 rendered her hospital treatment for which he had paid them, and whether there was any obligation on him, not as husband, but as the person who had inflicted a serious injury upon her to recompense the hospital authorities for the medical treatment necessary to save her life. The court said rather than the ground for upholding the claim of the Minister of Health was based on the fact that though the wife had been a deserting party until the infliction of the injury upon her, this feature merely suspended the husband's obligation of maintenance as long as the desertion continued. Thereafter if by reason of his wrongful action he either made it impossible

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18 *Du Preez* 1904 T.S. 157

for her to return to the household, or gave her just cause for refusing to do so, his obligation revived. The court said that this was the immediate effect of his infliction of this serious injury upon her.

In his judgment Young J noted that on the hospital admission form the person responsible for the fee was given as Behr and that he at no time disputed liability until a letter of demand was sent to him, whereupon he referred the plaintiff to the wife for payment.

Discussion

As stated previously this case did not revolve so much around the nature of the relationship between the government hospital in Bulawayo and the patient as it did around the relationship of the husband and wife. However, a reading of the judgement indicates that there was a general assumption that the relationship was at least quasi contractual[19] and that the government hospital was regarded in the same light as any other supplier of household necessities. There was talk of the wife's being authorised by her husband to obtain the necessary medical treatment, alternatively, ratification (of the contract for) the supply of services to the wife. There was also some discussion as to whether the husband should have placed a notice in the paper warning potential contractants of his wife's desertion so that they would know she no longer had the power to bind his credit. A husband's duty to provide his wife with the necessaries of life is usually exercised by contracting with the suppliers of those necessaries – hence the debate about the basis of the wife's authority to bind the husband contractually to pay for those necessaries. The fact that the court found that the husband was obliged to pay for the costs of the medical treatment his wife had received on the basis of the duty of maintenance he owed her rather than on the basis of the delictual claim which

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19 Murray CJ observed at p 630: "This legal obligation appears to be clearly established as existing while there is a common household, and presumably also where the parties are living apart by mutual consent. Where, however, the wife has left the home without the husband's consent, the right of a third party to recover from the husband the cost of necessaries supplied to her depends on whether the wife had or had not just cause for leaving the home. If she had such cause, the husband's legal duty to support his wife and provide her with necessaries continues despite the cessation of the joint household, and the tradesman who supplies her with necessaries such as food or clothing, the landlotd who lets her a lodging, the professional man who renders her necessary service, are entitled to recover from the husband. As it is put by Dr. Rubin in his handbook on *Unauthorised Administration* (*negotiorum gestio*) at p 62, the tradesman or landlord or professional man is discharging a legal duty resting upon the husband; he is a *gestor* who has administered the affairs of the *dominus*, i.e., the husband, and is therefore entitled to compensation from him. This is the basis upon which the judgment of Benjamin, J., in *Gammon v McClure*, 1925 CPD 137 at p. 139, is based, and the husband's liability to pay compensation to the gestor was enforced in *Coetzee v Higgins*, 5 E.D.C. 352, a case which has subsequently been referred to with approval (see e.g., *Excell v Douglas*, 1924 CPD 472 at p. 481)."

she clearly had against him is also of relevance since it indirectly supports the notion that the wife bound the husband contractually in exercising her right to obtain necessary medical treatment at his expense. The approach of the government hospital itself seemed to be in the usual contractual context. The admission form required the wife to state who would be responsible for payment of the hospital's fee and when the husband subsequently failed to make such payment, it sent him a letter of demand. The government had clearly regarded the husband as directly contractually obliged to it for the fees for his wife's medical treatment.

The case of *Shiels v Minister of Health* is also supportive of the notion that the public health sector can contract for the delivery of health care services to patients. In this case however, the health services also involved the sale of goods.

5.2.2 Shiels v Minister of Health[20]

Facts

The respondent had obtained judgement in a magistrate's court for the price of an artificial leg which has been manufactured for the appellant at a government institution. The appellant denied liability saying that while he admitted that the respondent had done certain work and manufactured an artificial limb for him it was a specific term of the contract that the limb to be manufactured by the appellant was to be a copy of a limb which had been previously manufactured for him in Glasgow and that it had to be double-articulated at the hip. He said that the limb which had been manufactured by the respondent was not a copy of the limb that had been made in Glasgow because it was not double articulated at the hip. The evidence showed that the making of an artificial leg is a highly skilled task involving a lengthy process of fitting and adaptation on the patient before it is finally completed. There was no question of the patient being able to obtain a ready-made leg to fit him. It emerged that the leg made by the respondent was in fact designed to be an improvement on the leg that had been made in Glasgow. The accounts department of the central hospital sent the appellant an account for the leg once it had been made and adjusted to fit him.

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20 *Shiels* 1974 (3) SA 276 (RAD)

Judgment

The court found that the contract which had eventuated between the appellant and the respondent had not been for a leg the same as the one made in Glasgow. It considered whether the appellant was entitled to summarily reject the leg after a trial of a day or two and refuse to pay the account without affording the respondent the opportunity of adjusting the leg so as to make it fit. The court referred to the case of *Theunissen v Burns*[21] dealing with 'almost identical facts' in which it was held that where a person had ordered three suits from a tailor and had been fitted by the tailor but had complained that they did not fit and refused to pay the bill, the tailor was entitled to a reasonable opportunity to take the suits back and make them fit. As the appellant in that case failed to afford the tailor that opportunity, he could not escape liability for the tailor's account and accordingly his appeal was dismissed. The court also referred to the case of *Kruger v Boltman*[22] involving a contract for the fitting and supply of a set of artificial teeth. The teeth were finished off and sent to the customer who refused to pay the bill because they did not fit properly. In its judgment in that case the court said that unless and until the respondent had been given an opportunity of remodelling the set, his claim for payment on the contract could not be resisted. The court in *Shiels'* case concluded that the principle established in those cases must apply to a contract such the present one involving the highly technical task of constructing an artificial leg and making it fit, particularly in the case of the appellant who, by his own admission was a difficult customer because he had a very short stump. It held that a reasonable opportunity must be afforded after the completed article has been despatched to the customer and that the appellant had not afforded the respondent that reasonable opportunity and that the appeal should be dismissed with costs.

Discussion

The important points to note about this case are that the court made no distinction between suppliers of goods in the private sector and the government as a supplier of goods. The same rules applied to both. It did not question the fact that a contractual

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21 *Theunissen* 21 S.C 421
22 *Kruger* 1933 (1) PH A3

relationship had arisen between the Minister of Health and Shiels. In fact it enforced the contract that it found to have arisen between them. The contract could be said to have been for a combination of sale of goods and for work[23] because it was not only for the manufacture of the leg but also for the fitting of the leg to the appellant. It is therefore not only health care services which may be the subject of a contract between the state and the patient but also goods. This would embrace not only artificial limbs but also *inter alia* medicines, dressings and other consumables, wheelchairs, dentures, spectacles and other assistive devices.

The most recent case to recognise a contractual relationship between a public provider and a patient is that of *Administrator Natal v Edouard*[24]. It is a South African case as opposed to the two that were previously cited which were decided by then Rhodesian courts with reference to South African legal principles.

5.2.3 Administrator, Natal v Edouard[25]

Facts

The respondent's wife was admitted to a provincial hospital for a Caesarian section in order to give birth to their third child. The respondent and his wife requested that a tubal ligation be performed on the wife at the same time as they could not afford to have any more children and the wife wished to be sterilised. The tubal ligation was not in fact performed and one year later the wife gave birth to a fourth child. The respondent sued for damages on the basis of breach of contract including the cost of supporting and maintaining the child born as result of the failure to perform the sterilisation operation, and general damages for the discomfort, pain and suffering and loss of amenities of life suffered by his wife.

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23 In *Smit v Workmen's Compensation Commissioner* 1979 (1) SA 51 (A) the test for the difference between a contract for services (*locatio conduction operarum*) and a contract of work (*locatio conduction operis*) was discussed at length. For further discussion of contracts of sale and contracts of work see *Sifris en 'n Ander, NNO v Vermeulen Broers* 1974 (2) SA 218 (T) (in which the court considered the dividing line between a contract of sale and a contract of work); *BK Tooling (Edms) Bpk v Scope Precision Engineering (Edms) Bpk* 1979 (1) SA 391 (A); *Wed (Pty) Ltd v Pretoria City Council And Others* 1988 (1) SA 746 (A); *Scholtz v Thompson* 1996 (2) SA 409 (C); *Klopper En Andere NNO v Engelbrecht En Andere NNO* 1998 (4) SA 788 (W). See also Van Oosten FFW 'Medical Law – South Africa' *International Encyclopaedia of Laws* Vol 3 Blanpain R (ed)

24 *Administrator Natal v Edouard* 1990 (3) SA 581 (A)

25 *Edouard* fn 24 *supra*

The two issues submitted to the Court for adjudication were whether the Administration was in law obliged, because of its breach of contract, to pay (i) a sum representing the cost to the respondent and Andrae of maintaining and supporting Nicole, and (ii) general damages for the non-patrimonial loss suffered by Andrae. It was agreed that, should the Court find for the respondent on the first issue, an amount of R22 500 was to be awarded, and that an affirmative finding on the second issue would carry an award of R2 500.

