Motivation By

THE SOUTH AFRICAN MEDICAL ASSOCIATION

(SAMA)

ON

THE ESTABLISHMENT OF A SEPARATE COUNCIL FOR MEDICAL PRACTITIONERS

1st Draft

A SEPARATE COUNCIL FOR DOCTORS.

INTRODUCTION

The South African Medical Association ("SAMA") is the professional association for doctors in South Africa. Our membership has requested us to examine the possibility of the establishment of a separate statutory council for doctors and we have prepared this document for consideration.

EXECUTIVE SUMMARY

The format of this document:

1. provides a survey of the **historical developments** which gave rise to the Health Professions Council of South Africa HPCSA as it presently exists
2. provides a comparative analysis of the positions in the other two statutory health Councils operating in South Africa
3. provides an international comparison on the two **key structural issues** of -
    a. the extent of **conglomeration** of health professions in their regulation
    b. the extent of **representation** of medical professionals within regulatory authorities
4. provides a global perspective on **medical professionalism** and its relevance to regulation
5. expands on problem areas that doctors have identified with the **functioning** of the HPCSA
6. provides **motivation** for the establishment of a separate and independently functioning statutory council for doctors. We conclude by making a practical recommendation on the way forward.

EXPANDED CONTENT

General

The Health Professions Council of South Africa is presently the body which regulates doctors in South Africa. Our brief is to examine the existing situation and provide motivation for the establishment of a separate council for doctors.

1. SURVEY OF HISTORICAL DEVELOPMENTS

The South African Medical and Dental Council was preceded by four provincial councils. These provincial councils were founded as follows:

Cape Province

Section 18 of the Medical and Pharmacy Act, 1891 established the Colonial Medical Council of the Cape Province which held its first meeting on 4 January 1892.

Natal

The Natal Medical Council was created in terms of section 18 of the Medical and Pharmacy Act of 1896, holding its first meeting on 9 October 1896.

Orange River Colony

The Medicine and Pharmacy council of the Orange River Colony was founded as a result of Ordinance 29 of 1904 and met for the first time on 13 July 1904.

Transvaal

The Transvaal Medical Council was established in terms of Ordinance 29 of 1904, holding its first meeting on 4 January 1905 in Pretoria.

The membership of these councils comprised of two types of representatives. Firstly those that were appointed by the national government of the time, and the second were elected representatives who served for a period of five years. Neither the Colonial Medical Council (of the Cape Province) nor the Natal Medical Council had functioning executive committees. The position was different in the Orange River Colony and Transvaal. The Orange River Colony was tasked, in terms of Ordinance 9 of the Medical and Pharmacy Ordinance to deal with all correspondence, consider all applications for registration of medical practitioners, pharmacists, dentists, midwives and nurses, and to appoint committees to determine regulations with reference to the registration of doctors, pharmacists and dentists.

Medical, Dental and Pharmacy Act 13 of 1928

This Act replaced the provincial councils and made provision for two statutory councils, namely the South African Medical Council and the South African Pharmacists' Commission.

Until 1944 the South African Medical Council was also responsible for the registration of nurses as well as dental technicians. In 1944 the South African Nursing Council was created by the Nursing Act (45 of 1944). In 1945, the South African Dental Technicians' Council was formed and this body took over the registration function.

1971 Amendment to Act 13 of 1928

Act 13 of 1928 was eventually amended in 1971 to make provision for the establishment of professional boards for the so-called supplementary health professions. These boards, although autonomous to a degree, had to report to the Medical and Dental Council. Policy decisions of the Boards were subject to approval by the Council and the administration of the Boards was subsidised financially by the South African Medical and Dental Council. The boards were limited to one representative at council meetings, with a vote only on matters pertaining to resolutions affecting a particular board.

The professional boards that were established in 1971 and subsequently were as follows:

- Physiotherapy
- Optometry

- Medical Technology
- Chiropody (Podiatry)
- Health Inspectors
- Occupational Therapy
- Psychology
- Radiography
- Medical Orthotists and Prothetists
- Speech Therapy & Audiology
- Dietetics
- Oral Hygiene
- Opticical dispensers
- Clinical Technologists

The Health Professions Act 56 of 1974

The Period 1974 - 2008

In 1974 Act 13 of 1928 (as amended) was repealed and replaced by the Medical, Dental and Supplementary Health Service Professions Act 56 of 1974 (known by its short title – the Health Professions Act).