Judgment

The court noted that the respondent's claim under consideration was unique only in the sense that it is based upon a complete failure to perform a sterilisation operation. It said that in the wealth of foreign case law of which the court was aware, the plaintiff's action was invariably based upon a failed sterilisation procedure (including a vasectomy), or a failure to warn that the procedure might not be 100% successful or that its effect might be reversible, and, on occasion, the incorrect dispensing of a prescription for birth-control pills. The court stated that in principle the precise nature of the breach of contract or neglect giving rise to the birth of an unwanted child is immaterial. Thus it can make no difference whether the breach of contract consists of a complete failure to carry out the agreed procedure, or of an ineffective surgical intervention. Van Heerden JA then canvassed in detail the various public policy issues surrounding claims for wrongful pregnancy in foreign jurisdictions. They are not canvassed here because they are not relevant in the present context as they are not peculiar to the law of contract but can also be based on the law of delict. The court observed that the claim in *Edouard*[26] was based on the law of contract. Van Heerden JA stated that because of the facts set out in the stated case, as amplified, it was common cause that:

- the respondent suffered damages in the form of child-raising expenses as a result of the breach,
- that such damages were a direct and natural consequence thereof, and
- that the loss was contemplated by the parties as a likely consequence of failure to perform the agreed sterilisation operation, more particularly

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26 *Edouard* fn 24 *supra*

because, to the knowledge of the Administration, the respondent and Andrae could not afford to support any more children.

He pointed out that the claim therefore satisfied all of the requirements of South African law for the recovery of damages flowing from breach of contract. Van Heerden JA noted that in the court *a quo* it was nonetheless contended that the claim should be disallowed because of considerations of policy and expediency but that in the appeal court, counsel for the appellant, correctly, in van Heerden JA's view, did not rely on considerations of expediency. Van Heerden JA expressed agreement with the views of Thirion J in the court a quo on this subject saying that there was in any event in South African law no authority for denying a claim for the recovery of contractual damages merely because it may be expedient to do so[27]. In the appeal against the judgment of Thirion J, however, counsel for the appellant did persist with the contention that the respondent's claim should have been rejected by reason of the dictates of public policy. Van Heerden JA was not as ready as Thirion J to accept the idea that in appropriate circumstances public policy may stand in the way of the recovery of damages for breach of contract where the contract itself is valid. He assumed for the purposes of the case in question that in South African law public policy may require the disallowance of a claim for damages founded upon a breach of a valid and enforceable agreement. The appeal court then proceeded to examine more closely the public policy objections to a claim for wrongful pregnancy which it identified as running along two broad themes - i) that the birth of a normal and healthy child cannot be treated as a wrong against his parents, and (ii) that as a matter of law the birth of such a child is such a blessed event that the benefits flowing from parenthood as a matter of law cancel or outweigh the financial burden brought about by the obligation to maintain the child[28]. The court observed with regard to damages that in South African law intangible loss is in principle awarded only in delict and then, apart from infringements of rights of personality, only in the case of a bodily injury. It said that if patrimonial loss is claimed, the tangible benefits accruing as a result of a breach of contract or the commission of a delict (other than those excluded by an application of the maxim *res inter alios acta*) must be brought into account and that the monetary value of those benefits must be set off against the gross loss. Van

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27 *Edouard* fn 24 *supra* at p 588

28 *Edouard* fn 24 *supra* at p 589

Heerden JA noted that it has, however, never been suggested that benefits of a non-pecuniary nature must also be 'subtracted' from a patrimonial loss nor is there any foundation for such a suggestion in South African law. The court held that the 'wrong' consists not of the unwanted birth as such, but of the prior breach of contract (or delict) which led to the birth of the child and the consequent financial loss. It referred with approval to the Bundesgerichtshof which states that although an unwanted birth cannot as such constitute a 'legal loss' (i.e. a loss recognised by law), the burden of the parents' obligation to maintain the child is indeed a legal loss for which damages may be recovered. The court quoted from a number of American cases in stating its view that public policy did not preclude a claim for contractual damages for an unwanted pregnancy[29]. Counsel for the appellant argued that an inevitable incident of birth is the creation of a legal duty obliging a parent to support the child and that statute law serves to reinforce the duty, eg s 6 of the Divorce Act[30]. He stated that while the pregnancy claim of the respondent was not one by which he sought to be relieved from his obligation to support the child, he did seek to have the Court determine the cost of that support and to obtain an order for recovery of that amount from the appellant. In the result the judgment of the court *a quo* served to transfer from the respondent to the appellant the obligation to maintain the child. He argued that this runs counter to public policy which demands that there be no interference with the sanctity accorded by law to the relationship between parent and child. Van den Heever JA expressed the view that there was a basic fallacy in this submission in that it in no way relieved the respondent (or his wife) from the

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29 *Edouard* fn 24 *supra* at p591-592: In concluding my discussion of the two themes I can do no better than quote the following judicial pronouncements: 'It is not at all that human life or the state of parenthood are inherently injurious; rather it is an unplanned parenthood and an unwanted birth, the cause of which is directly attributable to a physician's negligence, for which the plaintiff' seek compensation. Certainly there are positive aspects to child rearing and enduring benefits to parenthood, but that does not mean, to me, that parents who take measures to prevent the conception of a child should be burdened with all of the expenses that go along with raising that child - expenses that they would not have incurred had it not been for the negligence of another.'[*Cockrum v Baumgartner* 447 NE 2d 385 (1983) at 392-3 (dissent of Clark J)] And: 'I see no reason for departing from the rule that a negligent person is liable for the foreseeable consequences of his negligence. There is no justification for holding, as a matter of law, that the birth of an "unwanted" child is a "blessing". The birth of such a child may be a catastrophe not only for the parents and the child itself, but also for previously born siblings. The doctor whose negligence brings about such an undesired birth should not be allowed to say, "I did you a favour", secure in the knowledge that the Courts will give to this claim the effect of an irrebuttable presumption.' [*Terrell v Garcia* 496 SW 2d 124 1973 at 131 (dissent of Cadena J) And: 'We reject the proposition that as a matter of law and public policy no legally cognisable claim for child rearing damages can ever arise in such cases where the unplanned child is born normal and healthy. That... public policy... may foster the development and preservation of the family relationship does not, in our view, compel the adoption of a *per se* rule denying recovery by parents of child rearing costs from the physician whose negligence has caused their expenditure. In other words, it is not to disparage the value of human life and the societal need for harmonious family units to protect the parents' choice not to have children by recognising child rearing costs as a compensable element of damages in negligent sterilisation cases. We, therefore, decline to follow the majority rule of those jurisdictions which have held that in all cases, without regard to the circumstances, the benefits to the parents from the birth of a healthy child always outweigh child rearing costs and thus result in no injury or damage to the parents.'[*Jones v Malinowski* 473 A 2d 429 at 435 (1984)]

30 Divorce Act 70 of 1979

obligation to support the child. He said that at most it enabled the respondent to fulfil that obligation and that there could thus be no question that the obligation had in law been transferred from the respondent to the appellant.

The court did not allow the respondent's claim for the discomfort, pain and suffering and loss of amenities of life suffered by the child's mother in consequence of her pregnancy and the subsequent birth of the child on the basis of an absence of evidence of any such claim in the old authorities and that South African courts have in later years consistently indicated that only patrimonial loss may be recovered in contract[31].

Discussion

The court *a quo* found that the agreement between the respondent and the appellant was partially in writing in that the respondent and his wife had signed a consent form which stated:

"I, Andrae Edouard, request and hereby consent to the performance of a surgical operation by tubal ligation on myself for the purpose of producing incapability of procreation.... I acknowledge that I am fully aware of and understand the purpose and consequence of the said operation including the fact that permanent sterility in all cases may not result."

It is interesting that the court used the consent form as evidence of the existence of a contractual relationship between the parties because even in the absence of a contractual relationship, it would still be necessary in order to show that the operation had been performed with the informed consent of the patient and in order to preclude

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31 See *Edouard* fn 24 *supra* at p 596. The court noted: "An alternative contention put forward by counsel for the respondent is that there should be an extension of liability for breach of contract so that the innocent party may recover intangible damages, and in any event damages for pain and suffering. On the assumption that a Court has the power, in exceptional cases, to modify or alter our common law, it is hardly necessary to say that there must be compelling reasons for doing so."
It appears that since the middle of the present century English Courts have awarded an innocent party damages even in cases where he did not suffer physical inconvenience as a result of breach of contract. A striking example is to be found in the so-called holiday cases. In these the plaintiff had booked, through a travel agent, a holiday at a hotel. To his chagrin he discovered on arrival that the facilities available at the hotel were significantly inferior to the promised facilities. In consequence he claimed damages from the travel agent. It was held that he could recover an amount in respect of *inter alia* vexation and mental distress. In my view there is no sufficient reason of policy or convenience for importing into our law such an extension of contractual liability. To do so would be to graft onto a contractual setting elements of the *actio injuriarum*. Moreover, the party guilty of breach of contract would be liable to compensate the innocent party for loss which is not even recoverable by the Aquilian action. In any event, in most instances the principles of our law relating to liability for breach of contract appear to be adequate to afford the innocent party sufficient satisfaction. Take the holiday cases. The plaintiff would be entitled to claim the difference between the value of the promised facilities and those actually available to him. It is also conceivable that the latter facilities might have been virtually worthless, in which case the plaintiff could recover the full contract price. *Holmdene Brickworks (Pty) Ltd v Roberts Construction Co Ltd* 1977 (3) SA 670 (A) at p 687; *Novick v Benjamin* 1972 (2) SA 842 (A) at p 860; *Ranger v Wykerd and Another* 1977 (2) SA 976 (A) at p 987; *Dippenaar v Shield Insurance Co Ltd* 1979 (2) SA 904 (A) at p 917.

a claim in delict based on lack of consent. The fact that a person requests treatment and consents thereto does not necessarily mean that there is a contractual intention. Written evidence of consent to treatment such as that in a consent form is primarily to ensure that the patient gives proper consent and to protect the provider from allegations of violation of the right to bodily and psychological integrity. In Edouard's case the plaintiff in the court *a quo* had no choice but to proceed on the law of contract because the plaintiff had failed to comply with the requirements of the Limitation of Legal Proceedings (Provincial and Local Authorities) Act[32] in that he failed to give notice of his intention to institute legal proceedings for the recovery of delictual damages. This demonstrates the advantage to the patient in having both contract law and the law of delict to choose from when formulating a claim. It may be that in some cases a court for reasons of public policy, especially in circumstances where a delictual claim was precluded on a technicality such as the one in *Edouard*, would want to infer the existence of a contractual relationship if possible in order to afford the patient some relief.

Edouard's case falls into a particular category in that it involved a request that a particular elective procedure – namely sterilisation of the plaintiff's wife, be carried out and an undertaking on the part of the provider to do so. The provider failed to carry out this undertaking. This is a situation which is different in some respects to others in which health services are rendered for a number of reasons. Firstly, it is the health professional who usually proposes and recommends a particular course of treatment to the patient who then either accepts it or rejects it or asks for alternatives. This is not the case with sterilisation. Secondly, a sterilisation procedure is not a medical necessity. It falls into the same category as a limited number of other treatments such as cosmetic surgery. Thirdly, the patient's power to choose to have the treatment or not is not impaired by physical or mental suffering or threat of death or disability. The nature of the procedure is such that it implies and indeed contemplates a particular result or outcome and that the permutations, in terms of outcome, are much more limited than for other kinds of health services. Fourthly the procedure and its intended result is not what one would call therapeutic in the

32 Act No 94 of 1970

dictionary sense of "of or relating to the healing of disease."[33] Sterilisation is not a cure for an abnormal or pathological condition. It is submitted that these differences, when considered overall distinguish the dynamics of the provider-patient relationship in this context from the more common therapeutically based relationship. In Edouard's case, unlike the cases in which sterilisation operations were performed and failed, the procedure was not even carried out. The question was not therefore the guarantee of a cure which the courts are so reluctant to impute to a medical practitioner, but rather an undertaking to perform a particular procedure which was never fulfilled.

In the context of run of the mill health care services, one of the ironies of health care contracts generally is that they are seldom read to guarantee to cure a patient but at the same time the sole purpose for entering into them is usually the hope, and even the intention, to be cured on the part of the patient and the hope, and even intention, to cure the patient on the part of the provider. The fact that this does not always materialise is irrelevant. The reasons for failure of medical treatment are many and varied ranging from the sheer negligence of a provider to the individual manner in which different patients react to treatment. Why would one undergo the hardships of chemotherapy or cardiothoracic surgery unless it was in the hope or even belief that they are likely to be effective? Surely contracts for medical services should not be considered in quite the same light as the purchase of a lottery ticket? Allopathic medical treatment in particular can sometimes cause more damage than the health condition from which the patient initially suffers. It is generally not without a price not only in financial terms but also in terms of physical and mental pain and stress. The stakes for the patient are usually much higher than the few rands it costs to purchase a lottery ticket. The question of whether a provider is in breach of a contract for health services should depend upon the reasons for treatment failure. If the reasons are outside of the control of the provider then they should be regarded in the same light as acts of God in insurance contracts. If the reasons are within the control of the provider and such control was not adequately or sufficiently exercised so as to ensure the expected outcome then it is difficult to see why the patient should not succeed in a claim for breach of contract. The obvious problem with this approach is that it is

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33 Concise Oxford Dictionary

paralleled too closely by the requirements of a claim on the basis of the law of delict. Those who prefer to compartmentalise the law are likely to oppose such an approach.

5.2.4 Pizani v Minister of Defence[34]

This case does not involve a contractual relationship between the provider and the patient but it does explore the relationship between a public provider and a patient based upon legislation. For this reason it is presented here in counterpoint to the previous cases referred to in order to more closely examine the alternative to the law of contract as the basis of a public provider-patient relationship.

Facts

The appellant, had instituted action against the respondent for damages arising out of alleged negligent medical treatment performed upon him whilst he was a member of the Defence Force, the treatment having been performed by military doctors in the Defence Force. The respondent had raised a special plea that the action was barred, in respect of part of the relief claimed, by the provisions of s 113(1) of the Defence Act in that the action had been instituted more than six months after the cause of action in respect of that part of the action covered by the special plea had arisen. The appellant replicated that it was impossible for him to have become aware of the facts giving rise to that part of the cause of action referred to in the special plea by reason of the fact that he was under regulation 11 of chapter XV of the General Regulations for the SA Defence Force and the Reserve and the Military Discipline Code obliged to accept the arrangements made by the Surgeon-General of the Defence Force for the provision and administration of any treatment to him and that he was not in law entitled to seek any treatment for his injury other than that arranged for him by the Surgeon-General. It was alleged that the appellant was not aware of the negligence of the military doctors before a date six months prior to the institution of the action and that it was therefore impossible for him to comply with the provisions of s 113(1) of the Defence Act before that date. It was alleged in the alternative that it would be unconscionable conduct for the respondent to raise the special plea based on s 113(1) of the Act. A Provincial Division had upheld the special plea.

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34 *Pizani* 1987 (4) SA 592 (A)

Judgment

In its judgment the court made the following observations:

Regulation 7 imposes upon the Surgeon-General a general duty to arrange for the provision to a patient of, *inter alia*, the medical and hospital treatment which is required in respect of an injury from which the patient is suffering in order to effect his recovery. It provides that the Surgeon-General, or a medical officer designated by him for the purpose, shall from time to time determine the nature and extent of the treatment required by the patient and may authorise the provision or administration of such treatment.

Regulation 11 deals generally with the manner in which the Surgeon-General must provide treatment for a patient. Subparagraph (1) places on the Surgeon-General a general duty to provide treatment and to exercise control thereover. To this end he is required, as far as it is professionally and administratively possible, to make use of the facilities of the military medical service and such other state medical facilities as may be at his disposal. Treatment may be administered at the patient's residence, a hospital, a clinic, an outpatients' department of a hospital, the medical officer's consulting rooms or any other designated place. In certain instances where military facilities are not available or suitable the Surgeon-General may authorise the treatment of the patient at any other designated hospital or institution. In addition, whenever the Surgeon-General considers that the treatment of a patient cannot be undertaken by a medical officer of the South African Medical Corps or a district surgeon or where a second opinion is required, he may designate a medical officer not employed on a full-time basis by the state for the treatment of the patient (subpara 2(g)). He may also accept liability on behalf of the state for the cost of any treatment provided to a patient by any practitioner or hospital in a case of emergency.

Regulation 12 deals with the provision of medical appliances, such as artificial limbs, dentures etc. In terms of the regulation, the Surgeon-General determines the specification, type or pattern of medical appliance to be provided for a patient, subject to the proviso that a patient may at his own request be provided with an article of a different specification, etc on condition (i) that this is approved by the Surgeon-

General or officer acting on his authority and (ii) that any additional expenses arising from this special provision are recovered from the patient concerned.

Regulation 13 deals with the defrayment of the cost of any authorised treatment or medical appliance and provides generally that such cost is to be met by the state. Provision is made for the payment of fees to practitioners not in the full-time service of the state who treat patients. It is also provided that where a patient is treated at a non-military hospital or institution he must be accommodated in a general ward, provided that in certain circumstances a medical officer may authorise at state expense accommodation in a ward other than a general ward and that

"this regulation shall not be construed as prohibiting a member from arranging, in terms of a private agreement between him and the hospital concerned, for the use of such other ward by him or his dependent on condition that such member shall pay any additional expenses arising from such agreement directly to the hospital concerned and that the State shall not be liable therefor."

The court noted that the appellant's argument was that it is implicit in the regulations referred to above that it would be unlawful and a breach of the MDC for a member of the Permanent Force who suffered an injury to consult a private medical practitioner in order to get a second opinion or to check on the correctness of a diagnosis made by an army doctor.

It stated, however, that it was unable to discern such a necessary implication in the regulations in question and that the regulations make it obligatory for the Surgeon-General to provide at state expense medical treatment for an injured member of the Permanent Force and prescribe that the treatment shall be given by military doctors at military hospitals, etc. The court held that it was probably correct to say that it was implicit in the regulations that the patient concerned is in general obliged to accept treatment by military doctors and at military institutions. But this does not preclude him from seeking at his own expense a second opinion from a private medical practitioner. The court pointed out that the denial of the right of a member of the Permanent Force to consult a private doctor would constitute a serious derogation from his ordinary rights as an individual, especially where he suspected that the

treatment given to him by the army doctor might have been incorrect or even negligent, and it would require either an express provision in the regulations or a clear implication to establish the denial of this right. It found that there was no express provision and no such implication.

Discussion

Where regulations such as those applicable in *Pizani* impose a specific and detailed obligation upon the state to provide health care services at its own cost, it is submitted that this is highly likely preclude an inference of a contractual relationship between the public provider and the patient where the circumstances and scope of the services fall within the ambit of the regulations. Any attempt by the parties in such a situation to allege a contractual relationship between them would not only be unlikely but also superfluous since there is no need for such a contractual relationship in light of the existence of another legal basis for the provision of the health care services. It is difficult to conceive of a reason why the parties would wish to enter into a contractual relationship in circumstances where the law already imposes a specific obligation upon the provider to supply the relevant health care goods and services. The court was even prepared to accept a general obligation on the part of the patient to accept treatment by military doctors at military institutions. In this sense the military doctors and military institutions could almost be seen as having a right to treat the patient. The court refused, however, to accept the argument that this right was exclusive.