This Act provided for the continuation of the SAMDC and the Professional Boards.
With the advent of the "independant" Ciskei, Transkei. Venda and Boputathswana, the Ciskei and Transkei established their own regulatory authorities, while the practitioners in Venda and Boputatshwana remained under the control of the SAMDC.

In 1995 the SAMDC and the Councils of the Ciskei and Transkei were amalgamated in one body known as the Interim Medical and Dental Council of South Africa. The position of the Professional Boards in terms of powers and finances remained as before.
The Interim Council was tasked to develop the framework for regulation of the health professions. Initial proposals of having one body responsible for all health professions, including nurses, pharmacists and dental technicians, were abandoned. Representatives of the "supplementary health professions" objected to the situation where they had to report to a body consisting mainly of doctors and dentists, so it was decided that a

number of professional boards, including a Medical and Dental Professions Board, would be established.

As basis for this it was agreed that boards would retain autonomy on matters specific to the relevant profession, like standards of education and training, discipline and finance. In terms of the latter it was agreed that boards would have to be self-supporting in terms of financially managing the administration of a board. To achieve this, boards from the previous dispensation that were not financially viable were amalgamated with other boards.

The Health Professions Council, as an over arching body, would have the task of co-ordinating activities of boards, resolving conflict between boards and in general perform a supervisory function. Representation of the boards on the HPCSA was agreed on as mentioned later in this document.

Assets generated by the SAMDC, like the building and investments, were transferred to the HPCSA

Composition of Council

Various amendments to the Health Professions Act have been passed since 1976. For the purposes of the present issue, we will confine our discussion to those amendment Acts which deal with the issue of representation on the Council.

In terms of section 14 of the Health Professions Act, the Minister of Health was empowered, upon the recommendation of the Council, to establish a professional board for any profession in respect of which a register is kept in terms of this Act. The Minister could further regulate the functioning and constitution of such a board. This power to regulate was tempered by the following provision contained in section 15(5):

(5) Regulations relating to the constitution, functions and functioning of a professional board shall at least provide for—

- **the majority of the members of a professional board to be elected by the members of the profession involved**;

- persons representing the community to comprise not less than 20 per cent of the membership of a professional board, with a minimum of one such representative for every profession;

- relevant educational institutions to be represented;

- the health authorities to be represented;

- one or more persons versed in law to be appointed, where appropriate;

- the establishment by a professional board of such committees as it may deem necessary, each consisting of so many persons appointed by the board as the board may determine, but including at least one member of the board who shall be the chairperson of such committee, and the delegation to any person or any committee so established, such of its powers as it may from time to time determine, but shall not be divested of any power so delegated;

- the procedure to be followed for the appointment and election, as the case may be, of the members of a professional board;

- the election of a chairperson and vice chairperson by the members of a professional board and the powers and functions of such a chairperson and vice chairperson; and

- the term of office of the members of a professional board"

As can be seen from the above, the professional board was primarily elected from the ranks of the profession concerned.

With regard to the composition of the Council, the following applied (section 5):
"5. Constitution of council.—(1) The council shall be representative and shall consist of the following members, namely—

- **not more than 25 persons designated by the professional boards, on a basis proportional to the number of persons registered to practise the professions falling under each professional board: Provided that each professional board shall be entitled to designate at least one person registered in terms of this Act;**

- one person in the employment of the Department of Health, appointed by the Minister;

- one person in the employment of the Department of Education, appointed by the Minister of Education;

- nine persons registered in terms of this Act, appointed by the Minister;

- one person from the South African Medical Services, appointed by the Minister of Defense;

- three persons appointed by the Committee of University Principals;

- two persons appointed by the Committee of Technikon Principals;

- nine public representatives, one from each province, appointed by the Member of the Executive Council responsible for health in each province: Provided that such representatives shall not be persons registered in terms of this Act;

- one person versed in law, appointed by the Minister."