It is significant that the court refused to read into the regulations an interpretation which precludes the patient from entering into a contract at his own expense with a private doctor since such a provision would constitute a serious derogation from his ordinary rights. The case was decided prior to the advent of the Constitution in terms of which everyone has a right to have access to health care services. It would have been interesting to see the view of the court had the Constitution been applicable at the time. It may nevertheless be argued that the judgment contains the kernel of a notion that even where someone has access to health care services, he is not precluded from questioning or rejecting them, especially where there is a reasonable belief that they may be defective or inadequate, although there may be a general positive legal obligation upon him to receive such services. In the language of the Constitution one

might say that the right to bodily and psychological integrity will not easily be taken to have been restricted by way of a purported narrowing of a person's choices concerning health services.

5.3 Provincial Health Legislation and the Intention of the State

Since health care services are rendered largely by the provinces, it will be instructive to examine more closely some of the provincial legislation that governs the rendering of health services in order to establish whether or not a contractual relationship is intended. It is not sufficient to assume that if one province excludes the possibility of a contractual relationship with a patient that they all do. However, as will appear from the more detailed consideration below it would seem that even the provinces with the most comprehensive legislative provisions on the delivery of health care services have not consciously contemplated the possibility of a contractual relationship with patients but seem to base the relationship rather on administrative law and regulatory provisions.

The Eastern Cape Provincial Health Act[35] states that health service users are entitled, within provincial government, financial and human resources, to right of access to available comprehensive provincial health care services (section 12(c)). Section 13 stipulates that "Except to the extent limited by financial and human resources, health service users shall be entitled, as health service users, to access to comprehensive provincial health care services offered by designated provincial and district health care establishments" and that all health service users entering the comprehensive provincial health care system shall, subject to regulations promulgated in terms of the Act be entitled on the basis of need and subject to available provincial, financial and human resources to comprehensive provincial health care services including, but not limited to primary health care and secondary and tertiary health services on the terms and conditions specified in the regulations.

It would seem that although the possibility of contracting is left open by the use of terminology such as 'access', a contractual relationship is probably not contemplated

35 Act No 10 of 1999

between the public provider and the patient because the access is to be "on the terms and conditions specified in the regulations". The regulations are likely, practically speaking, to preclude the need for contractual terms and conditions to govern the provider patient relationship and their existence would tend to support an inference or conclusion that a contractual relationship is not intended by the private provider. In the absence of evidence of an intention to contract, one would not usually infer that a contract has been entered into[36]. The health services in this instance are comprehensive and include services at primary, secondary and tertiary level. A restriction is represented by the fact that the services are only available at designated facilities but this is likely in practice to mean that not every level of service is available at every facility simple because certain facilities may be designated purely as tertiary services providers while others are designated as purely primary services providers for obvious reasons. Not every rural clinic can have a magnetic resonance imaging scanner or a laminar flow operating theatre.

The KwaZulu-Natal Health Act[37] states in section 29(2) that "a health care user is entitled to the progressive realization, within the Province's available resources, to the right –

(a)

(b) of access to available primary health care services."

The Act defines "primary health care services" as "accessible first level health services included as part of the package of basic essential health services as prescribed by the Minister in regulations." Section 30(1) states that "[E]veryone is entitled within the Province's available resources and funds allocated to the Department and as a matter of right, to the progressive realization of access to primary health care services offered by designated public health care establishments." To the extent that these provisions seek to narrow the constitutional right of access to health care services to purely primary health care services they are probably unconstitutional. If only primary health care services were available in the province due to a lack of resources this might not be the case but the KwaZulu-Natal Department of Health in fact provides as a matter of course, secondary and tertiary

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36 Although see the later discussion on tacit contracts.

37 Act No 40 of 2000

level services in many of its hospitals. The manner in which this legislation is worded could give rise to the understanding that while a contractual relationship is not intended with regard to primary health care services because these are available as of right in terms of the legislation, this is not necessarily true for secondary and tertiary health care services which are not apparently governed by the legislation. In other words while a contractual relationship is not envisaged with regard to primary healthy care services it is a possibility with regard to secondary and tertiary services. In terms of the regulations to the KwaZulu-Natal Health Act, a "free public health care user" means a public health care user who is deemed a free public health care user in terms of Departmental guidelines and does not pay for public health care services on the basis of a means test as determined by the Department. The regulations define a "full-paying public health care user" as "a public health care user who by virtue of his or her financial circumstances, is neither a free nor a part paying public health care user and is treated as a full-paying public health care user in terms of Departmental policy." There is no mention of the level of health care, i.e. primary, tertiary or secondary, in this context. Regulation 3 of the regulations to the KwaZulu-Natal Health Act makes provision for the classification of public health care users by the head of the public health care establishment[38]. If one examines the provisions of

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38 3. (1) The head of the public health care establishment or his or her designee must, at the time of the public health care user's admission to or treatment in a public health care establishment or as soon thereafter as possible, classify the public health care user as a -
(a) free public health care user;
(b) part-paying public health care user;
(c) full-paying public health care user; or
(d) private health care user.
(2) A person is deemed to be a full-paying public health care user until he or she proves that he or she qualifies as a free or
part-paying public health care user.
(3) A part-paying public health care user, full-paying public health care user or private health care user treated at public health care establishment must sign an acknowledgement of debt for fees incurred in the course of receiving health care services at the public health care establishment.
(4) The head of a public health care establishment or his or her designee may, where necessary, make an assessment of the financial circumstances of the person responsible for the payment of the fees of the person to be admitted or treated.
(5) For purposes of subregulation (4), the head of the public health care establishment or his or her designee may require the person responsible for payment of public health care establishment fees to furnish relevant information or documentation which the head of the public health care establishment may deem necessary.
(6) A person who is required to furnish any information or document contemplated in subregulation (5) and a dependent of that person may not be admitted to or treated in a public health care establishment unless the information or documentation has been furnished: Provided that, a person may be treated where, in the opinion of the head of the public health care establishment or his or her designee, refusal to admit or treat a person could have dangerous or detrimental consequences to the person seeking admission or treatment.
(7) The head of a public health care establishment or his or her designee may, at any time, reassess the financial circumstances of a person responsible for fees of a public health care user.
(8) The head of a public health care establishment or his or her designee may, after reassessing the ability of a person to pay fees as contemplated in subregulation (7), determine that a public health care user should be treated as a full-paying public health care user where the public health care user-
(a) fails to provide the necessary documentation of his or her financial circumstances within the period stipulated by the
head of the public health care establishment or his or her designee; or

regulation 3 in detail the following is noteworthy in terms of the question of whether or not there is an intention to contract –

(1) Patients who in terms of the regulations are required to pay fees must sign an acknowledgement of debt for such fees in respect of health services received;

(2) The head of a public health establishment can require certain documentation of a patient's financial circumstances in order to classify the patient as a free public health care user, a part-paying public health care user, a full paying public health care user or a private health care user and may reassess such classification at any time;

(3) The patient can be refused admission to a public health establishment unless the financial information required for the purposes of the assessment and classification of the patient is furnished;

(4) The head of a public health establishment can determine that the fees must be paid at a higher rate but not exceeding the prescribed rate;

(b) has been classified or reclassified as a free or part-paying public health care user where the health care user or person
liable for the payment of fees is a member of a medical aid scheme: Provided that -
(i) the public health care user must be reclassified as a part- paying public health care user when the benefits enjoyed under the health care user's medical aid scheme are depleted;
(ii) no charge other than that applicable to part-paying public health care users may be charged for any service, treatment, appliance or prosthesis not covered by the health care user's medical aid scheme; and
(iii) the charge, other than the charge applicable to part-paying public health care users, for any service, treatment, appliance or prosthesis not fully covered by the health care user's medical aid scheme, must not exceed the amount covered by the health care user's medical aid.

(9) Subject to subregulation (10), the head of a public health care establishment or his or her designee may determine that the fees be paid at a higher rate not exceeding the prescribed rate.
(10) The head of the public health care establishment or his or her designee must satisfy himself or herself that owing to any change in the financial circumstances of the person responsible for fees, the person is able to pay fees at a rate higher than the rate previously assessed.
(11) A head of a public health care establishment or his or her designee may not reassess fees when the person responsible for payment is deceased.
(12) A person who is aggrieved by an assessment or re-assessment made by a designee of the head of a public health care establishment may appeal to the head of the public health care establishment.
(13) A person who is aggrieved by an assessment or re-assessment made by the head of a public health care establishment may appeal to the Head of Department.
(14) An appeal to the Head of Department contemplated in subregulation (13) must be accompanied by the recommendations of the head of a public health care establishment.
(15) The decision of the Head of Department on the appeal contemplated in subregulation (13) is final.
(16) The Head of Department may bring an action against a person for damages incurred by the Department as a result of the person knowingly or wilfully furnishing any information or documentation which is false, incorrect or misleading.

(5) A person who is aggrieved by an assessment or re-assessment made by the head of the public health establishment may appeal to the Head of the provincial health Department whose decision is final;

(6) The Head of Department can bring an action against a person for damages incurred by the Department as a result of the person knowingly or willfully furnishing any information or documentation which is false, incorrect or misleading.

It is submitted that the fact that signature of an acknowledgement of debt for fees by the patient or other person responsible for payment is a regulatory requirement is not necessarily indicative of an intention to contract with regard to the delivery of health services on the side of the public provider or the patient since the patient is apparently bound by law to sign it. It is more likely an attempt to ensure that the patient or other person responsible for payment is aware of his or her obligation to pay the fees and to shift the risk of the costs of the collection of such fees from the province to the person responsible for payment. This is borne out by the fact that the patient cannot negotiate the fees payable. They are determined on the basis of objective evidence as assessed by the head of the health establishment. The head of the health establishment can unilaterally decide to alter the level of fees payable within the limits of the prescribed rate and the remedy provided for a decision of the head of the health establishment is an administrative one as opposed to a contractual one. The legal basis for the debt, in the absence of a contract, would be the regulations themselves since regulation 5 lists the circumstances in which a person is *not* required to pay for treatment and services at a public health care establishment.

The nature of the damages for which the Head of Department can bring an action is not specified but if one looks at the basis of the damages they tend to suggest civil wrongdoing rather than breach of contract[39]. Although deliberate misrepresentation is a ground for damages in the law of contract, the fact that the regulations do not allow

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39 The wording of the regulation suggested that an element of culpability is required. By contrast, in certain circumstances under the law of contract even an innocent misrepresentation is grounds for a claim for damages. See *Phame (Pty) Ltd v Paizes* 1973 (3) SA 397 (A). See also *Labuschagne v Fedgen Insurance Ltd* 1994 (2) SA 228 (W). This is not true of the law of delict. In *Ericsen v Germie Motors (Edms) Bpk* 1986 (4) SA 67 (A) the court stated: "There is in our law no basis for an action for damages in delict founded upon an innocent (ie non-fraudulent or non-negligent) misrepresentation."

a contractual remedy to a patient who is aggrieved by a decision as to what fees he should pay suggests that the damages contemplated might be in terms of the law of delict. It would be administratively unjust to allow a contractual remedy to one party to the contract – i.e. the provincial government, while denying a remedy of the same nature to a patient. Of course one would have to consider the circumstances of each case before ruling out the possibility of a contractual relationship.

The Gauteng District Health Services Act[40] defines 'primary health care services' as "comprehensive health care services that includes preventative, promotitive, curative and rehabilitative health acre within the context of community participation, inter-sectoral collaboration and an adequate referral system". The Act seeks to transfer the responsibility for the delivery of primary health care services to municipalities in terms of section 19. Such assignments of functions are contemplated in section 156 of the Constitution. This raises the question, however, that if a municipality is liable for the rendering of primary health care services, does this mean that a provincial health facility that offers secondary and tertiary level health care services is lawfully entitled to refuse to treat a person requiring primary health care services who has not availed themselves of those services at the local municipal health clinic? If the answer is that such a patient may not be refused such primary health care services by the provincial facility this would render the delivery of appropriate levels of health care by facilities at a level that can most appropriately, efficiently and effectively deliver those services highly problematic from the point of view of the practical organization of health services delivery. Primary health care services delivered at facilities that are designed for the rendering of more complex secondary and tertiary levels of health care are much more expensive than those same services rendered at their proper level within the health care system such as community based clinics and health care facilities. Gauteng appears not to have enacted any legislation resembling that of KwaZulu-Natal that specifically grants a patient a right to a particular level of health service. In terms of the Hospitals Ordinance Amendment Act[41], Gauteng legislation provides for a similar system of classification of patients into part paying and private as does the KwaZulu-Natal legislation. Section 31(2) of Ordinance 14 of 1958 as amended by the

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40 Act No 8 of 2000
41 Act No 4 of 1999

1999 Act stipulates that the superintendent, chief executive officer or his or her designee may call for such information or documents as he or she may deem necessary or as may be prescribed in any regulation and no person shall be admitted into any provincial hospital or receive treatment thereat unless such information or documents have been furnished by or on behalf of such person. The Gauteng legislation contains the same exception as the KwaZulu-Natal legislation to the effect that a patient can be admitted where in the opinion of the superintendent, treatment cannot be deferred without danger or detrimental consequences to the patient. In General Notice 7867 of 2000 entitled: "Amendment To The Regulations Relating To The Classification Of And Fees Payable By Patients At Gauteng Provincial Hospitals, Mortuary Fees, And Fee Pertaining To Ambulances And The Amendment Of Hospital Tariffs, Mortuary And Ambulance Tariffs With Effect From 1 November 2000"[42] the statement is made with regard to financial principles that:

"All health services rendered by the state are chargeable. However, no emergency service may be refused if a patient cannot pay for it and no patient, including an externally funded patient, will be required to meet all costs of essential medical services should such costs place an excessive financial burden on her/him."

The liability of an externally funded patient is stated as follows:

"Externally funded patients will pay the full rate prescribed by the UPFS. In cases where services are rendered to patients by a private health care practitioner, the patient or her/his funder will be liable for the facility fee component of the UPFS tariff to the public health facility concerned. It is the responsibility of the private practitioner to render an account to the patient or her/his funder for any professional fee due to the private practitioner."

The proposed regulations also state the following "Administrative Principles":

- Patients who are not externally funded are eligible to pay reduced fees for services received. The onus rests on the patient to prove her/his eligibility to be categorized as a subsidized patient. If a patient refuses to do this, then he/she must be regarded as a full paying patient.

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42 Provincial Gazette No 174 Part 1 13 November 2000

- The eligibility of a patient to pay reduced fees will be based on a standard means test or the membership of the patient to certain groups exempted from paying for public health services.

- Patients paying reduced fees will be encouraged to pay cash. In such cases a payment receipt but not an invoice will be produced. In cases where the reduced fee cannot be paid in full and the patient is not reclassified into a group exempt from payment, a credit agreement must be entered into with the patient or her/his guardian.

- Patients funded by a medical scheme registered in terms of the Medical Schemes Act[43], are governed by the provisions of that Act with regards to the minimum benefits for which the funder is liable. For the purposes of charging for services not covered by the funder, the patient will be classified as provided for in principle 7 and will be liable for the payment of the applicable fees.

- A facility fee plus a professional fee will be charged for each procedure group. The professional fee will not be charged where a patient utilizes the services of his/ her private clinician.

It seems in view of these similarities that the position is much the same for Gauteng as it is for KwaZulu-Natal and that there is apparently no intention to contract with patients on the part of the provincial government of Gauteng. The fact that a credit agreement, which is undoubtedly a contract, must be entered into where the patient cannot pay the fee in full and is not reclassified, does not necessarily mean that initial relationship involving the rendering of health services by the provincial government is contractual. It could be argued that the requirement of the credit agreement is based upon the need to establish the amount and frequency of the payments that must be made by the patient over time and also to facilitate debt collection procedures by the province should the patient fail to pay. The need for the contract in other words arises not so much in order to facilitate the delivery of and payment for health services but to ensure payment as required by regulations. The health services themselves may

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43 Medical Schemes Act fn 1 *supra*

already have been rendered by the time that the credit agreement becomes necessary. If the credit agreement is as a matter of routine practice entered into in advance of the rendering of the health services, for instance as part of the admission procedures to the hospital, then it could be argued that the relationship between the patient is of a contractual nature. However, in this instance there would still be a strong administrative law element in the relationship given the imbalance of power between the contracting parties and the fact that many of the essential terms of the 'contract' are determined by regulations.

As far as the Western Cape is concerned the Health Act[44] still applies. It effected some minor amendments to the provisions of this Act insofar as they affect the Western Cape Province in 2002[45]. The Western Cape has made entitled 'Regulations Relating To The Uniform Patient Fee Schedule For Health Care Services Rendered By The Department Of Health: Western Cape For Externally Funded Patients,'[46] primarily concerning public sector patients who are members or beneficiaries of medical schemes and other funds that pay for health services. The Regulations apply only to 'externally funded patients' and define this phrase as follows:

"externally funded patient' means a patient whose health services are funded or partly funded in terms of-
(a) the Compensation for Occupational Injuries and Diseases Act, 1993 (Act 130 of 1993), or
(b) by the Road Accident Fund created in terms of the Road Accident Fund Act, 1996 (Act 56 of 1996), or
(c) a medical scheme registered in terms of the Medical Schemes Act,1998 (Act 131 of 1998), or
(d) another state department, local authority, foreign government or any other employer, or who exceeds the generally accepted income means test as implemented by the Provincial Government: Western Cape;"

They set tariffs for various categories of health facilities and health services delivered by the public health sector in the Western Cape to persons who are externally funded patients. Regulation 3 states that an externally funded patient who receives any medical treatment or any medical service, listed and categorised in Schedule 2, from a department of health facility, must pay the applicable tariff for such medical treatment

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44 Act No 63 of 1977

45 Western Cape Health Act Amendment Act No 6 of June 2002. Notice No 164 in Provincial Gazette No 5891 of 18 June 2002

46 Provincial Gazette No 5977 Notice No 21 of 29 January 2003

or medical service received in accordance with the tariff of fees and charges as set out in Schedule I of the regulations

The Northern Province Health Services Act[47] states in section 34 that subject to the provisions of section 36 every manager must admit for treatment in or at any health service or facility in his or her charge so far as adequate and appropriate accommodation is therein available, persons suffering from or subject to any of the diseases, injuries or conditions for the treatment of which such health service or facility is established. Section 36 deals with classification of patients and contains similar provisions relating to documentary proof of financial status as the legislation of KwaZulu-Natal and Gauteng. In terms of section 35, the remedies for a person who is aggrieved at the classification are administrative. The Member of the Executive Council for Health of the province is given the power to prescribe fees for the treatment of a person in a health service or facility in section 41 of the Act.