Health Professions Amendment Act, 2008

The Health Professions Act 56 of 1974 has since been amended via the Health Professions Amendment Act 29 of 2007. A major concern for doctors is the manner in which the new Amendment Act alters the composition of the HPCSA and the professional boards. These amendments,

- Make clear and more comprehensive the objects and functions of council in order to ensure that the objectives are achieved in line with the national health policy determined by the Minister;

- Reduce the number of council members from 25 to 16, and to further regulate the appointment of the president and members of the council and the registrar;

- Empower the Minister to appoint members of the professional boards on the basis of nominations as opposed to elections by members of the profession concerned;

- Empower the Minister, after consultation with the council and the board, to make regulations relating to unprofessional conduct as opposed to this function being performed by the council only;

- Empower the Minister to make regulations "after", and not "in" consultation with the council.

Conclusions

During the normal window for public comments on the Health Professions Amendment Act, 2008, SAMA attempted various forms of constructive engagement aimed at voicing its objections to key aspects of the new amendments. The gist of SAMA's concerns and objections is listed above, under the said Act. Briefly, in order to engage, the following activities were undertaken:

- A comprehensive written submission was forwarded to the Parliamentary Portfolio Committee for Health (PPCH)
- Numerous requests to make verbal presentations in parliament were unsuccessful.
- Numerous attempts to get direct audience with the chairperson of the Portfolio Committee were ignored.

A major frustration for SAMA during this period was the unwillingness, on the part of the authorities, to engage with the substantive objections. In the 'Introduction' section of SAMA's written submission, it was clearly stated that "SAMA supports all legislative measures aimed at accentuating the protection and promotion of public interest and public health. However, it is SAMA's belief that certain Sections of the Bill are unlikely to positively contribute to the aforesaid objectives. Furthermore, it is our view that the promulgation of the Bill, without taking cognizance of the comments contained herein may well lead to compromising public interests and may render the Bill, once promulgated, subject to legal challenge". In spite of this SAMA deliberately chose not to follow the litigation route.

It is also clear from the above survey of the development and coming into being of the HPCSA in its current form that there was, at all stages a degree of governmental influence in the composition of the governing body. Ministerial appointments of Council members have always occurred to a greater or lesser extent. It would therefore be unrealistic to expect this feature of the professional regulator to change. However, level of governmental influence should not be to the extent of disempowering members of the profession, and this is a principle that must be upheld.

There was a notable exception immediately subsequent to 1994, where the Council was elected in a fully democratic fashion. Regrettably the outcome of this election did not result in a demographically representative Council. The HPCSA and the Professional Boards, led by The Medical and Dental Professions Board, reviewed the election system and implemented demographic criteria to be met at the first election subsequent to that of 1999. This resulted in a minimum of 60% of board members being elected from designated groups

It is also clear from the recent amendments of the Act (listed above) that there has been further marginalization of the very professionals whose objects it seeks to regulate. The intentional marginalization of health professionals is further pointed out in the section: *"Comment on the objectives as outlined in the explanatory notes to the Act"* . Here, it is stated that a point of departure is to understand that the primary

accountability of Statutory Councils is to the public and their function is to protect and promote public interest, as opposed to serving the interests of those governed by Councils. Clearly the objects and functions of the council should be to protect the public and promote public interest, as well as to simultaneously promote the professional interest of those regulated by the council.

2. Comparative analysis of the positions in other statutory Councils

The Nursing Council

The Nursing Council was established by means of the Nursing Act 45 of 1944. This Act amended subsequently by Act 69 of 1957, Act 50 of 1978 and replaced by Act 33 of 2005. Throughout the various incarnations of the Nursing Act, the Nursing Council's concerned have always contained members that were appointed by Ministers and, in this respect there was and continues to be a very similar position to the HPCSA (and its predecessors)

Composition of Council.—(1) (a) The Council consists of not more than 25 members, of whom 14 must be registered in terms of section 31 (1) (a) and (b), appointed by the Minister taking into account their expertise in nursing education, nursing, community health, primary health care, occupational health and mental health.

(b) Of the 25 members—

- one person must be an officer of the national department;
- one person must have special knowledge of the law;
- one person must have special knowledge of financial matters;
- one person must have special knowledge of pharmacy;
- one person must have special knowledge of education;
- one person must have knowledge of consumer affairs;
- three persons must represent communities;
- one person must be registered in terms of section 31 (1) (c); and
- one person must be registered in terms of section 31 (1) (d).