The North West Health Bill, which seems not to have been passed into law at the time of writing simply states in section 24 that the medical administrator or head of clinical services of a provincial hospital shall, subject to any regulations, determine the order in which persons shall be admitted to such hospitals having regard to the urgency of their need for treatment as far as adequate and appropriate accommodation is available. The Mpumalanga Hospitals Bill[48], which also seems not to have been passed into law, leaves matters such as fees for health services to regulations. It contains provisions that are similar to the North West Health Bill. The Free State Provincial Health Act[49] provides in section 36 that the MEC shall by notice in the Provincial Gazette regulate the package of health care to be provided. It stipulates that the health care package at each level of care shall be accessible, acceptable, affordable, efficient, comprehensive and integrated with promotive, preventative, curative and rehabilitative services. It requires the Department of Health in the province to ensure progressive implementation of health services at all levels of care in order to avoid and remove duplication and fragmentation of health services,

47 Act No 5 of 1998 Provincial Gazette No 4 of 1999
48 A 1997 Bill
49 Act No 8 of 1999

improve and maintain the quality of health services within the available resources and remove all barriers to access to health services where possible. The Department is also tasked with reviewing and monitoring the efficiency of the respective health packages on a regular basis. The user is not expressly given any specific rights relating to access to health services in this Act although there are rights to information, informed consent, confidentiality and to complain. Section 35 states that health care providers shall fulfil every duty owed to each patient including the duty inter alia to "provide the best quality care appropriate". There is no suggestion of a contractual relationship between the province and the patient for the provision of health care services to the patient.

In view of the foregoing it seems that whilst provincial governments may be free to contract with patients for the provision of health services they generally seem to prefer the expression the public provider patient relationship in terms of regulations, thereby bringing it within the scope of administrative law. This said, one must bear in mind the distinctions made between paying and non-paying patients and between the different levels of services in some of the provincial legislation and regulations. It may well be that in particular circumstances the facts may indicate that there is sufficient evidence of a contractual relationship with the patient and the existence of such a relationship can thus never be completely discounted. The fact that provinces enter into contracts with medical schemes to treat medical scheme patients on certain terms and conditions may lead to a conclusion that a patient is a party to the contract because it is a contract for the benefit of the patient. However this would depend on the nature of the terms of the particular contract between the scheme and the provincial government in question.

Even if provincial governments had indicated more strongly a preference for a contractual basis for the provider- patient relationship, if one considers the circumstances, with the Constitution as backdrop, in which a private health care provider may legitimately refuse to treat a person, they are no different in principle to the circumstances in which a public health care provider may refuse to treat one. The freedom of a private provider of health care services to refuse treatment is not as wide, in legal terms, as it may first appear. The Constitution prohibits unfair

discrimination in general and upon a number of specific bases. A health care provider who turns away a patient on the grounds of his of her race, age, gender, disability sex, sexual orientation, culture, religion, language, belief, birth, marital status, ethnic or social origin or pregnancy is likely to be in violation of that patient's constitutional right to equality as well as his or her right of access to health care services. If a private health care provider cannot supply a good reason on legal or ethical grounds for turning a patient away, such as the provider's own ill health, disability, lack of competence in a specialised area, non-compliance with licensing requirements or lack of capacity, it is submitted that unfair discrimination is likely to be raised as a possibility or even a probability[50] for the private provider's refusal to treat the patient on the premise that if there is no good reason why the provider does not wish to treat the patient and there must be a reason for the provider's refusal, one must start looking to other kinds of reasons as possibilities. It is submitted that the range of acceptable reasons, other than those based on legal and ethical principles, for a private provider's turning away a person needing health care services given the foregoing is likely to be fairly narrow. It is also submitted that the same holds true for public health care service providers except that, to the extent that their decision constitutes an administrative one, they will be obliged to give reasons in terms of the PAJA and these are open to interrogation in terms of administrative law. It is important to remember, however, that this Act also applies to private persons, natural and juristic, when exercising a public power or performing a public function in terms of an

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50 The Promotion of Equality and Prevention of Unfair Discrimination Act No 4 of 2000 (which is not yet in operation as at the time of writing" states in section 13 concerning burden of proof:
"(1) If the complainant makes out a prima facie case of discrimination-
(a) the respondent must prove, on the facts before the court, that the discrimination did not take place as alleged; or
(b) the respondent must prove that the conduct is not based on one or more of the prohibited grounds.
(2) If the discrimination did take place-
(a) on a ground in paragraph (a) of the definition of 'prohibited grounds', then it is unfair, unless the respondent proves that the discrimination is fair;
(b) on a ground in paragraph (b) of the definition of 'prohibited grounds', then it is unfair-
(i) if one or more of the conditions set out in paragraph (b) of the definition of 'prohibited grounds' is established; and
(ii) unless the respondent proves that the discrimination is fair."
The Schedule to this Act stipulates unfair practices in the health sector in section 3 as follows:
"3 Health care services and benefits
(a) Subjecting persons to medical experiments without their informed consent.
(b) Unfairly denying or refusing any person access to health care facilities or failing to make health care facilities accessible to any person.
(c) Refusing to provide emergency medical treatment to persons of particular groups identified by one or more of the prohibited grounds.
(d) Refusing to provide reasonable health services to the elderly."
Section 8, dealing with discrimination on the grounds of gender states that subject to section 6, no person may unfairly discriminate against any person on the ground of gender, including limiting women's access to social services or benefits, such as health, education and social security.

empowering provision which adversely affects the rights of any person and which has a direct, external legal effect.

5.4 Arguments in Favour of Contractual Relationship

It is submitted that there are a number of aspects about the public provider-patient relationship that support the idea that it is contractual. The concept of informed consent, for instance, tends to strengthen the idea of a contractual relationship rather than diminish it even though informed consent is traditionally discussed rather more in the context of the law of delict than of the law of contract. Informed consent requires that the patient is fully informed of the nature of the proposed treatment, its consequences and the consequences of not having it, the risks associated with it and alternatives to it.[51] In this sense it is very much akin to the contractual principles of meeting of minds[52], contractual capacity[53] and of involuntary reliance[54]. The

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51 See generally *Castell v De Greef* 1994 (4) SA 408 (C) A; *C v Minister Of Correctional Services* 1996 (4) SA 292 (T); *Broude v Mcintosh and Others* 1998 (3) SA 60 (SCA); *Minister of Health And Others v Treatment Action Campaign and Others* (No 2) 2002 (5) SA 721 (CC)

52 In *Seeff Commercial And Industrial Properties (Pty) Ltd v Silberman* 2001 (3) SA 952 (SCA) at p958 the court notes that: "A basic rule is that -
'an acceptance of an offer made ought to be notified to the person who makes the offer, in order that the two minds may come together'. (Per Bowen LJ in *Carlill v Carbolic Smoke Ball Co* [1893] 1 QB 256 (CA) at 268. See also *R v Nel* 1921 AD 339 at 344; *Reid Bros (South Africa) Ltd v Fischer Bearings Co Ltd* 1943 AD 232 at 241.) If the patient does not understand what it is that the health care provider is proposing in terms of treatment then any consent given will not be properly informed. The health care provider and the patient must be *ad idem* as to what it is that the health care provider is permitted by the patient to do to him or her.

53 Minors are generally not recognised as being capable of giving informed consent in much the same way that they are not recognised as having contractual capacity until they have reached a certain age. Strauss SA, *Doctor, Patient and the Law: A Selection of Practical Issues* at p 5 observes that "Obtaining a legally 'safe' consent where the patient is a minor, i.e. an unmarried persons below the age of 21 years, is a matter of general concern to medical practitioners. Where a parent or guardian is available to give consent there are no problems". In terms of section 39(4) of the Child Care Act, No 74 of 1983 "Notwithstanding any rule of law to the contrary-
(a) any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon himself; and
(b) any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical treatment of himself or his child."
In terms of the law of contract, "In Roman Dutch law the judgment of a minor is considered immature throughout his minority and he is consequently not bound by his contracts" (*Edelstein v Edelstein* 1952 (3) SA 1 (A)). In *Dhanabaktium v Subramanian* 1943 AD p 160 the court stated at p 167 that: "According to the common law a minor cannot bind himself by contract without the assistance of his guardian subject to certain qualifications."

54 Christie *The Law of Contract* 4th ed at p 322, referring to *Pretorius v Natal South Sea Investment Trust Ltd* 1965 (3) SA 410 (W) where the court observes that: "There is an 'involuntary reliance of the one party on the frank disclosure of certain facts necessarily lying within the exclusive knowledge of the other such that, in fair dealing, the former's right to have such information communicated to him would be mutually recognised by honest men in the circumstances'" states as follows: "The test of involuntary reliance here applied is in accordance with the principle underlying the requirement of disclosure of material facts in contracts of insurance. The insured must disclose all material facts because the insurer involuntarily relies on him for information on such facts: it might theoretically be possible to ascertain these facts by other means but it would not be practical in the business sense". It is submitted that the patient is in the same position more or less as the insurance company. He or she is involuntarily reliant upon the health care professional who knows his or her unique situation as well as being in possession of expert medical knowledge that may not be readily available elsewhere, to disclose the material facts. Whilst it may be possible to obtain the relevant information from other sources or health care providers it is not always practically or financially possible for the patient to do so. See also *Absa Bank Ltd v Fouche* 2003 (1) SA 176 (SCA) where the court observes that: "I am prepared to assume, though not without some hesitation, that the information about the alarm and the guards can be classed as falling within the exclusive knowledge of the branch officials. My hesitation stems from the fact that information which is, if desired, as readily ascertainable as this was, should not be categorised as exclusive knowledge. 'Exclusive knowledge' in this sense is knowledge which is

classification of patients into various categories and the requirement that they must pay a certain amount for such services could be indicative of an intention to contract, especially where there is a requirement that if the fee cannot be paid in a single cash amount, the person responsible for the payment must enter into a credit agreement with the provider. Although it is not necessarily sufficient to ground the inference of a contract on its own since the doctrine of consideration is not part of the South African law of contract, it is submitted that in certain circumstances the requirement of payment for health services may be an indicator of a contractual intention. Other circumstances which may be indicative of a contractual relationship are where the patient has requested a specific procedure for a particular reason such as those in *Edouard*[55]. The fact that the procedure is elective as opposed to essential to the health or wellbeing of the patient may also have a bearing. In practice a court is unlikely to refuse to acknowledge a contractual relationship between a public provider and a patient where this can be demonstrated on a balance of probabilities where the provider itself asserts that there was no intention on its part to contract. Clearly the inference of a contract between the parties will depend upon the circumstances of each case and also public policy considerations. The question of the existence of a contractual relationship between a public provider and a patient is rarely likely to arise outside of the context of litigation in any event given the nature of the delivery of health care services in the public sector and the absence of any form of negotiation between the parties in most instances. It is, however, of some significance that in the South African cases many of the parties seem to have chosen to base their claims on the law of delict as opposed to that of contract. Of the four cases discussed in this section only one South African case, that of *Edouard*[56], is based squarely upon the law of contract. If a court should find that there is a constitutional obligation upon the state specifically to deliver health care services, especially if this obligation is reinforced by national health legislation, then the likelihood in the abstract, of the existence of a contractual relationship between the patient and the public provider is diminished since there may be no logical need for it – particularly in circumstances where the patient has no choice but to use the public health system and is not obliged to pay for health care services in terms of a means test.

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inaccessible to the point where its inaccessibility produces an involuntary reliance on the party possessing the information (Christie RH *The Law of Contract* 4th ed at 322)."

55 *Edouard* fn 24 *supra*

56 *Edouard* fn 24 *supra*

5.5 Arguments Against Contractual Relationship

Since the existence of a contract is fundamentally dependent upon the intention of the parties to enter into a contract, however, it does not necessarily follow that a contract arises in every instance in which a public provider of health care services renders such services to a patient. In *Magware's* case[57] the Minister of Health when faced with a claim for damages arising from the negligent application of a plaster cast by hospital staff, in his plea denied the existence of a contractual relationship between the parties. The court decided the case in the absence of a contractual relationship on the basis of the law of delict.

In *Dube v Administrator, Transvaal*[58] (W) Trollip J noted that the plaintiff's action was founded on negligence and not on contract. This does not necessarily mean, however, that a contract did not exist between them. The fact is that a plaintiff can choose the legal basis of an action for damages when the circumstances support both a claim in terms of the law of contract and one in terms of the law of delict. Similarly the Administrator Transvaal may have chosen to deny the existence of a contract with the patient for strategic reasons in order to make it more difficult for the plaintiff to prove his claim, placing upon him the onus of proving the existence of a contract if this was the route that he chose to go. The plaintiff's claim in *Mtetwa v Minister of Health*[59] was based upon three alternative causes of action, namely:

(a) an implied contractual agreement between the parties, with a breach of a material term of that agreement by one of the defendant's employees and the resultant liability of the defendant on the basis of the actions of a servant conducted within the course and scope of his employment with his principal; alternatively

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57 *Magware v Minister of Health NNO* 1981 (4) SA 472 (Z) (see later for detailed discussion of the facts and the judgement).

58 *Dube* 1963 (4) SA 260 (W)

59 *Mtetwa* 1989 (3) SA 600 (D) at p601-602

(b) a claim in delict arising from the failure by the defendant's employees to employ reasonable skill and care in their treatment of the plaintiff, by treating her negligently, with the resultant liability of the defendant being based upon the actions of a servant acting within the course and scope of his employment with his principal; alternatively

(c) a wrongful, unlawful and intentional assault on the plaintiff by one or more servants of the defendant, the liability of the defendant being based upon the actions of an employee-servant acting within the course and scope of his employment with his principal.

The case is discussed in more detail under the section on the law of delict due to the fact that it essentially revolved around the question of vicarious liability. It is clear from this, however, that the basis of a claim for damages in the health care context can range from contractual to delictual and even criminal law. The fact that a contract arises between a provider and a patient does not by any means preclude a delictually based duty of care. Neither does it preclude the possibility of a criminal action for assault, in the absence of the informed consent of the patient although this point will be discussed in more detail at a later stage. As stated previously the existence of obligations on the basis of constitutional and administrative la, to render health care services to a patient may preclude an inference that a contractual relationship arose between them. The question of the administrative contract, which is something of a hybrid straddling administrative law and the law of contract, appears not to have found total recognition in South African law at present judging from the statements of the writers referred to previously. It is submitted that this is a prime example of the reluctance of some South African courts to allow cross-pollination of one area of law by another. In fact it is even more than that since it constitutes a failure to recognised that constitutional principles and values are fundamental to all areas of law and that there is a positive constitutional obligation upon the courts to develop the common law in accordance with these. There may be circumstances in which a contract is implicitly precluded as the basis of the relationship between a public provider and a patient. The case of *Pizani v Minister Of Defence*[60] offers an example of this.

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60 *Pizani* fn 34 *supra*

5.6 Conclusions Regarding Health Care Relationships

In the context of health services delivery, one must consider the law holistically whilst at the same time retaining an awareness of its different facets. It would be a mistake to think only in terms of the law of contract or only in terms of the law of delict or administrative law when considering the provider-patient relationship. This is demonstrated by a series of cases in which relationships which began essentially by way of a contract between the parties gave rise to obligations based upon the law of delict[61]. The boundaries between these different areas of law are permeable because

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61 Beginning with *Van Wyk v Lewis* 1924 AD 438 and ending most recently with *Pinshaw v Nexus Securities (Pty) Ltd and Another* 2002 (2) SA 510 (C). In *Van Wyk v Lewis* the defendant performed an emergency operation on the plaintiff but accidentally left a swab in her body. Some twelve months later, the plaintiff evacuated the swab through her bowel into which it had found its way. The plaintiff alleged that the defendant had acted negligently and unskilfully in failing to remove the swab and sued him for two thousand pounds. The Appellate Division confirmed the judgment for the defendant of the trial court and held that the action was based on tort, the defendant had been obliged to act with reasonable skill, having regard to the general level of skill and diligence possessed and exercised at the time by members of the branch of his profession to which he belonged. It held further that the onus of establishing negligence lay with the plaintiff and that the latter could not, in the circumstances of the case, rely on the maxim *res ipsa loquitur*. The Appellate Division found that the defendant had acted reasonably and had therefore not been negligent, in relying upon the theatre sister to count the swabs used in the surgery and that if the theatre sister had been negligent, her negligence could not be attributed to the defendant in any way. Innes CJ in discussing the basis of the plaintiff's claim observed that the line of division where negligence is alleged is not always easy to draw, "for negligence underlies the filed both of contract and of tort. Cases are conceivable where it may be important to decide on which side of that line the cause of action lies. But the present is not such a case..." Wessels JA stated in his judgement at 455 that "...The case... is one of those...where the relationship between the parties arises out of a contract but where the act complained of is an injury or delict done in consequence of carrying out the contract. The delict grows out of a breach of duty which the law implies from the contract between the parties – the duty of the surgeon who contracts to operate not to do so negligently..."
In *Pinshaw*, the plaintiff was an elderly widow who had taken up permanent residence with her family in Australia. Exchange control regulations did not permit her to remit sufficient funds and assets to that country and she therefore entered into a contract with the first defendant, dealing in this context with the second defendant, who signed on behalf of the first defendant. In terms of the contract the plaintiff agreed to invest R1 million in stock market equities to be managed and controlled by the first respondent. The funds were placed under the control of the second defendant, who was the director of the first defendant in charge of private client portfolio management. The contract included a clause which indemnified the first defendant or any of its directors or employees against any losses and liability or damage for claims brought by the client by reason of the operation of his or her account unless the claims were attributable to fraud, bad faith, dishonesty or gross negligence on the part of the first defendant, its directors or its employees. The plaintiff's entire portfolio was invested in one stock (C Ltd), of which the second defendant was the senior manager. The portfolio dropped in value to approximately R343 000 as a result of the investment. The plaintiff instituted action for pure economic loss and alleged that the trading in such a high-risk investment had been to her detriment and not in furtherance of her interest. She proceeded against the first defendant based on contract, alleging breach of fiduciary duty and grossly negligent action. She also claimed against the first and second defendant in delict, averring that, in dealing with the portfolio on behalf of the first defendant, the second defendant had acted fraudulently or recklessly or grossly negligently in the course of the first defendant's business and within the scope of his authority, and held the first defendant liable for the conduct of the second defendant. The second defendant took exception to the plaintiff's particulars of claim insofar as they related to the alternative cause of action based on alleged recklessness or gross negligence, claiming them to be vague and embarrassing, lacking averments necessary to sustain the cause of action. The basis of the exception was that the second defendant alleged that he did not owe the plaintiff a legal duty to act with care and, without this duty of care being established, the cause of action could not succeed. The second defendant alleged that it was the first defendant, not himself, which was contractually bound and obligated to the plaintiff and that she should seek redress there. The court stated that it was apparent that the pleading has been so framed in order to meet the exclusionary clause, clause 16, of the contract. This clause excluded the liability of Nexus and its directors and employees (of whom Van Zyl was one) 'unless the claims are attributable to fraud, dishonesty or gross negligence' or unless the losses are attributable to 'fraud, bad faith, or gross negligence'. The existence of clause 16, said the court, may have an impact on the substantive question of unlawfulness. In deciding whether Van Zyl owed Mrs Pinshaw a legal duty, the court said that it must have regard to all the circumstances, including the existence and terms of the contract with Nexus and including clause 16 itself. If in all the circumstances Van Zyl owed Mrs Pinshaw some duty, there were two ways of looking at the position. The duty might be a duty qualified by clause 16. Alternatively, it might be a wider duty to exercise reasonable care in the management of the portfolio. In that case it would be for Van Zyl, who was not a party to the contract, to show that he was entitled to the benefit of clause 16. Mrs Pinshaw, however, had impliedly conceded the entitlement and so the court did not take this aspect further. Comrie J then went on to discuss the case of

they are based upon the same grundnorm – the Constitution. There should be general recognition by the courts of the substantive and fundamental objects and purposes behind the legal principles to be found in the various areas of South African law so as to facilitate the development of the common law by the courts in a manner which will ensure a single totally internally consistent and coherent system of law. Whilst the division of the law into different branches and legal disciplines facilitates complex analyses of legal principles within those branches and disciplines it does not further the development of the common law by the courts as envisaged by the Constitution and does not promote consistency, justice, reasonableness or fairness within the South African legal system as a whole. A certain level of legal synthesis, as opposed to analysis, is necessary in order to achieve this. In the real world, people do not operate businesses or fulfil public functions in terms of only one particular area of law. Health