The Pharmacy Council

The Pharmacy Act 53 of 1974 established the Interim Pharmacy Council, which has subsequently become the Pharmacy Council. As with the Nursing council and the HPCSA, a number of the representatives on the Pharmacy Council are appointed by the Minister, either as a result of nominations or directly on the discretion of the Minister.

Constitution of council.—

(1) The council shall consist of 25 persons elected or appointed as follows:

- nine pharmacists registered with the council, resident in the Republic of South Africa and elected by pharmacists;
- nine pharmacists nominated by the Members of the Executive Council responsible for health matters in the provinces of the Republic and appointed by the Minister;
- an officer of the Department appointed by the Minister;
- two pharmacists who are members of the staff of a university at which provision is made for the education and training of pharmacists, nominated by such a university and appointed by the Minister: Provided that such pharmacists shall not be from the same university;
- four other persons appointed by the Minister, one of whom shall be a person appointed on account of his or her legal knowledge.

Conclusion

It is therefore clear that the positions in the Nursing and Pharmacy Councils are essentially the same as the HPCSA in respect of influence and, to a certain extent, control by the Minister of Health. It must be noted though that out of the 25 member councils, the number of councilors with the professional training background of the relevant professions is 16 and 20 for nurses and pharmacists respectively. By comparison it has been argued earlier that with the HPCSA, the number of representatives from the professional boards has recently been decreased from 25 to 16, further diluting the professional voice in the council. Previously representatives from

professional boards comprised 25 out of a council of 47 members, this is what has now been decreased to 16.

3. A Survey Of International Councils and Comparison On The Two Key Structural Issues of Representation and Conglomeration

Comparison of Representation

We have conducted a short survey of the positions in a selection of other countries with regard to the composition of their respective statutory medical councils.

In general there is consistency in that the councils are composed of a combination of elected representatives from the profession, representatives of academic institutions and appointed members of government (provincial and national).

Ghana

The Medical and Dental Council of Ghana is composed as follows:

Chairman

7 Elected representatives

4 Representatives from universities

6 Representatives of Government departments (including 2 persons nominated by the minister of Health)

Malawi

The Medical Council of Malawi consists of the following membership:

The Chief of health Services of the Ministry of Health as ex officio member

1 medical practitioner serving in the public service

1 dentist serving in the public service

1 medical practitioner representing the Christian Health Association of Malawi

5 members who are medical practitioners or dentists representing the Medical Association of Malawi.

1 medical practitioner representing the College of medicine

The Secretary for Justice and Solicitor General as ex officio member

At least 3 other members from the general public, one of whom is a medical practitioner or a dentist in the private sector

Singapore

The Singapore Medical Council consists of:

The Director of Medical Services

2 registered medical practitioners appointed by the Minister (of Health) on the nomination of the Council of the National University of Singapore, one of whom shall be the Dean of the Faculty of medicine of that university

9 registered medical practitioners (resident in Singapore) elected by the fully registered medical practitioners resident in Singapore

7 registered medical practitioners (resident in Singapore) appointed by the Minister

India

The Medical Council of India consists of the following members:

1 member from each state other than a Union territory to be nominated by the Central Government in consultation with the State Government concerned

1 member from each university, to be elected from amongst the members of the medical faculty of the University by members of the Senate of the university, or in case the University has no senate, by members of the Court

1 member from each State in which a State register is maintained to be elected amongst themselves

7 members to be elected among themselves

8 members to be nominated by the Central Government

Pakistan

The Pakistan medical and Dental Council comprises the following:

1 medical member to be elected by the National Assembly from amongst its members

1 medical member from each province to be nominated by the Provincial Government generally the Secretary of Health of the respective Provincial Government

1 member to be elected from amongst the members of the Syndicate of each Pakistani University from amongst the members of the Medical Faculty and Dental Faculty of the

University or, if the University has both a Medical and Dental Faculty, from amongst the members of the two faculties

4 members to be elected from amongst themselves by the registered medical practitioners (one from each province)

4 members to be nominated by the Central Government, of whom at least one is a member of the Armed Forces Medical Services

2 members to be elected from amongst themselves by the registered dentists

1 member to be elected by the teaching staff of each Medical and Dental Institution in Pakistan from amongst the Professors on its staff.

1 member, belonging to the legal profession, to be nominated by the Chief Justice of Pakistan

The Director General of Health, Government of Pakistan (ex officio)

Ireland

The Medical Council of Ireland has 25 members including elected and appointed members. The Council is comprised of 13 non-medical members and 12 medical members representing a range of medical specialties, teaching bodies and members of the public and stakeholders, all of whose appointments have been approved by the Minister of health and Children

Canada

The provinces in Canada each has its own regulatory authority, and the Medical Council of Canada has limited powers.

The Medical Council of Canada consists of the following:

The Registrar and one other appointee from each provincial and territorial medical regulatory authority

1 member from each university in Canada that has a medical school

5 members from the public

2 student representatives

2 post graduate resident representatives

Summary

It is evident that in all instances, except India, the majority of council members are from the professional ranks of those whom the council seeks to regulate. This makes the composition of the HPCSA an anomaly by comparison. In the context of this, it is difficult to understand how the recent Health professions Amendment Act 29 (2007) can be justified. This difficulty in understanding extends to the entire HPCSA, in its current form.

Comparison of Conglomeration

COUNTRY	PROFESSION	REGULATOR
UK	**Doctors**	General Medical Council
UK	*Dentists*	General Dental Council
USA	**Doctors**	Medical Board in each state
USA	*Dentists*	Dental board in each state
Canada	**Doctors**	Medical board in each province
Canada	*Dentists*	Dental board in each province
India	**Doctors**	Medical Council of India
India	*Dentists*	Dental Council of India
Malaysia	**Doctors**	Malaysian Medical Council
Malaysia	*Dentists*	Malaysian Dental Council
Singapore	**Doctors**	Singapore Medical Council
Singapore	*Dentists*	Singapore Dental Council

Table-1: Name of Regulator (For Doctors and Dentists) by Country

Table-I lists a sample of countries that are generally regarded as having prominent medical professions around the globe. –

Observations:

The Federation of State Medical Boards in the USA is a coordinating body on which the state boards have representation, the real power in terms of regulation rests with the various state medical boards)

The United Kingdom is the only country (in table-1) that has any significant conglomeration of professions under one Regulator. In that country, the Council for Professions Supplementary to Medicine regulates 14 different professions, the list of which bears a striking resemblance to the professions regulated by the HPCSA in this country. The notable exception is that doctors and dentists are not included in this list since both have separate specific dedicated Regulators respectively.

The rest of the countries in table-1 have one Regulator that only regulates doctors, and no other professions. The same applies to dentists. This trend demonstrates again the anomaly of the South African scenario where doctors and dentists are regulated together with the other health professions under one umbrella Regulator, the HPCSA.

4. A Global Perspective on Medical Professionalism

A comprehensive paper on medical professionalism was presented by the prominent Canadian medical ethicist, Jeff Blackmer, to the World medical Association (WMA) in 2007. In his paper, Blackmer provides a comprehensive definition of medical professionalism as follows:

"Medical professionalism describes the skills, attitudes, values and behaviors common to those undertaking the practice of medicine. It includes concepts such as the maintenance of competence for a unique body of knowledge and skill set, personal integrity, altruism, adherence to ethical codes of conduct, accountability, a dedication to self-regulation, and the exercise of discretionary judgment. Professionalism is also the moral understanding among medical practitioners that gives reality to what is commonly referred to as the social contract between medicine and society. This contract in return grants the medical profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation".

It is worth noting that Blackmer admits that there are numerous definitions for medical professionalism and goes on to describe his own definition as a synthesis of the various

definitions he has come across. A significant emphasis in the definition is the matter of 'self regulation'. He goes on to describe the phenomenon of self regulation as follows:

"Traditionally, as for many of the 'learned professions', physicians have been held responsible for professionally-led self-regulation, which many see as a privilege that must be continually earned. In practice, this requires physicians to form organizations that will receive allegations of professional misconduct or clinical negligence, investigate the complaints, render a judgment and impose a penalty. This activity and process is generally separate from the legal or civil litigation systems of that country. The rationale for self-regulation is that physicians, by virtue of their extensive educational requirements and their unique grasp of a complex body of medical knowledge, obtained through years of training and experience, are felt to be in the best situation to be able to judge their peers.