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Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd 1985 (1) SA 475 (A) as follows at p 518-519: "Lawyers will know that this case was preceded by *Administrator, Natal v Trust Bank van Afrika Bpk* 1979 (3) SA 824 (A) which held that in our law Aquilian liability could in principle arise from negligent misstatements which caused pure financial loss, but cautioned against an extension which was either too wide or too rapid. In 1985 Lillicrap's case came before the same Court on exception. It was a claim for pure economic loss arising out of a contract by a firm of consulting and structural engineers to render professional services to Pilkington Brothers. There were two complications: first, at some stage Salanc had been interposed as the contracting party, and the engineers had become in effect sub-contractors to Salanc; second, any claim against the engineers in contract had apparently become prescribed. So Pilkington Brothers sued the engineers in delict for damages for alleged negligent performance of their duties undertaken initially in terms of the direct contract and later in terms of the sub-contract. Two principal questions arose for decision. The first was the question of concurrency. Given the antecedent contract, could the claim for pure economic loss be brought in delict? The Court answered affirmatively at 496F: 'In modern South African law we are of course no longer bound by the formal actiones of Roman law, but our law also acknowledges that the same facts may give rise to a claim for damages *ex delicto* as well as one *ex contractu*, and allows the plaintiff to choose which he wishes to pursue. See *Van Wyk v Lewis* 1924 AD 438; Hosten (op cit at 262); R G McKerron *Law of Delict* 7th ed at 3; J C Van der Walt in Joubert *The Law of South Africa* vol 8 para 5 at 7 - 11. The mere fact that the respondent might have framed his action in contract therefore does not per se debar him from claiming in delict. All that he need show is that the facts pleaded establish a cause of action in delict.'
That this conclusion applied also to a claim for pure economic loss appears from the very next sentence of the judgment of Grosskopf AJA: 'In the present case we are concerned with a delictual claim for pecuniary loss....' Given that concurrency was in principle permissible, the second question which arose was whether in the circumstances of Lillicrap's case (as alleged, the case having been decided on exception) the engineers owed Pilkington Brothers a legal duty of care in delict over and above their contractual duties. This depended on whether the engineers had acted wrongfully, as distinct from culpably. The Court of Appeal, by a majority, held against Pilkington Brothers for what were essentially reasons of policy. The Court was being invited to extend Aquilian liability, and should react cautiously; there was no need for delictual liability as the position was governed by the contractual arrangements; the parties reasonably expected that such arrangements would apply, and not be circumvented by action in delict; and (distinguishing *Van Wyk v Lewis* 1924 AD 438) there was no infringement of rights of property or person. Grosskopf AJA said at 501G: 'To sum up, I do not consider that policy considerations, require that delictual liability be imposed for the negligent breach of a contract of professional employment of the sort with which we are here concerned.'" Comrie J then went on to make a statement which it is submitted is of considerable significance in the context f the delivery of health care services. He said at 519-520: "It may be noted that Lillicrap was, by the terms of the majority judgment, confined to the case of the negligent performance of a contract to render professional services. It was not put so widely as to refer to persons professing skill in a calling. While many persons financial services have excellent qualifications, I am not aware that they are required to undergo graduate study and rigorous training of the kind which are a *sine qua non* of the right to practise as a professional engineer. It seems to me that on this ground too, Lillicrap's case is technically distinguishable from the present matter."
It must be borne in mind that the judicial debate embodied in these cases centred around Aquilian liability for pure economic loss flowing from a contractual relationship. However, as Comrie J pointed out at the start of his review of the cases that had been decided on this subject since *Lillicrap*: "As far as possible I shall confine the review to cases of pure economic loss, actual or inferred, though it will be seen that such a neat compartmentalisation is not readily achievable." For the sake of convenience, further discussion of the judgment in *Pinshaw* is to be found later on in this chapter in the context of the law of delict. It must be noted however, that the decision in *Lillicrap* came in for significant criticism (See Boberg, *The Law of Delict Vol I: Aquilian Liability* p 15-16 and the critics there listed) much of it for precisely the reason that the approach of the court assumed that compartmentalisation of the law at any level is not only possible but also necessary for reasons which, in distillation, seem to amount to little more than a predilection for purism.

services delivery is a good example of this because it contains elements of constitutional, statutory and common law - this last most notably in the areas of contract and delict. When a public provider is considering its obligations and options in any given situation it needs to know what these are across all of the relevant legal disciplines. The same applies for the patient. Since one particular area of law impacts upon another and may even modify a particular conclusion drawn on the basis of only one legal discipline it is logical to view the issue from a global perspective. Before one can identify the point of law upon which a particular unique situation hinges, one has to examine all of the possibilities. The law of contract is particularly versatile and flexible in terms of relationships *inter partes*. They can exclude the operation of certain legislative provisions by agreement, they can also expressly include them by agreement, they can exclude or include certain legal consequences arising not only from the law of contract but the law of delict and other areas of the common law, the nature of the relationship in contractual terms is very much dependent on the power balance between them and the dynamics of the situation in which they come together which raises all kinds of public policy issues. They may agree on things that are impermissible in terms of public policy or the Constitution or contrary to certain overriding statutory provisions. It would be overly simplistic to consider their relationship only in terms of the law of contract - especially in the context of health services delivery which is so essential to the wellbeing of both the individual and the collective.

5.7 Summary and Conclusions

It seems that while the state undoubtedly as the capacity to enter into contracts with patients for the delivery of health care services it is not often that it does so and indeed, it is likely, as for instance in the case of *Edouard*[62], that conscious thought was only given to the existence of a contractual relationship once it became apparent that there was a need to litigate against the state in this matter. The intention to contract is central to the question of whether or not a contract in fact came into being and whilst it may be relatively simple to establish that intention on the part of the patient it is not nearly as simple to do so in respect of the state. Generally speaking,

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62 *Edouard* fn 24 *supra*

from the point of view of the state, only officials having a sufficient degree of seniority and who have been delegated the power to do so can bind the state contractually.

Medical officers and nurses employed within public hospitals to render health services to patients generally do not occupy sufficiently high ranks within the public service to have the delegated authority to bind the state contractually. They would have no need, as employees of the state, to enter into contracts with patients themselves and it is unlikely that in the normal course of their daily activities that they would apply their minds to entering into contracts with patients on behalf of the state. Hospital superintendents, who may well have the power to enter into contracts on behalf of the state in terms of delegations from the head of the relevant provincial department of health, do not consult with patients for this purpose and indeed do not have much direct dealings with patients except possibly where there is a problem.

In terms of the Public Finance Management Act[63] the head of department is the accounting officer of a government department and his or her responsibilities are set out in section 36 of this Act. One of the obligations of an accounting officer is to must settle all contractual obligations and pay all money owing, including intergovernmental claims, within the prescribed or agreed period. In terms of the Act, an accounting officer may not commit a department, trading entity or constitutional institution to any liability for which money has not been appropriated.

There are strict rules with regard to contracts entered into by the state. For instance in terms of section 86(3) of the Public Finance Management Act:

"any person, other than a person mentioned in section 66 (2) or (3), who purports to borrow money or to issue a guarantee, indemnity or security for or on behalf of a department, public entity or constitutional institution, *or who enters into any other contract which purports to bind a department, public entity or constitutional institution to any future financial commitment*, is guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding five years". [writer's italics].

The nature of the responsibilities of an accounting officer in terms of the Public Finance Management Act are such that the accounting officer is unlikely to want to

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63 Fn 2 *supra*

delegate the power to bind the state contractually to a large number of much lower ranking officials such as those who are employed at the 'coal face' in the delivery of health care services. For this reason it is submitted that it is largely a legal fiction to say that a patient contracts with the state for health care services.

The most likely legal scenario is that there is no contractual relationship at all and that patients receive health care services from the state in terms of empowering statutes such as the Health Act[64] and the National Health Act[65] read in conjunction with legislation such as the PAJA. There is legally speaking no need for a contract to govern the relationship between provider and patient since there is sufficient legislation governing the situation already. For instance patients are obliged to pay fees to public hospitals in terms of regulations and they are entitled to health care services in terms of the Constitution and other relevant national and provincial legislation. They would have a claim in delict for damages suffered in consequence of medical malpractice by the state. This said, it is submitted that to the extent that the contractual fiction within the public health sector serves its purpose, as it did in the case of *Edouard*, it is a useful one whose demise is not likely in the foreseeable future.

The position with regard to the private sector is very different as will be shown in the following chapter. The law of contract is alive and well, although flourishing in a somewhat Victorian fashion, with regard to health service delivery in the private sector. Contractual relationships are perhaps more necessary in a milieu in which, in contrast to the public sector, few if any functions and powers regarding health service delivery are derived directly from specific empowering legislation. There is no law that requires private entities to provide health care services. They do so of their own volition. Similarly there is no law which states the nature of the services they must provide. It is largely only the 'how' that is regulated within the private sector as opposed to the 'what' and the 'why'.

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64 Act No 63 of 1977

65 Act No 61 of 2003. It is not yet effective.