The argument against self-regulation is that it may be perceived as being overly self serving. As a result, many countries have developed a system of regulation whereby lay members of the public participate actively in the process. In almost all cases, these public members make up a minority of the total membership of the regulatory bodies"

In January 2007 the secretary general of the World Medical Associations (WMA), Otmar Kloiber, released a warning that some governments around the world are working on a global strategy to reduce the influence of the medical profession. In his statement he goes on to argue that when it comes regulation of doctors, the medical profession does at least as good a job as government: In most cases, the self governing bodies do much better, but governments often do not like to accept that".

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In his definition above, Blackmer refers to "unique grasp of a complex body of medical knowledge". It is true that the technological revolution and resultant change in access to medical information have caused doctors, and others, to re-examine the nature of the doctor-patient relationship and the interactions between these two parties. This is an example of a modern day challenge of the doctor that is deeply understood mainly among doctors, especially those in clinical practice.

It has already been argued earlier that the composition of the HPCSA has resulted in the marginalization of the very medical professionals it seeks to regulate. Therefore the structure of the HPCSA contravenes the principle of self regulation, and this has caused widespread dissatisfaction among medical practitioners in South Africa.

5. Some of the current problems with the functioning of the HPCSA

SAMA, acting on behalf of its members and in the interest of the medical profession, has on numerous occasions had interactions with pertinent policies and regulations that were under consideration regarding the HPCSA and its functions. Our experience has been that whenever there has been legislation that introduced objectionable changes to the functioning of the HPCSA, our challenges have consistently proved to be fruitless. An example of this was our well motivated objection to the recently introduced additional powers of the Minister to appoint members of the council. In this instance there was lack of engagement and dialogue on the part of the Regulator, and this left the medical profession frustrated and helpless.

Earlier on we described the structure of the Medical and Dental Board (MDB) and linked it to the structure of the council. It is clear that the design and composition of these two structures automatically lends the MDB to a beurocratic environment. Therefore the MDB cannot be expected to discharge its functions diligently under these circumstances. This has the effect of undermining the contribution of the medical profession in the running of regulatory affairs that affect them directly.

Another weakness in the structure of the HPCSA is the dilution of representation of doctors at Council. This means, doctors can consistently be out-voted, even on those issues they possess unique knowledge on. This can compromise patient care, and by extension the very public interest the council is mandated to protect.

The other way in which the structure of the HPCSA works against the medical profession is that it lends itself to abuse by incumbent officials. The lack of accountability to constituent professions, which are the subjects of its regulatory functions, exposes the medical profession to the risk of authoritarian and autocratic tendencies. When these

risks materialize, the lack of avenues for remedy is another cause of frustration for the medical profession.

Doctors are of the view that the registration fees which are payable by them to Council are disproportionately high in comparison to other registered categories within the HPCSA. This is a unique feature of the HPCSA, in that the majority of its finances come from the contribution of medical doctors through their annual subscriptions. This is because doctors constitute the 2nd biggest number of all the professions under the HPCSA umbrella (the highest being Basic Ambulance Assistants), as well as paying the 2nd highest annual subscription rate (the highest being Psychologists). On analyzing this combination of both the 'numbers subscribed' and 'subscription rates' for all professions, it is clear that the medical practitioners contribute the bulk of HPCSA revenues by far. While the bulk of its revenues comes from doctors, it is common knowledge that these funds are redistributed within the HPCSA to subsidise the other professions under its umbrella. This is unfair, especially given the level of marginalization of doctors described earlier.

The medical profession, by its nature, deals with weighty issues that require high level engagements and interventions. In this regard it is essential that the medical profession is afforded direct audience with the Minister of Health when it is necessary. The current structure of the HPCSA precludes this direct access, except with the facilitation of the president of council. This will always pose a problem when instances arise where the president is unwilling to do this. It is clear that medical profession can effectively be blocked from having audience with the Minister due to a design defect in the structure and functioning of the HPCSA.

Therefore under the HPCSA, the medical profession cannot affect the implementation of its own decisions, even with the best intentions of the MDB to do so.

6. Motivation For Professional Self Regulation & Establishment Of A Separate And Independently Functioning Statutory Council For Doctors.

The first world health professions conference on regulation was held in May, 2008 in Geneva co-hosted by the World Health Professionals Alliance (WHPA). This conference heard a lot of in-depth discussion of the merits and demerits of professionally led regulation. Some of the statements that were made by the leaders of global health professional organizations after the conference are captured below as follows:

Burton Conrod, President of the FDI World Dental Federation: "We expect the health professions as well as the public to play a major role whenever professional regulation is under discussion. We are confident that self-regulation offers the most effective way of protecting the public. There is no evidence to demonstrate that other models are any better."

Jon Snaedal, President of the World Medical Association: "It is no coincidence that at a time when there is a shortage of health professionals around the world self-regulation is being challenged by governments. Limiting the freedom of health professions to self regulate should not be seen by governments as a way of solving the problem."

Kamal Midha, President of the International Pharmaceutical Federation: "The WHPA will now consider holding another similar conference to follow up the issues we heard this weekend. The public needs to be aware that self-regulation is an effective way of stimulating good practice and preventing poor practice in the interests of the patient."

This conference also heard an input on models of professional regulation, from Margaret Grant, an Australian health regulator. She described five broad forms of regulation as follows:

- **Government regulation** is preferred when professional conduct creates a high risk and/or had a significant impact for a community.

Disadvantages include difficulties in covering all possible eventualities in legislation, leaving the chance of exploitation of ambiguities, the high cost of enforcement, the stifling of innovation and the possible slowness.

- **Self-regulation** offered flexibility to take rapid action to meet new difficulties, and where peers established rules of conduct these were more likely to reflect the concerns of the profession and in turn compliance was therefore more likely.

  A major disadvantage is that rules could be seen to be serving the interests of the professionals rather than the interests of clients or the wider community.

- **Co-regulation**, where standards of practice and conduct established by a profession were referred to in legislation is, she said, a more contemporary approach than government only or self-regulation only.

- In "**meta-regulation**", a profession is responsible for direct regulation but accountable to government, which regulated the Regulators through policy and legislative frameworks

- **Quasi-regulation**, Professional practice is influenced indirectly by other government rules, instruments and standards such as: – public health legislation, tax legislation, funding mechanisms, hospital standards.

The forms of regulation described above are rather pure. The practical reality of professional regulation is more likely to contain elements from more than one of these categories. However the medical profession has always preferred models that are primarily underpinned by self regulation. This has not just been a long standing tradition but, as we have argued here, it is also based on substance and merit. Therefore the South African Medical Association supports the principle of self regulation as the most pragmatic route for the medical and dental professions in this country.
Grant described the critical factors for professional regulation, regardless of any form that has been chosen, as being the three criteria of **effectiveness**, **responsiveness**, and **coherence** with the underlying values of the national legal system.

In this document we have advanced several arguments to show that the current HPCSA is structurally and functionally unsuitable to meet the regulatory needs of doctors and dentists in this South Africa. It is clear that the HPCSA, in its current form, is neither effective nor responsive in the way it deals with many important matters, already described. Therefore it is the considered opinion of SAMA that we must seek the establishment of a separate medical and dental council to see to the regulatory affairs of doctors and dentists in South Africa.

Conclusion

In order to promote the concept of a separate independent statutory council for medical and dental practitioners, we advise that a decision has been taken, in consultation with the South African Dental Association, to include the dental profession as part of this submission. As there is a historical relationship between the medical profession and the dental profession in South Africa, we view it as logical and necessary to have the dental profession on board.

Further, with 17 000 current members as SAMA, we represent more than 50% of medical practitioners in South Africa across all disciplines.

This memorandum to the honorable Minister of Health is a proactive step by SAMA to improve the regulation of the medical and dental professions in South Africa, and consequently optimise the contribution of these professions in our health system. We have endeavored to provide a factual account of past events, as well as a balanced context for the honorable Minister's consideration as he works through this important aspect of our health care delivery process.

Signed: -

Dr Norman Mabasa

Chairman

The South African Medical Association